Agenda Item 7.6.3
Board Meeting: January 23 - 24, 2014
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Annual Review of Board Position Statements:
Position Statements with Substantive Changes

Summary of Request:

Board Position Statements are reviewed on an annual basis. This report contains the existing position statements that have substantive changes.

Current Position Statements with Substantive Changes

15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death
15.6, Board Rules Associated With Alleged Patient "Abandonment"
15.8, Role of the Nurse in Moderate Sedation
15.15, Board's Jurisdiction Over a Nurse's Practice in Any Role and Use of the Nursing Title
15.18, Nurses Carrying Out Orders From Advanced Practice Registered Nurses
15.22, APRNs Providing Medical Aspects of Care for Themselves or Others with Whom There is a Close Personal Relationship.

Overview of Proposed Substantive Changes:

Position Statement 15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death, has additional irreversible signs of death to align with information from the American Heart Association and the Frequently Asked Question (FAQ) - Initiation of CPR - A Nurse's Duty to Initiate. There is an additional reference to the American Heart Association Guidelines.

Position Statement 15.6, Board Rules Associated With Alleged Patient "Abandonment" has both substantive and editorial changes. The substantive changes relate to the new section under the heading Emergency Preparedness and Workplace Violence to provide guidance to nurses in the event of these types of situations. These proposed changes are also reflected in the section headed: Board Disciplinary Action. There are editorial changes throughout the Position Statement including spelling corrections, rule reference changes to align with rule references throughout the Position Statements and some word substitutions. The references at the end of the Position Statement are reordered and one additional reference is added based on the proposed new section in the Position Statement.

Position Statement 15.8, Role of the Nurse in Moderate Sedation, contains editorial and substantive changes. Several spelling corrections are made. References to APRN authorization or recognition have been changed to licensure to align with Board rules and processes. References to the APRN specialty has been changed to population focus to align with Board rules and the Consensus Model. In addition, the work "registered" is added in reference to the advanced practice registered nurse. The substantive change is, after utilizing the Six-Step Decision-Making Model, nurses may determine that using US FDA approved computer-assisted personalized sedation systems are safe when certain safety requirements are met such as, appropriate training and the availability of anesthesis providers should an emergency arise.

Position Statement 15.15, Board's Jurisdiction Over a Nurse's Practice in Any Role and Use of the Nursing Title, reflects amendments to the Nursing Practice Act [Section 301.004 (a) (5)] as a result of S.B. 1058 of the 83rd Regular Session of the Texas Legislature in 2013.

Position Statement 15.18, Nurses Carrying Out Orders From Advanced Practice Registered Nurses, has both editorial and substantive changes. References to the APRN specialty has been changed to population focus to align with Board rules and the Consensus Model. The substantive changes reflect S.B. 406 of the 83rd Regular Session of the Texas Legislature in 2013 regarding prescriptive authority under the delegated authority of a physician and references prescriptive authority agreements throughout the position statement.

Position Statement 15.22, APRNs Providing Medical Aspects of Care for Themselves or Others with Whom There is a Close Personal Relationship, includes both substantive changes and editorial changes. The substantive changes reflect the new changes to Chapter 222, related to Advanced Practice Nurses with Prescriptive Authority. This includes a change to the title of the Position Statement as well as references to specific rule sections within Chapter 222 and explanatory language to guide the APRN. The editorial changes relate to using the abbreviation APRN for advanced practice registered nurses throughout the Position Statement.

Pros and Cons

Pros:
Adoption of the position statements with substantive changes will provide updated guidance to nurses based on current practice standards, and will offer clarification on frequently asked questions.

Cons:
None noted.

Recommendations:

Move to adopt the position statements with substantive changes with allowance for non-substantive word editing for purposes of clarity as may be deemed necessary by Board staff.

15.2 The Role of the Licensed Vocational Nurse in the Pronouncement of Death

LVNs do not have the authority to legally determine death, diagnose death, or otherwise pronounce death in the State of Texas. Regardless of practice setting, the importance of initiating CPR in cases where no clear Do Not Resuscitate (DNR) orders exist is imperative. The Board of Nursing (BON) has investigated cases involving the failure of a LVN to initiate CPR in the absence of a DNR order.

It is within the LVN scope of practice as defined by Rule 217.11(1)-(2) (effective 9/28/2004) and *Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice*, for a LVN to gather data and perform a **focused** assessment regarding a patient, to recognize significant changes in a patient's condition, and to report said data and observation of significant changes to the physician. The LVN's focused assessment should include nursing observations to determine the presence or absence of the following presumptive or conclusive signs of death:

Presumptive Signs of Death

- The patient is unresponsive,
- The patient has no respirations,
- The patient has no pulse,
- Patient's pupils are fixed and dilated,
- The patient's body temperature indicates hypothermia: skin is cold relative to the patient's baseline skin temperature,
- The patient has generalized cyanosis, and

Conclusive Sign of Death

- There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin which does blanch with pressure).
- While these signs of irreversible death would not be expected to be seen in most practice settings, the American Heart Association also includes the following irreversible signs of death:
  - decapitation (separation of the head from the body),
  - decomposition (decay or putrification of the body),
  - rigor mortis (stiffness of the limbs and body that develops 2 - 4 hours after death and may take up to 12 hours to fully develop).

Upon reporting his/her clinical findings to the physician, and in accordance with facility policy, the LVN may accept reasonable physician's orders regarding the care of the client; i.e.: notification of family, postmortem care, contacting the funeral home or appropriate legal authority, documentation; however, a LVN may not accept an order that would require the LVN to "pronounce death," or to complete the state-required "medical certification" of a death that occurs without medical attendance.

Employers are also encouraged to develop policies and procedures directing staff in postmortem care and procedures, including appropriate measures that can be completed while waiting for a return call from the attending physician.

The BON has no jurisdiction over physician practice, facility policies, or the laws regulating pronouncement of death in Texas. Additional information on Texas regulations regarding pronouncement of death may be found in Chapters 193 and 671 of the Texas Health and Safety Code, as well as through the Department of State Health Services. A LVN is not responsible for the actions of a physician who elects to pronounce death by remote-means. Physicians are licensed by, and must comply with, rules promulgated by the Texas Medical Board as well as other laws applicable to the physician's practice setting.

References:

Texas Statutes, Health and Safety Code: http://www.statutes.legis.state.tx.us/

2010 American Heart Association Guidelines for Cardiopulmonary Resusitation and Emergency Cardiovascular Care

(BVNE Statement adopted 06/1999; revised BON statement 01/2006; Revised 01/2007; 1/2008; 1/2009; 1/2011; 01/2012; 01/2013; 01/2014)
(Reviewed - 01/2010)

15.6 Board Rules Associated With Alleged Patient "Abandonment"

The Texas Board of Nursing (BON or Board), in keeping with its mission to protect the public health, safety, and welfare, holds nurses accountable for providing a safe environment for ~~clients~~patients and others over whom the nurse is responsible [~~Rule~~ 22 TAC §217.11(1)(B)]. Though the Nursing Practice Act (NPA) and Board Rules do not define the term *"abandonment,"* the Board has investigated and disciplined nurses in the past for issues surrounding the concept of *abandonment* as it relates to *the nurse's duty to the patient*. The Board's position applies to licensed nurses (LVNs and RNs), including RN's with advanced practice ~~authorization~~licensure (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse Anesthetists) in Texas.

Nurse's Duty ~~To A~~to a Patient

All nurses, regardless of practice setting or position title/role, are required to adhere to the NPA and Board Rules. The "core" rules relating to nursing practice~~, however,~~ are Rules 22 TAC §217.11, Standards of Nursing Practice, and 22 TAC §217.12, Unprofessional Conduct. The standard upon which all other standards are based is 22 TAC §217.11(1)(B) "...promote a safe environment for clients and others." This standard supersedes a~~ny~~ physician's order or facility's policy, and has previously been upheld in a landmark case, *Lunsford v. Board of Nurse Examiners,* 648 S.W. 2d 391 (Tex. App. -- Austin 1983). The concept of the nurse's duty to promote ~~client~~patient safety also serves as the basis for behavior that could be considered unprofessional conduct by a nurse.

Patients under the care of a nurse are vulnerable by virtue of illness, injury, and/or the dependent nature and unequal power base of the nurse-patient relationship. Persons who are especially vulnerable include the elderly, children, the mentally ill, sedated and anesthetized patients, those whose mental or cognitive ability is compromised, and patients who are physically disabled, immobilized, restrained, or secluded. It is this dual-vulnerability (patient status and nurse's power base) that creates the nurse's duty to protect the ~~client~~patient. The distinction between a nurse leaving employment versus a nurse violating a duty to a patient through leaving an assignment is often confused. The first is an employment issue; the other is potentially a licensure issue.

There is also no routine answer to the question, *"When does the nurse's duty to a patient begin?"* The nurse's duty is not defined by any single event such as clocking in or taking report. From a BON standpoint, the focus for disciplinary sanctions is on the relationship and responsibility of the nurse to the patient, not to the employer or employment setting.

Employment Issues

Though the Board has no jurisdiction over employers or employment-related issues, other laws regulating facility licensure may apply certain responsibilities to the employer for provision of ~~client~~patient safety, such as development of effective patient care systems or provision of adequate numbers of qualified staff. Specific requirements for a given facility may be obtained by contacting the applicable licensing authority for the institution.
The Board believes that the following additional examples of employment issues would not typically involve violations of the NPA or Board Rules:

- Resignation without advance notice, assuming the nurse's current patient care assignment and/or work shift has been completed.
- Refusal to work additional shifts, either "doubles" or extra shifts on days off.
- Other work-related issues, such as frequent absenteeism or tardiness, or conflicts between staff/employees.

The Board believes nurses should be vigilant and exercise ~~good~~sound professional judgment when accepting assignments that may be requested by employers who need nurses to fill vacant shifts for licensed nursing staff, or other staffing-related situations. *Clear communication* between staff and supervisors is essential to arrive at solutions that best focus on patient care needs without compromising either patient safety or a nurse's license.

Licensure Issues

As previously noted, the rules most frequently applied to nursing practice concerns are ~~Rule~~ 22 TAC §217.11, Standards of Nursing Practice, and ~~Rule~~ 22 TAC §217.12, Unprofessional Conduct. In relation to questions of "abandonment," standard 22 TAC §217.11 (1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing assignment." This standard should not be ~~mis-interpreted~~misinterpreted to mean ~~that the~~a nurse may simply notify the supervisor that he/she is leaving the premises, regardless of whether or not another qualified licensed nurse is available to assume care of the nurse's patients. Specific procedures to follow in a given circumstance (nurse becomes ill, family emergency, etc.) should be delineated in facility policies (which the Board does not regulate).

Some actions may be more obvious examples of unprofessional conduct that could result in sanctions on the nurse's license. Examples of conduct that could lead to Board action on the nurse's license may include:

- Sleeping on the job, which effectively makes the nurse unavailable to observe the patient or respond to the patient's needs, even though the nurse is physically present.
- Simply walking off the job in mid-shift without notifying anyone, and without regard for patient safety;
- Failing to initiate or complete an agreed assignment when the nurse is the sole care provider, and/or the nurse is a consultant or supervisor in a home or homelike setting; and/or failing to notify a supervisor in a timely manner that the assignment will not be done, and/or falsifying records to the effect that the missed nursing visit was indeed completed ; and/or
- Leaving the assigned patient care area and remaining gone~~/~~ or unavailable for a period of time such that the care of any/all patients may be compromised due to lack of available licensed staff.

The Board may impose sanctions on a nurse's license for actions that potentially place patients at risk for harm, or when harm has resulted because a nurse violated his~~/~~ or her duty to the ~~client~~patient by leaving a patient care assignment in a manner inconsistent with the Board Rules.

Emergency Preparedness and Workplace Violence

A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during an emergency, including but not limited to disasters, infectious disease outbreaks or bioterrorism. These situations are challenging for all nurses and their employers, therefore the Board recommends policies and procedures be developed, and periodically reviewed, to provide clear guidance and direction to nurses in order for patients to receive safe and effective care.

The Occupational Safety and Health Administration (OSHA) defines workplace violence to include "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (OSHA website). A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during a violent situation that may occur in the workplace. For example, when an active shooter is present in the workplace, the nurse should take steps to protect patients if there is time and using a method that does not jeopardize the nurse's personal safety or interfere with law enforcement personnel. These steps may include evacuating the area or preventing entry to an area where the active shooter is located. However, during an active shooter situation a nurse may find there is not sufficient time to do anything but to ensure his or her own safety. In this instance, as soon as the situation has resolved the nurse should promptly resume care of patients.

Board Disciplinary Actions

Complaints of "patient abandonment" when it is obvious from the allegation that it is an employment issue will not be investigated by the Board. In these circumstances, however, both parties (the nurse and the employer) may be advised to strive for alternate solutions to avoid similar situations in the future.

Some general factors that would be considered in investigating a complaint of leaving an assignment by a nurse would include, but not be limited to:

- the extent of dependency or disability of the patient;
- stability of the patient;
- the length of time the patient was deprived of care;
- any harm to the patient/level of risk of harm to the patient;
- steps taken by the nurse to notify a supervisor of the inability to provide care;
- previous history of leaving a patient-care assignment;
- emergencies that require nurses to respond, including but not limited to disasters, disease outbreaks, and bioterrorism;
- workplace violence, including but not limited to an active shooter situation;
- other unprofessional conduct in relation to the practice of nursing;
- general nurse competency regarding adherence to minimum nursing standards.

As with all allegations received by the Board, the alleged conduct by a nurse will be thoroughly investigated to determine what, if any, violations of the NPA and rules have occurred. If evidence of violations exists, the Board must then determine what level of sanction is appropriate to take on the nurse's license, and what specific stipulation requirements will be applied. Depending upon the case analysis, Board actions may range from the case being closed with no findings or action, all the way to suspension and/or revocation/voluntary surrender of the nurse's license.

Safe Harbor Peer Review:

If a nurse feels he/she is being asked to accept an assignment that would potentially cause the nurse to violate his/her duty to a patient, the nurse may be able to invoke "safe harbor," depending on whether or not the nurse's employer meets requirements that would make it mandatory for the employer to have a peer review plan in place. This is established in the NPA, Chapter 303 Peer Review, and in 22 TAC §217.20 Safe Harbor Peer Review and Whistleblower Protections. Safe Harbor has two effects related to the nurse's license:

1. It is a means by which a nurse can request a peer review committee determination of a specific situation in relation to the nurse's duty to a patient; and

2. It affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with ~~Rule~~ 22 TAC §217.20. For the nurse to activate this immunity status, the nurse must notify the assigning supervisor at the time the assignment request is made, and the nurse must submit the required information in writing as specified in ~~Rule~~ 22 TAC §217.20(d)(3)(A) or on the Board's Safe Harbor Quick Request Form.

Links to Related Articles ~~(all of the following are located on the Board's web page)~~:
- ~~Safe Harbor Form http://www.bon.texas.gov/practice/safe.html~~
- FAQ on Floating http://www.bon.texas.gov/practice/faq-floating.html
- FAQ on Overtime/Hours of Work http://www.bon.texas.gov/practice/faq-overtime.html
- FAQ on Peer Review http://www.bon.texas.gov/practice/faq-peerreview.html
- FAQ on Staffing Ratios http://www.bon.texas.gov/practice/faq-staffing.html
- ~~FAQ on Floating http://www.bon.texas.gov/practice/faq-floating.html~~
- FAQ on When Does a Nurse's Duty to a Patient Begin and End http://www.bon.texas.gov/practice/faq-nurseduty.html
- Safe Harbor Form http://www.bon.texas.gov/practice/safe.html
- United States Department of Labor, Occupational Safety and Health Administration: Workplace Violence https://www.osha.gov/SLTC/workplaceviolence/

(Adopted 01/2005; Revised 01/2006; 01/2007; 01/2009; 01/2011; 01/2014)
(Reviewed - 01/2008; 01/2010; 01/2012; 01/2013)

15.8 Role of the Nurse in Moderate Sedation
*Note: This position statement is **not** intended to apply to either:*

(1) The practice of the registered nurse who holds licensure ~~authorization to practice~~ as an advanced practice registered nurse in the role and population focus ~~specialty~~ of nurse anesthetist (CRNA) functioning within his/her authorized scope of practice, or to

(2) The Registered Nurse practicing in an acute care setting, such as critical care, where the patient in question is intubated, receiving mechanical ventilatory support, and continuously monitored by the patient care RN.

Role of the LVN:

The administration of pharmacologic agents via IV or other routes for the purpose of achieving moderate sedation requires mastery of complex nursing knowledge, advanced skills, and the ability to make independent nursing judgments during an unstable and unpredictable period for the patient. It is the opinion of the Board that the one-year vocational nursing program does not provide the Licensed Vocational Nurse (LVN) with the educational foundation to assure patient safety for optimal anesthesia care inclusive of both the administration of pharmacologic agents intended to induce moderate sedation and/or assessment and monitoring of the patient receiving moderate (conscious) sedation.

In alignment with 22 TAC §217.11, *Standards of Nursing Practice*, Board Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, and Board Position Statement 15.10, *Continuing Education: Limitations for Expanding Scope of Nursing Practice,* the Board also maintains that continuing education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to both medication administration and patient monitoring associated with moderate sedation.

Though the Board cannot dictate physician practice, it is the Board's position that a LVN cannot administer medications or monitor patients receiving moderate sedation as a delegated medical act.

Role of the RN or non-CRNA Advanced Practice Nurse:

Though optimal anesthesia care is best provided by qualified certified registered nurse anesthetists (CRNAs) or anesthesiologists, the Board recognizes that the demand in the practice setting necessitates provision of moderate sedation by registered nurses and non-CRNA advanced practice nurses in certain practice situations.

All licensed nurses practicing in Texas are required to "know and comply" with the Nursing Practice Act (NPA) and Board Rules. Rule 217.11(1)(B) requires the nurse to "promote a safe environment for clients and others." This standard establishes the nurse's duty to the patient/client, which **supersedes any physician order or any facility policy.** This "duty" to the patient requires the nurse to use informed professional ~~judgement~~judgment when choosing to assist or engage in a given procedure. [See Position Statement 15.14 Duty of a Nurse In Any Practice Setting].

As the NPA and rules are not prescriptive to specific tasks a nurse may or may not perform, a RN or non-CRNA advanced practice registered nurse should consider evidence-based practice guidelines put forth by professional organizations with clinical expertise in the administration of pharmacologic agents used for sedation/anesthesia as well as advanced airway management and cardiovascular support. A number of professional specialty organizations have well-defined standards and recommendations for ongoing nursing education and competency assessment related to administration and monitoring of patients receiving moderate sedation.

These organizations include the American Association of Nurse Anesthetists (AANA), the American Nurses Association (ANA), the Association of PeriOperative Registered Nurses (AORN), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) The AWHONN position statement is also endorsed by the American Association of Critical Care Nurses (AACN). Statements published by the American Society of Anesthesiologists (ASA) also support the positions of the above nursing organizations. The Board advises the nurse use caution in applying moderate sedation standards of any individual or specialty group who are not also experts in the field of advanced airway management/anesthesia. The Board encourages the use of the BON's "Six-Step Decision-Making Model for Determining Nursing Scope of Practice."

Employing institutions should develop policies and procedures to guide the RN or non-CRNA advanced practice nurse in administration of medications and patient monitoring associated with moderate sedation. Policies and procedures should include but not be limited to:

- Performance of a pre-sedation health assessment by the individual ordering the sedation and the nurse administering the sedation
- Guidelines for patient monitoring, drug administration, and a plan for dealing with potential complications or emergency situations developed in accordance with currently accepted standards of practice
- Accessibility of emergency equipment and supplies
- Documentation and monitoring of the level of sedation and physiologic measurements (e.g. blood pressure, oxygen saturation, cardiac rate and rhythm)
- Documentation/evidence of initial education and training and ongoing competence of the RN administering and/or monitoring patients receiving moderate sedation

Use of Specific Pharmacologic Agents

It is up to facilities and physicians to determine specific pharmacologic agents to be used to induce moderate sedation. The Board advises the RN or non-CRNA advanced practice registered nurse use caution, however, in deciding whether or not s/he has the competency to administer the specific pharmacologic agents ordered by the physician. What is within the scope of practice for one RN is not necessarily within the scope of practice for another RN. (See references to §217.11 & Six-Step Decision-Making Model above). With regard to this issue, the Board recommends the RN also take into consideration:

1. Availability of and knowledge regarding the administration of reversal agents for the pharmacologic agents used; and
2. If reversal agents do not exist for the pharmacologic agents used or the criteria outlined in (1) above are not met, then the nurse must consider his/her individual

knowledge, skills, and abilities to rescue a patient from un-intended deep sedation/anesthesia using advanced life support airway management equipment and techniques.

RNs or non-CRNA Advanced Practice Registered Nurses Administering Propofol, Ketamine, or Other Anesthetic Agents to Non-Intubated Patients

Of concern to the Board is the growing number of inquiries related to RNs and non-CRNA advanced practice registered nurses administering Propofol, Ketamine, or other drugs commonly used for anesthesia purposes to non-intubated patients for the purpose of moderate sedation in a variety of patient care settings. It is critical for any RN who chooses to engage in moderate sedation to appreciate the differences between *moderate sedation* and *deep sedation/anesthesia.*

Moderate Sedation Versus Deep Sedation Anesthesia

According to the professional literature, "moderate sedation" is defined as a medication-induced, medically controlled state of depressed consciousness. Included in the literature from various professional organizations is the caveat that, while under moderate sedation, the patient at all times retains the ability to independently and continuously maintain a patent airway and cardiovascular function, and is able to respond meaningfully and purposefully to verbal commands, with or without light physical stimulation. Reflex withdrawal to physical stimulation is not considered a purposeful response. Loss of consciousness for patients undergoing moderate sedation should not be the goal and thus pharmacologic agents used should render this result unlikely. If the patient requires painful or repeated stimulation for arousal and/or airway maintenance, this is considered deep sedation.

In a state of deep sedation, the patient's level of consciousness is depressed, and the patient is likely to require assistance to maintain a patent airway. Deep sedation occurring in a patient who is not appropriately monitored and/or who does not have appropriate airway support may result in a life-threatening emergency for the patient. This is not consistent with the concept of moderate sedation as defined in this position statement or the professional literature and is generally considered to be beyond the scope of practice of the RN.

Although Propofol is classified as a sedative/hypnotic, according to the manufacturer's product information, it is intended for use as an anesthetic agent or for the purpose of maintaining sedation of an intubated, mechanically ventilated patient. The product information brochure for Propofol further includes a warning that "only persons trained to administer general anesthesia should administer ~~propofol~~Propofol for purposes of general anesthesia or for monitored anesthesia care/sedation." The clinical effects for patients receiving anesthetic agents such as Propofol may vary widely within a negligible dose range. Though reportedly "short-acting", it is also noteworthy that there are ***no*** reversal agents for Propofol.

As the US FDA approves computer- assisted personalized sedation systems, a nurse utilizing the Six-Step Decision-Making Model for Determining Nursing Scope of Practice may reach a sound decision whether to engage in nursing practice utilizing such a device in accordance with the US FDA approval requirements. US FDA approval requirements for computer-assisted personalized sedation

systems include requirements for completion of training in addition to safety requirements, such as the availability of anesthesia providers. A nurse is required to complete training prior to using any computer-assisted personalized sedation system and is encouraged to retain proof of training.

The patient receiving anesthetic agents is at increased risk for loss of consciousness and/or normal protective reflexes, regardless of who is administering this medication. Again, this is not consistent with the concept of moderate sedation outlined in the professional literature.

Though the RN or non-CRNA advanced practice registered nurse may have completed continuing education in advanced cardiac life support (ACLS) and practiced techniques during the training program, this process does not ensure ongoing expertise in airway management and emergency intubation. The American Heart Association (AHA) cautions ACLS providers about attempting tracheal intubation in an emergency situation since "*Repeated safe and effective placement of the tracheal tube, over the wide range of patient and environmental conditions encountered in resuscitation, requires considerable skill and experience. Unless initial training is sufficient and ongoing practice and experience are adequate, fatal complications may result*."[1] It is also important to note that no continuing education program, including ACLS programs, will ensure that the RN or non-CRNA advanced practice registered nurse has the knowledge, skills and abilities to rescue a patient from deep sedation or general anesthesia. Furthermore, it is the joint position of the AANA and ASA that, "because sedation is a continuum, it is not always possible to predict how an individual patient will respond." These organizations state that anesthetic agents, including induction agents, should be administered only by qualified anesthesia providers who are trained in the administration of general anesthesia.

Therefore, it is the position of the Board that the administration of anesthetic agents (e.g. propofol, methohexital, ketamine, and etomidate) is outside the scope of practice for RNs and non-CRNA advanced practice registered nurses ***except*** in the following situations:

- when assisting in the physical presence of a CRNA or anesthesiologist (the CRNA or anesthesiologist may direct the RN to administer anesthetic agents in conjunction with the CRNA or anesthesiologist intubating or otherwise managing the patients airway)
- when administering these medications as part of a clinical experience within an advanced educational program of study that prepares the individual for licensure as a nurse anesthetist (i.e. when functioning as a student nurse anesthetist)
- when administering these medications to patients who are intubated and mechanically ventilated in critical care settings
- when assisting an individual with current competence in advanced airway management, including emergency intubation procedures
- when utilizing a US FDA approved Computer-Assisted Personalized Sedation System in accordance with the US FDA approval requirements, where appropriate safety requirements are met (such as availability of anesthesia providers) after completing appropriate training.

While the physician or other health care provider performing the procedure may possess the necessary knowledge, skills and abilities to rescue a patient from deep sedation and general anesthesia, it is not prudent to presume this physician will be able to leave the surgical site or abandon the procedure to assist in rescuing the patient. In the case of an appropriately licensed practitioner performing a procedure that can be safely abandoned to rescue or intubate the patient

the RN may administer the anesthetic agent when directed. In this instance, the RN is responsible for accepting the assignment and for knowing the rationale, effects, and correctly administering the medication [22 TAC 217.11 (1)(T) & (1)(C)].

The Board again stresses that the nurse's duty to assure patient safety [Rule 217.11(1)(B)] is an independent obligation under his/her professional licensure that supersedes any physician order or facility policy.[2, 3] It is important to note that the nurse's duty to the patient obligates him/her to decline orders for medications or doses of medications that have the potential to cause the patient to reach a deeper level of sedation or anesthesia. The nurse's duty is outlined in detail in Board Position Statement 15.14 *Duty of a Nurse in Any Practice Setting.*

> **Recommended Reference Article:** The Institute for Safe Medication Practices (ISMP) published an article in the November 3, 2005 Acute Care Edition of the Medication Safety Alert Newsletter titled *"Propofol Sedation: Who Should Administer?"* [http://www.ismp.org/Newsletters/acutecare/articles/20051103.asp]. This article highlights patient safety concerns related to administration of agents, such as Propofol, to non-intubated patients. The concerns mirror-image those of the Board as noted in this position statement.

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[1] American Heart Association in collaboration with International Liaison Committee on Resuscitation, Guidelines 2003 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care: International Consensus on Science, Part 3: Adult Basic Life Support. *Circulation.* 2003; 102(suppl I): page I-100.

[2] American Association of Nurse Anesthetists and American Society of Anesthesiologists. Joint Position Statement, May, 2004, "AANA–ASA Joint Statement Regarding Propofol Administration" http://www.aana.com/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=764

[3] Lunsford vs. BNE, 1983, 648 S.W. 391, Tex. App–Austin 1983

(Board Action 01/1992; Revised 01/2003; 01/2004; 01/2006; 01/2007; 01/2009; 01/2012; 01/2013; 01/2014)
(Reviewed - 01/2008; 01/2010; 01/2011)

15.15 Board's Jurisdiction Over A Nurse's Practice in Any Role and Use of the Nursing Title

An individual who holds licensure as a licensed vocational nurse (LVN) or as a registered professional nurse (RN) or as an advanced practice registered nurse (APRN) in Texas is responsible and accountable to adhere to the Nursing Practice Act and Board Rules which have the force of law with regard to licensed nursing practice in the state of Texas. Standards of Nursing Practice [22 TAC §217.11(1)(T)] require that each nurse practice within the level of his/her educational preparation, experience, knowledge, and physical and emotional ability. The Standards of Nursing Practice establish the nurse's duty to the client. This "duty" requires the nurse to intervene appropriately to protect and promote the health and well being of the client or others for whom the nurse is responsible [22 TAC §217.11(1)(B)].

RNs Functioning in LVN Positions/ RNs or LVNs Functioning in Unlicensed Positions/Nurse Functioning in another Role

The Nursing Practice Act (NPA) and Board Rules do not preclude a RN, including a RN/APRN, from seeking employment in lower positions (such as LVN, unlicensed, or technical positions), with purportedly fewer responsibilities or in roles the nurse has the knowledge, education, experience, and valid certificate or license to perform. However, a nurse, who is also licensed by another state agency, is required to comply with the NPA and Board Rules for any acts that are also within the scope of nursing practice [Tex. Occ. Code Ann. § 301.004 (a) (5)]. The Board holds a licensed registered professional nurse, who is working in a lower level position, or other role, responsible and accountable to the level of education and competency of a RN. Likewise, a LVN working as an unlicensed person, or in another role, is responsible and accountable to the educational preparation and knowledge of a LVN. This expectation does not apply to individuals formerly licensed as LVNs or RNs or APRNs whose nursing license has been retired, placed on inactive status, surrendered, or revoked.

Use of the Title "LVN" or "RN" when Providing Related Services

The use of the titles "Licensed Vocational Nurse," or "LVN," or "Registered Nurse," "RN," or any designation tending to imply that one is a licensed nurse is limited to those individuals appropriately licensed by the Board. The use of titles implying that an individual holds licensure as a nurse in the State of Texas is restricted by law (Tex. Occ. Code Ann. § 301.351, and Board Rule, 22 Tex. Admin. Code § 217.10). A RN is not automatically a LVN and may not use the title LVN unless the RN also holds an active LVN license. The dually licensed RN/LVN will be held to the standards of the RN license even when working as an LVN. The dually licensed RN/APRN will be held to the standards applicable to the APRN role and ~~specialty~~population focus when working as an RN in that role and ~~specialty~~population focus. Use of any protected nursing title by an individual who is not duly licensed as either a LVN or RN in Texas, or who does not hold a valid compact license to practice nursing poses a potential threat to public safety related to this act of deception and misrepresentation to the public who may be seeking the services of a licensed nurse.

In the opinion of the Board, the expressed or implied use of the title "LVN," or "RN," or any other title that implies nursing licensure requires compliance with the NPA and Board Rules. As stated in Rule 217.11(1)(A), the nurse is accountable to adhere to any state, local, or federal laws impacting the nurse's area of practice.

(Board Action 09/1998; Revised. 01/2001; 01/2003; 01/2004; 01/2005; 01/2008; 1/2013; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012)

15.18 Nurses Carrying out Orders from Advanced Practice Registered Nurses

Advanced practice registered nurses (APRNs) are registered nurses who hold licensure from the board to practice as advanced practice registered nurses based on completion of an advanced educational program acceptable to the Board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced practice registered nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings, including, but not limited to, homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice registered nurse acts independently, under the delegated authority of a physician and/or in collaboration with other health care professionals in the delivery of health care services. Advanced practice registered nurses utilize mechanisms, including Protocols, prescriptive authority agreement, or other written authorization, that provide them with the authority to provide medical aspects of care, including the ordering of dangerous drugs, controlled substances, or devices that bear or are required to bear the legend: "Caution: federal law prohibits dispensing without a prescription" or "RX only" or any other legend that complies with federal law. The Protocols, prescriptive authority agreements, or other written authorization may vary in complexity based on the educational preparation and advanced practice experience of the individual advanced practice registered nurse. Protocols, prescriptive authority agreements, or other written authorization are not required to describe the exact steps that an advanced practice registered nurse must take with respect to each specific condition, disease, or symptom. Protocols, prescriptive authority agreements, or other written authorization are not required for nursing aspects of care.

The Board recognizes that in many settings, nurses and advanced practice registered nurses work together in a collegial relationship. A nurse may carry out an advanced practice registered nurse's order in the management of a patient, including, but not limited to, the administration of treatments, orders for laboratory or diagnostic testing, or medication orders. A physician is not required to be physically present at the location where the advanced practice registered nurse is providing care. The order is not required to be countersigned by the physician. The advanced practice registered nurse must function within the accepted scope of practice of the role and ~~specialty~~population focus in which he/she has been ~~authorized~~licensed by the Board.

As with any order, the nurse must seek clarification if he/she believes the order is inappropriate, inaccurate, nonefficacious or contraindicated by consulting with the advanced practice registered nurse or the physician as appropriate. The nurse carrying out an order from an advanced practice registered nurse is responsible and accountable for his/her actions just as he/she would be with any physician order.

(Board Action, 01/2001; Revised 01/2005; 01/2009; 01/2012; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2013)

15.22 APRNs Providing Medical Aspects of Care for ~~Themselves or Others~~ Individuals with ~~Whom~~whom there is a Close Personal Relationship

Advanced Practice Registered Nurses (APRN) often find themselves in situations where they may feel compelled to provide medical aspects of care or prescribe medications for themselves, their family members, or other individuals with whom they have a close personal relationship. APRNs are prohibited from ordering, prescribing or dispensing both medications and devices for personal use [22 TAC §222.10 (a) (2)]. When ordering, prescribing, or dispensing a medication or a device for any person, the APRN is expected to meet all standards of care including assessment, documentation of the assessment, diagnosis, and documentation of the plan of care prior to ordering, prescribing, dispensing, or administering a medication or device [22 TAC 222. 10 (a) (3)].

~~Such practices~~ The practice of providing medical aspects of care for individuals with whom an APRN has a close personal relationship raises a number of ethical questions. The Board is concerned that ~~advanced practice registered nurses~~APRNs in these situations risk allowing their personal feelings to cloud their professional judgment and objectivity. It is the opinion of the Board of Nursing that ~~advanced practice registered nurses~~APRNs should not provide medical treatment or prescribe medications for ~~themselves or~~ any individual with whom they have a close personal relationship.

(Board Action 10/2003; 01/2009; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013)