

**Review of Position Statements:
Current Position Statements with Changes**

Summary of Request:

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

Current Position Statements with Changes

- 15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death
- 15.3, LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
- 15.4, Educational Mobility
- 15.6, Board Rules Associated With Alleged Patient “Abandonment”
- 15.12, Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs
- 15.26, Simulation in Prelicensure Nursing Education

Historical Perspective:

Board position statements do not have the force of law, but are a means of providing direction for nurses on issues of concern to the Board relevant to protection of the public. Board position statements are reviewed annually for relevance and accuracy to current practice, the Nursing Practice Act and Board rules. Several position statements have proposed changes.

Position Statement 15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death, lists more than one conclusive sign of death therefore one word in the applicable section heading was changed.

Position Statement 15.3, LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines has the additional guidance for LVNs, RNs, and employers related to midline catheters. This addition was prompted by e-mail inquiries related to midline catheters and aligns with the current position of the Board.

Position Statement 15.4, Educational Mobility, adds information related to educational mobility for military personnel and veterans.

Position Statement 15.6, Board Rules Associated with Alleged Patient “Abandonment,” deletes one reference to the frequently asked question: When Does a Nurse’s Duty to a Patient Begin and End. When the website redesign was launched in 2014 this frequently asked question was divided into several parts for ease of persons accessing the website. There is not a mechanism to link from the Position Statement to each of the relevant parts.

Position Statement 15.12, Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs, retained one reference to the DSM-IV rather than the current DSM-V.

Position Statement 15.26, Simulation in Prelicensure Nursing Education, has existed on the website as both a position statement and a guideline. The guideline is being revised based on research and to provide guidance to nursing education programs. Elimination of the position statement will decrease any confusion the public could experience from having to reference two documents. Eliminating the duplication will provide a one source document containing the

information and guidance to nursing education programs related to simulation in prelicensure nursing education.

Pros and Cons

Pros:

Adoption of the position statements with changes will provide clear guidance to nurses based on current practice standards.

Cons:

None noted.

Staff Recommendation:

Move to adopt the position statements with 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 22 TAC §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 Signs 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 putrefication 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:

American Heart Association (2010) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

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

(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; [01/2015](#))

(Reviewed - 01/2010)

15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines

The basic educational curriculum for Licensed Vocational Nurses (LVNs) does not mandate teaching of principles and techniques of insertion for peripheral intravenous catheters, or the administration of fluids and medications via the intravenous route. Knowledge and skills relating to maintaining patency and performing dressing changes of central line intravenous catheters is also not mandated as part of basic LVN education. As such, basic competency in management of intravenous lines/intravenous therapy is not a given for any specific LVN licensee.

Applicable Nursing Standards

LVN practice is guided by the Nursing Practice Act (NPA) and Board Rules. 22 TAC §217.11, *Standards of Nursing Practice*, is the rule most often applied to nursing practice issues. Two standards applicable in all practice scenarios include:

- §217.11(1)(B) implement measures to promote a safe environment for clients and others, and
- §217.11(1)(T) accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability.

Additional standards in Rule 217.11 that may be applicable when a LVN chooses to engage in an IV therapy-related task include (but are not limited to):

- (1)(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same,
- (1)(D) Accurately and completely report and document: (i) ..client status....(ii) nursing care rendered...(iii) physician, dentist or podiatrist orders...(iv) administration of medications and treatments....(v) client response(s)...
- (1)(G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices,
- (1)(H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,
- (1)(R) Be responsible for one's own continuing competence in nursing practice and individual professional growth,
- (2)(A) Shall utilize a systematic approach to provide individualized, goal-directed nursing care ...[(i)-(v)], and
- (2)(C) ...perform other acts that require education and training as prescribed by board rules and policies, commensurate with the LVN's experience, continuing education, and demonstrated LVN competencies.

Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, provides additional clarification of the Standards Rule as it applies to LVN Scope of Practice. Instruction and skill evaluation relating to LVNs performing insertion of peripheral IV catheters and/or administering IV fluids and medications as prescribed by an authorized practitioner may allow a LVN to expand his/her scope of practice to include intravenous therapy.

It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central venous catheters, including venipuncture, administration of IV fluids, and/or administration of IV push medications, until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to the LVN's IV therapy practice. The BON does not define or set qualifications for an "IV Validation Course" or for "LVN IV

certification." The LVN who chooses to engage in intravenous therapy must first have been instructed in the principles of intravenous therapy congruent with prevailing nursing practice standards.

Insertion of PICC Lines [or Midline Catheters](#)

The Board has further determined that the one-year vocational nursing program does not provide the Licensed Vocational Nurse (LVN) with the educational foundation to assure client safety in insertion of Peripherally Inserted Central Catheters (PICC lines) [or Midline Catheters](#), inclusive of vein selection, insertion/advancement of the catheter, determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion. Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, [and Position Statement 15.10, Continuing Education: Limitations for Expanding Scope of Practice](#), further 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 insertion of PICC lines [or midline catheters](#). Therefore, it is the Board's position that insertion of PICC lines [or midline catheters](#) is beyond the scope of practice for LVNs.

Administration of IV Fluids and Medications

The ability of a LVN to administer specific IV fluids or drugs, to prepare and/or administer IV "piggy-back" or IV "push" medications, or to monitor and titrate "IV drip" medications of any kind is up to facility policy. The LVN's practice relative to IV therapy must also comply with any other regulations that may exist under the jurisdiction of other regulatory agencies or entities. The LVN who accepts an assignment to engage in any aspect of intravenous therapy is responsible for adhering to the NPA and Board rules, particularly 22 TAC §217.11, *Standards of Nursing Practice*, including excerpted standards listed above and any other standards or rules applicable to the individual LVN's practice.

All nursing actions related to peripheral and/or central intravenous lines, as well as IV administration of medications, must be completed in accordance with the orders of the prescribing practitioner, as well as written policies, procedures and job descriptions approved by the health care employer.

(Board Action: 06/1995; revised 09/1999; 01/2005; 01/2011; 01/2012; 01/2014; [01/2015](#))
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2013)

15.4 Educational Mobility

The Board of Nursing ([Board](#)) supports educational mobility for nurses prepared at the VN, ADN, Diploma and BSN levels and encourages the elimination of needless repetition of experiences or time penalties. Furthermore, the Board encourages existing nursing education programs approved by the Texas Board of Nursing to develop articulation arrangements that specify their policies regarding transfer of academic credits to facilitate educational mobility, especially in underserved areas of the state.

[The Board honors and supports military personnel and veterans and their educational mobility. There are several Board approved education programs that offer articulated credit or other options for military personnel with medical training and/or experience.](#)

(Board Action 01/1989; Revised 01/1992; 01/2005; 01/2008; [01/2015](#))
(Reviewed - 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014)

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 patients and others over whom the nurse is responsible [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 licensure (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse Anesthetists) in Texas.

Nurse’s Duty 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 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 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 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 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 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 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 22 TAC §217.11, Standards of Nursing Practice, and 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 misinterpreted to mean 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 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:

- 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

- It affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with 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 22 TAC §217.20(d)(3)(A) or on the Board's Safe Harbor Quick Request Form.

Links to Related Articles

- 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 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; [01/2015](#))
(Reviewed - 01/2008; 01/2010; 01/2012; 01/2013)

15.12 Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs

The Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses are multi-disciplinary psychiatric diagnoses used for the purpose of applying objective criteria, establishing a practice framework and communicating findings with other health care professionals. The current version is the DSM-5 (Fifth Edition).

In accordance with the Nursing Practice Act (NPA), Section 301.002(2) and (5), acts of medical diagnosis or prescription of therapeutic or corrective measures are beyond the scope of practice for licensed vocational nurses as well as registered nurses who are not Board authorized in an appropriate Advanced Practice Registered Nurse (APRN) role and specialty.

The use of DSM-~~IV~~5 diagnoses by a Registered Nurse recognized by the Board as an Advanced Practice Registered Nurse in the role and specialty of either a Clinical Nurse Specialist (CNS) in Psychiatric/Mental Health Nursing or as a Psychiatric/Mental Health Nurse Practitioner is authorized provided he/she is acting within the scope of his/her advanced practice role and specialty and that the diagnoses utilized are appropriate for the individual APRN's advanced education, experience, and scope of practice. APRNs must also utilize protocols or other written authorization when providing medical aspects of care in compliance with Rule 221 "Advanced Practice Nurses." When patient problems are identified that are outside the CNS/NP's scope of practice or expertise, a referral to the appropriate medical provider is indicated.

(Board Action, 09/1996; revised 01/2005; 01/2006; 01/2008; 01/2009; 01/2010; 01/2011; 01/2014; [01/2015](#))

(Reviewed - 01/2007; 01/2012; 01/2013)

15.26 [Deleted 1/2015](#)