

Review of Position Statements: Current Position Statements with Changes

Summary of Request

Board Position Statements are reviewed on an annual basis. Board staff tracks national practice trends, updated practice guidelines and evidence throughout the year relevant to the Board Position Statements. This report contains the existing position statements with proposed changes for the Board's consideration.

Current Position Statements with Changes

- 15.1, Nurses Carrying out Orders from Physician Assistants
- 15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death
- 15.5, Nurses with Responsibility for Initiating Physician Standing Orders
- 15.7, The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes
- 15.8, Role of the Nurse in Moderate Sedation
- 15.12, Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs
- 15.13, Role of LVNs and RNs in School Health
- 15.20, Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility
- 15.25, Administration of Medication & Treatments by LVNs
- 15.27, The Licensed Vocational Nurse Scope of Practice
- 15.28, The Registered Nurse Scope of Practice

Historical Perspective

Position Statement 15.1, *Nurses Carrying out Orders from Physician Assistants*, can be misinterpreted when taken out of context. A purpose has been added as well as additional clarifying language to avoid confusion. In addition, clarifying language will be added to the introduction to the position statements on the website to indicate that each position statement is meant to provide guidance in the context of the totality of the position statement. Footnotes were added to this position statement to provide additional references.

The American Heart Association (AHA) updates the guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care (ECC) periodically. The 2010 publication has been updated with the 2015 publication. The 2015 publication was reviewed for relevant changes to Position Statements 15.2, *The Role of the Licensed Vocational Nurse in the Pronouncement of Death*, and 15.20, *Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility*. The reference has been updated to reflect the current publication. There are additional proposed changes to Position Statement 15.20, *Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility*. In several places, the word "registered" was placed prior to "nurse" to provide clarity when sentences are extracted from the position statement out of context. In addition, the bold font is extended in the beginning and ending sections to capture the term "registered nurse" as

the subject of the position statement. In some cases, the use of the word “nurse” applies to all levels of licensure even when taken out of the context of the position statement document therefore there are uses of the word “nurse” that are not proposed to be changed. Two new sentences have been added under the heading “Documentation” that serve to educate the intended population of the position statement related to the LVN role as this is a setting where there is a large LVN presence.

There is an editorial change in Position Statement 15.5, *Nurses with Responsibility for Initiating Physician Standing Orders*, related to the ending section number of Chapter 193 in the Texas Medical Board Rules.

In reviewing Position Statement 15.7, *The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes*, it was noted that the referenced Association of Women’s Health, Obstetric and Neonatal Nurses’ (AWHONN) position statement was updated and published January 14, 2015. The title changed slightly and the Board’s position statement has been updated to reflect this change (and also reflects the date references were accessed and verified).

Position Statement 15.8, *Role of the Nurse in Moderate Sedation*, has a few recommended changes in the latter portion of the position statement. The purpose of the changes is to provide clarification for nurses and to align with the FDA approval statement related to the computer-assisted personalized sedation system. There are also changes related to the updated guidelines from the American Heart Association (AHA). The AANA-ASA joint position statement reference was also updated to the most current version.

Position Statement 15.12, *Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs*, has proposed editorial changes in relation to the terms “population focus” and “licensed” for the APRN and an alignment with rule references as used throughout the position statements.

Position Statement 15.13, *Role of LVNs and RNs in School Health*, has updated references to the delegation rules in Chapters 224 and 225. The delegation rule changes in Chapter 225 were effective February 24, 2014 and the delegation rule changes in Chapter 224 were effective January 27, 2015. One additional footnote was also added.

Position Statement 15.25, *Administration of Medication & Treatments by LVNs*, contains editorial changes for clarity.

Similar changes are proposed to Position Statements 15.27, *The Licensed Vocational Nurse Scope of Practice*, and 15.28, *The Registered Nurse Scope of Practice*, related to updated dates on the reference list.

Pros and Cons**Pros:**

Adoption of the position statements with changes will provide clear guidance to nurses and nursing stakeholders 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.

15.1 Nurses Carrying out Orders from Physician's Assistants

The purpose of this position statement is to provide guidance to nurses with regard to carrying out orders from Physician Assistants (PAs).

The Nursing Practice Act (NPA) includes the "administration of medications or treatments ordered by a physician, podiatrist or dentist" as part of the practice of nursing.¹ There are no other health care professionals listed thus leading to questions regarding nurses carrying out orders from other licensed healthcare providers. Although PAs are not included in the NPA, the Board recognizes that nurses work collaboratively with PAs to provide patient care in various practice settings. ~~The Board recognizes that in some practice settings nurses work in collegial relationships with physician assistants (PAs) who may relay a physician's order for a client being cared for by a nurse.~~

~~A nurse may carry out a physician's order for the administration of treatments or medications relayed by a physician assistant (PA) when that order originates with the PA's supervising physician. Supervision must be continuous but does not require the physical presence of a supervising physician at the place where the PA services are performed provided a supervising physician is readily available by telecommunications. The supervising physician should have given notice to the facility that he/she is registered with the Texas Medical Board (TMB) as the supervising physician for the PA and that he/she has authorized the PA to relay orders. The PA must be licensed or registered by the TMB. A list of physician assistants credentialed by the medical staff and policies directing their practice should be available to the nursing staff.~~

The PA is licensed and regulated by the Physician Assistant Board.² PAs may order medical aspects of care as delegated by a physician consistent with laws, rules and regulations applicable to the PA practice including those of the Texas Medical Board (TMB) Chapter 193.³ The order relayed by the PA may originate from a protocol. If the order originates from a protocol, the PA may select specific tasks or functions required to implement the protocol, provided they are within the scope of the protocol. The protocol must be signed by the supervising physician and should be made available as necessary to verify authority to provide medical aspects of care. If the tasks or functions ordered fall outside the scope of the protocol, the PA must consult with the physician to obtain a verbal order before the nurse may carry out the order. As with any order, the nurse must seek clarification if he/she believes the order or treatment is inaccurate, non-efficacious or contraindicated by consulting with the PA and physician as appropriate.⁴ ~~The nurse may request to review the PA's protocol as one mechanism for clarification of orders and treatments. A list of physician assistants credentialed by the medical staff and policies directing their practice should be available to the nursing staff.~~

¹ TOC§301.002(2)

² TOC Chapter 204 and 22 TAC Chapter 185

³ 22 TAC §§185.2 (17); 185.10 and 193.2 (17) & (18)

⁴ 22 TAC §217.11(1)(N)

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 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:

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

[American Heart Association \(2015\) 2015 American Heart Association \(AHA\) Guidelines Update for Cardiopulmonary Resuscitation \(CPR\) and Emergency Cardiovascular Care \(ECC\)](#)

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; [01/2016](#))
(Reviewed: 01/2010; 01/2015)

15.5 Nurses with Responsibility for Initiating Physician Standing Orders

According to the Texas Nursing Practice Act [Tex. Occ. Code Ann. §301.002(3)], the term "Nurse" means "a person required to be licensed under this chapter to engage in professional or vocational nursing." The practice of either professional or vocational nursing frequently involves implementing orders from a physician, podiatrist, or dentist. Timely interventions for various patient populations can be facilitated through the use of physician's standing orders that authorize the nurse to carry out specific orders for a patient presenting with or developing a condition or symptoms addressed in the standing orders.

The specifics of how authorization occurs for a LVN or RN to implement a set of standard physician's orders are defined in the Texas Medical Board's (TMB) Rule 193 (22 Tex. Admin. Code §§193.1-193.1220) relating to physician delegation. This rule holds out two (2) methods by which nurses may follow a preapproved set of orders for treating patients:

- 1) Standing Delegation Orders; and/or
- 2) Standing Medical Orders.

These terms are defined in 22 Tex. Admin. Code §193.2 as follows:

(19) Standing delegation order -- *Written instructions, orders, rules, regulations, or procedures prepared by a physician and designed for a patient population with specific diseases, disorders, health problems, or sets of symptoms. Such written instructions, orders, rules, regulations or procedures shall delineate under what set of conditions and circumstances action should be instituted. These instructions, orders, rules, regulations or procedures are to provide authority for and a plan for use with patients presenting themselves prior to being examined or evaluated by a physician to assure that such acts are carried out correctly and are distinct from specific orders written for a particular patient, and shall be limited in scope of authority to be delegated as provided in §193.4 of this title (relating to Scope of Standing Delegation Orders). As used in this chapter, standing delegation orders do not refer to treatment programs ordered by a physician following examination or evaluation by a physician, nor to established procedures for providing of care by personnel under direct, personal supervision of a physician who is directly supervising or overseeing the delivery of medical or health care. As used in this chapter, standing delegation orders are separate and distinct from prescriptive authority agreements as defined in this chapter. Such standing delegation orders should be developed and approved by the physician who is responsible for the delivery of medical care covered by the orders. Such standing delegation orders, at a minimum, should:*

- (A) include a written description of the method used in developing and approving them and any revision thereof;*
- (B) be in writing, dated, and signed by the physician;*
- (C) specify which acts require a particular level of training or licensure and under what circumstances they are to be performed;*

- (D) state specific requirements which are to be followed by persons acting under same in performing particular functions;*
- (E) specify any experience, training, and/or education requirements for those persons who shall perform such orders;*
- (F) establish a method for initial and continuing evaluation of the competence of those authorized to perform same;*
- (G) provide for a method of maintaining a written record of those persons authorized to perform same;*
- (H) specify the scope of supervision required for performance of same, for example, immediate supervision of a physician;*
- (I) set forth any specialized circumstances under which a person performing same is to immediately communicate with the patient's physician concerning the patient's condition;*
- (J) state limitations on setting, if any, in which the plan is to be performed;*
- (K) specify patient record-keeping requirements which shall, at a minimum, provide for accurate and detailed information regarding each patient visit; personnel involved in treatment and evaluation on each visit; drugs, or medications administered, prescribed or provided; and such other information which is routinely noted on patient charts and files by physicians in their offices; and*
- (L) provide for a method of periodic review, which shall be at least annually, of such plan including the effective date of initiation and the date of termination of the plan after which date the physician shall issue a new plan.*

(20) Standing medical orders -- Orders, rules, regulations or procedures prepared by a physician or approved by a physician or the medical staff of an institution for patients which have been examined or evaluated by a physician and which are used as a guide in preparation for and carrying out medical or surgical procedures or both. These orders, rules, regulations or procedures are authority and direction for the performance for certain prescribed acts for patients by authorized persons as distinguished from specific orders written for a particular patient or delegation pursuant to a prescriptive authority agreement.

A third term, "Protocols", is defined narrowly by the TMB and applies to RNs with advanced practice licensure (APRN) by the BON, or to Physician Assistants only:

(18) Protocols -- Written authorization delegating authority to initiate medical aspects of patient care, including delegation of the act of prescribing or ordering a drug or device at a facility-based practice. The term protocols is separate and distinct from prescriptive authority agreements as defined under the Act and this chapter. However, prescriptive authority agreements may reference or include the terms of a protocol(s). The protocols must be agreed upon and signed by the physician, the physician assistant and/or advanced practice registered nurse, reviewed and signed at least annually, maintained on site, and must contain a list of the types or categories of dangerous drugs and controlled substances available for prescription, limitations on the number of dosage units and refills permitted, and instructions to be given the patient for follow-up monitoring or contain a list of the types or categories of dangerous drugs and controlled

substances that may not be prescribed. Protocols shall be defined to promote the exercise of professional judgment by the advanced practice registered nurse and physician assistant commensurate with their education and experience. The protocols used by a reasonable and prudent physician exercising sound medical judgment need not describe the exact steps that an advanced practice registered nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

By definition, both vocational and professional nursing excludes “acts of medical diagnosis or the prescription of therapeutic or corrective measures”[Tex. Occ. Code Ann. §301.002(2) and (5)]. Based on the above definitions in the TMB rules, RNs who do not have advanced practice licensure from the BON may not utilize "protocols" to carry out physician orders. Likewise, vocational nurses (LVNs) are also prohibited from utilizing protocols as defined by the TMB, as neither LVNs nor RNs may engage in acts that require independent medical judgment.

A nurse responsible for initiating physician's standing medical orders or standing delegation orders may select specific tasks or functions for patient management, including the administration of a medication required to implement the selected order provided such selection is within the scope of the standing orders. The selection of such tasks or functions for patient management constitutes a nursing decision that may be carried out by a LVN or RN. In addition, this position statement should not be construed to preclude the use of the term “protocol” for a standard set of orders covering the monitoring and treatment of a given clinical condition (e.g., insulin protocol, heparin protocol, ARDS protocol, etc.) provided said standard orders meet the requirements for standing delegation or standing medical orders as defined by the TMB.

The written standing orders under which nurses function shall be commensurate with each nurse’s educational preparation and experience. The nurse initiating any form of standing orders must act within the scope of the Nursing Practice Act, Board Rules and Regulations, and any other applicable local, state, or federal laws.

(Board Action: 07/1988; Revised: 01/1992, 07/2001; 01/2005; 01/2006; 01/2007; 01/2009; 01/2011; 01/2014; [01/2016](#))

(Reviewed: 01/2008; 01/2010; 01/2012; 01/2013; 01/2015)

15.7 The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes

Role of the LVN

The LVN can provide basic nursing care to patients with epidural or intrathecal catheters. It is the opinion of the Board that the licensed vocational nurse shall not be responsible for the management of a patient's epidural or intrathecal catheter including administration of any medications via either epidural or intrathecal catheter routes. Management of epidural or intrathecal catheters requires the mastery of complex nursing knowledge and skills that are beyond the competencies of the vocational nursing program or a continuing education course.

Role of the RN

The Board has determined that it may be within the scope of practice of a registered professional nurse to administer analgesic and anesthetic agents via the epidural or intrathecal routes for purposes of pain control. As with all areas of nursing practice, the RN must apply the Nursing Practice Act (NPA) and Board Rules to the specific practice setting, and must utilize good professional judgment in determining whether or not to engage in a given patient-care related activity.

The Board believes that only licensed anesthesia care providers as described by the American Society of Anesthesiologists and the American Association of Nurse Anesthetists, as authorized by applicable laws should perform insertion and verification of epidural or intrathecal catheter placement. Consistent with state law, the attending physician or the qualified provider must order the drugs, dosages, and concentrations of medications to be administered to the patient through the catheter. These interventions are beyond the scope of the registered professional nurse in that independent medical judgment and formal advanced education and skills training are required to achieve and maintain competence in performing these procedures.

RNs who choose to engage in administration of properly ordered medications via the epidural or intrathecal routes must have documentation that the RN has participated in educational activities to gain and maintain the knowledge and skill necessary to safely administer and monitor patient responses, including the ability to:

- Demonstrate knowledge of the anatomy, physiology, and pharmacology of patients receiving medications via the epidural or intrathecal routes;
- Anticipate and recognize potential complications of the analgesia relative to the type of infusion device and catheter used;
- Recognize emergency situations and institute appropriate nursing interventions to stabilize the patient and prevent complications;
- Implement appropriate nursing care of patients to include:
 - a) observation and monitoring of sedation levels and other patient parameters;
 - b) administration and effectiveness of medication, catheter maintenance and catheter placement checks;
 - c) applicable teaching for both patients and their family/significant others related to expected patient outcomes/responses and possible side effects of the medication or treatment; and
 - d) knowledge and skill to remove catheters when applicable.

Appropriate nursing policies and procedures that address the education and skills of the RN and nursing care of the patient should be developed to guide the RN in the administration of epidural and/or intrathecal medications. RNs and facilities should consider evidence-based practice guidelines put forth by professional specialty organizations(s), such as the American Association of Nurse Anesthetists and the American Society of Anesthesiologists when developing appropriate guidance for the RN in a particular practice setting. For example, the Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) has a clinical position statement on "Role of the Registered Nurse ~~(RN)~~ in the Care of the Pregnant Woman Receiving Analgesia/Anesthesia by Catheter Techniques ~~(Epidural, Intrathecal, Spinal, PCEA Catheters)~~." This nationally recognized practice guideline states that it is beyond the scope of practice of the obstetrical nurse to institute or change the rate of continuous infusions via epidural or intrathecal catheters. The American Association of Nurse Anesthetists has a similar position.

The Board also encourages the use of the BON's "Six-Step Decision-Making Model for Determining Nursing Scope of Practice." Finally, standing medical orders approved by the medical and/or anesthesia staff of the facility should include, but not necessarily be limited to, the following:

- 1) The purpose and goal of treatment;
- 2) The dosage range of medication to be administered including the maximum dosage;
- 3) Intravenous access;
- 4) Treatment of respiratory depression and other side effects including an order for a narcotic antagonist;
- 5) Options for inadequate pain control; and
- 6) Physician/CRNA availability and back-up.

References

American Association of Nurse Anesthetists (2011) Provision of pain relief by medication administered via continuous catheter of other pain relief devices. Accessed ~~12/4/2013~~ [12/10/2015](#) from:

<http://www.aana.com/resources2/professionalpractice/Documents/PPM%20PS%202.8%20Continuous%20Catheters%20and%20Devices.pdf>.

Association of Women's Health, Obstetric, and Neonatal Nurses (~~2007~~[2015](#)) Role of the registered nurse ~~(RN)~~ in the care of the pregnant woman receiving analgesia/ [and](#) anesthesia by catheter techniques ~~(epidural, intrathecal, spinal, PCEA catheters)~~. Accessed ~~12/4/2013~~ [12/10/2015](#) from:

http://www.awhonn.org/awhonn/binary.content.do?name=Resources/Documents/pdf/5_Epidural.pdf. ~~http://onlinelibrary.wiley.com/doi/10.1111/1552-6909.12532/epdf~~

(LVN role: BVNE 1994; Revised: BON 01/2005) (RN role: BON 06/1991; Revised: 01/2003; 01/2004; 01/2005; 01/2011; 01/2014; [01/2016](#))

(Reviewed: 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015)

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 as an advanced practice registered nurse in the role and population focus 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. 22 TAC §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 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 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 is encouraged to use ~~utilizing~~ the Six-Step Decision-Making Model for Determining Nursing Scope of Practice ~~may to~~ 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 [immediate](#) 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.”⁴~~ [has identified factors that contribute to misplacement of the endotracheal tube during resuscitation including: “inadequate training, lack of experience” and patient characteristics such as physiology and movement.](#)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.”² 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 [immediate](#) 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 [22 TAC §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.

~~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.~~

~~1 American Heart Association (2015) Guidelines for CPR & ECC. Retrieved from: <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/>~~

~~2 American Association of Nurse Anesthetists and American Society of Anesthesiologists. (2013) *Joint Position Statement, May, 2004, Regarding Propofol Administration*" "AANA-ASA Joint [Position Statement](#) Regarding Propofol Administration"~~

~~<http://www.aana.com/resources2/professionalpractice/Documents/PPM%20PS%20Joint%20AANA-ASA%20Propofol.pdf>~~

~~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; [01/2016](#))

(Reviewed: 01/2008; 01/2010; 01/2011; 01/2015)

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~~ [licensed](#) in an appropriate Advanced Practice Registered Nurse (APRN) role and [specialty population focus](#).

The use of DSM-5 diagnoses by a Registered Nurse ~~recognized~~ [licensed](#) by the Board as an ~~Advanced Practice Registered Nurse~~ [APRN](#) in the role and [specialty population focus](#) 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 population focus](#) 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 22 TAC §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; [01/2016](#))

(Reviewed: 01/2007; 01/2012; 01/2013; 01/2015)

15.13 Role of LVNs and RNs in School Health

The Board of Nursing (BON) recognizes that the youth of Texas are our most valuable natural resource. The BON acknowledges that although students come to school with complex and diverse health care needs, they should be provided an education in the least restrictive environment. The BON recognizes that the school children of Texas have the right to receive safe, appropriate, specialized health services that may be required to assure the child's inclusion in the school environment.

Registered Nurses in the School Setting

The Texas Education Agency defines a school nurse in 19 Texas Administrative Code (TAC) §153.1022 (a) (1) (D) as "... an educator employed to provide full-time nursing and health care services and who meets all the requirements to practice as a registered nurse (RN) pursuant to the Nursing Practice Act and rules and regulations relating to professional nurse education, licensure, and practice and has been issued a license to practice professional nursing in Texas." The ~~Board of Nursing (BON)~~ believes that school nursing is a professional registered nursing (RN) specialty. School nursing involves the identification, prevention and intervention to remedy or modify students' health needs. The RN has the educational preparation and critical thinking skills as well as clinical expertise which are essential to nursing in the school setting. These activities involve the comprehensive assessment of the nursing/health care needs of the student, the development of a plan of care, implementation of the plan, and evaluation of the outcomes. The provision of these services by the RN contributes directly to the students' education and to the successful outcome of the educational process. These essential components of professional nursing practice are the responsibility of the RN in compliance with 22 TAC §217.11(3)(A).

Vocational Nurses in the School Setting

The vocational nurse has a directed scope of practice under supervision of a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist, or dentist.¹ The provision of nursing care when provided by a Licensed Vocational Nurse (LVN) in a school setting should be under the supervision of the RN. The RN, in compliance with the BON's Standards of Nursing Practice [22 TAC §217.11], assigns those aspects and activities to the LVN that are within the LVN's educational preparation and demonstrated competency to provide. The RN monitors, coordinates, and evaluates the provision of health services necessary to meet individual student health needs essential in achieving educational objectives.

When LVNs are utilized in the school setting and are supervised by the RN, the RN needs to consider how closely they can supervise the LVN and how the RN will direct, guide, and influence the outcome of the LVN's performance² and respond to any situations where the LVN needs onsite supervision.

RN Delegation to Unlicensed Personnel

Due to the growing number of students entering the school system with special health care needs, the BON recognizes that not all health-related services can be provided by a RN or LVN. Therefore, the RN may delegate tasks in the school setting in compliance with the BON's Delegation Rules [located in Chapters](#) 224 and 225. School is considered

an independent living environment as defined in [Rule Chapter 225](#)³; however, acute or emergency situations in the school setting may be delegated in accordance with the rules in both Chapter 224 and Chapter 225. For example, the RN may decide to delegate to an unlicensed person, the emergency administration of Epi-pens, Glucagon, Diastat, oxygen, metered dose inhalers, or nebulizer treatments for the relief of acute respiratory symptoms and the use of a hand held magnet to activate a vagus nerve stimulator to prevent or control seizure activity under 22 TAC §224.6(4) in order to stabilize the child and prevent complications from delaying treatment. The decision to delegate a specific task is always at the discretion of the RN in accordance with 22 TAC §224.8(b)(1)(C) or 22 TAC §~~225.9(e)~~[225.9\(d\)](#).

Other Laws Impacting School Health Care

In a school setting, the administration of medication may be assigned to an unlicensed person by the public school official in accordance with the rules of the Texas Education Code. The RN's obligation under 22 TAC §225.~~13~~[14](#) is to ~~(1)~~ verify the training of the unlicensed person, ~~and (2)~~ verify the competency of the unlicensed person to perform the task safely, ~~and provide adequate supervision~~. If the RN is unable to assure ~~(1) and (2)~~ [these criteria](#) have been met, the RN must ~~(b)~~ notify the public school official of the situation.

Summary

Given the complexity, the current number, and the future projections of increasing numbers of children entering the school system with complex nursing and health-related needs, the BON believes that the RN must establish an individualized nursing care plan for each child as applicable. The RN may be assisted by LVNs and unlicensed assistive personnel in the delivery of services to ensure the delivery of safe, effective health care to the school children of Texas.

¹ Tex. Occ. Code, Section 301.353 and 22 Tex. Admin. Code §217.11 (2)

² 22 Tex. Admin. Code §217.11 (2)

³ [22 Tex. Admin. Code §225.1](#)

(Adopted: 11/1996; Revised: 11/1997; 01/2003; 01/2005; 01/2008; 01/2009; 01/2011; 01/2013; 07/2013; [01/2016](#))

(Reviewed: 01/2006; 01/2007; 01/2010; 01/2012; 01/2014; 01/2015)

15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility

The Board of Nursing (BON) has approved this position statement, *only applicable to long term care settings*, in an effort to provide guidance to [registered nurses in long term care facilities](#) and to clarify issues of compassionate end-of-life care. The Texas Nurses Association (TNA) through its Long Term Care (LTC) Committee has identified that registered nurses have expressed repeated concern about the inappropriate initiation of cardiopulmonary resuscitation (CPR) when a resident without a "do not resuscitate" order (DNR) experiences an unwitnessed arrest. There is growing sentiment on the part of the long term care nurse community that the initiation of CPR would appear futile and inappropriate given the nursing assessment of the resident.

The nursing community generally considers that initiation of CPR in such cases is not compassionate, and is not consistent with standards requiring the use of a systematic approach to provide individualized, goal directed nursing care [BON Standards of Nursing Practice, 22 TAC § 217.11(3)]. This position statement is intended to provide guidance, for [registered](#) nurses, in the management of an unwitnessed resident arrest without a DNR order **in a long term care (LTC) setting**. The position also addresses the related issues of:

- Obligation (or duty) of the [registered](#) nurse to the resident,
- Expectation of supportive policies and procedures in LTC facilities,
- The RN role in pronouncement of death.

These related issues are addressed in this position statement because the BON is often required to investigate cases of death where it appears there is a lack of clarity about a [registered](#) nurse's obligation when there is no DNR order. The BON will evaluate cases involving the failure of a RN to initiate CPR in the absence of a DNR based on the following premise:

A DNR is a medical order that must be given by a physician and in the absence thereof, it is generally outside the standard of nursing practice to determine that CPR will not be initiated.

However, there may be instances when LTC residents without a DNR order experience an unwitnessed arrest and it is clear according to the comprehensive nursing assessment that CPR intervention would be a futile and inappropriate intervention given the condition of the resident.

In the case of an unwitnessed resident arrest without DNR orders, determination of the appropriateness of CPR initiation should be undertaken by the registered nurse through a resident assessment, and interventions appropriate to the findings initiated.

Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed.

Presumptive Signs of Death

1. The resident is unresponsive,
2. The resident has no respirations,
3. The resident has no pulse,
4. Resident's pupils are fixed and dilated,
5. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature,
6. The resident has generalized cyanosis, and

Conclusive Sign of Death

7. 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).

There may be other circumstances and assessments that could influence a decision on the part of the registered nurse not to initiate CPR. However, evaluation of the prudence of such a decision would occur on a case-by-case basis by the BON.

Documentation

After assessment of the resident is completed and appropriate interventions are taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON establish legal documentation standards, [BON Standards of Nursing Practice, 22 TAC § 217.11 (1)(D)]. Examples of important documentation elements include:

- Description of the discovery of the resident
- Any treatment of the resident that was undertaken
- The findings for each of the assessment elements outlined in the standards
- All individuals notified of the resident's status (e.g., 9-1-1, the health care provider, the administrator of the facility, family, coroner, etc.)
- Any directions that were provided to staff or others during the assessment and/or treatment of the resident
- The results of any communications
- Presence or absence of witnesses

Documentation should be adequate to give a clear picture of the situation and all of the actions that were taken or not taken on behalf of the resident.

Even if the [registered](#) nurse's decision not to initiate CPR was appropriate, failure to document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. [Registered Nurses](#) should be aware that actions documented at the time of death provide a much more credible defense than needing to prove actions not appropriately documented were actually taken. [As stated in Position Statement 15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death, it is beyond the scope of practice of the LVN to legally determine death, diagnose death, or otherwise pronounce death in the State of Texas. Therefore, the LVN cannot make a determination to withhold CPR.](#)

Obligation (“Duty”) of the Nurse to the Resident

Whether CPR is initiated or not, it is important for the nurse to understand that the nurse may be held accountable if the nurse failed to meet standards of care to assure the safety of the resident, prior to the arrest such as:

- Failure to monitor the resident's physiologic status;
- Failure to document changes in the resident's status and to adjust the plan of care based on the resident assessment;
- Failure to implement appropriate interventions which might be required to stabilize a client's condition such as: reporting changes in the resident's status to the resident's primary care provider and obtaining appropriate orders;
- Failure to implement procedures or protocols that could reasonably be expected to improve the resident's outcome.

Care Planning and Advanced Directives

Proactive policies and procedures, that acknowledge the importance of care planning with the inclusion of advanced directives, are also important. Evidence indicates that establishing the resident's wishes at the end of life and careful care planning prevents confusion on the part of staff and assures that the resident's and family's wishes in all aspects of end of life care are properly managed.

The admission process to long term care facilities in Texas requires that residents be provided information on self-determination and given the option to request that no resuscitation efforts be made in the event of cardiac and/or respiratory arrest. Facilities are required to have policies and adequate resources to assure that every resident and resident's family upon admission to a long term care facility not only receive such information, but have sufficient support to make an informed decision about end of life issues.

It is further expected that advanced care planning is an ongoing component of every resident's care and that the nursing staff should know the status of such planning on each resident. The Board recognizes that end of life decisions on the part of residents and families can be difficult. However, the Board believes that principled and ethical discussion about the CPR issue with the resident and family is an essential element of the resident care plan.

RN Role in Pronouncement of Death

Texas law provides for RN pronouncement of death [Health & Safety Code §§ 671.001-.002]. The law requires that in order for a [registered](#) nurse to pronounce death, the facility must have a written policy which is jointly developed and approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances a RN can make a pronouncement of death.

It is important that nurses understand that the assessment that death has occurred and that CPR is not an appropriate intervention are not the equivalent to the pronouncement of death. Texas statutory law governs who can pronounce death, and only someone legally authorized to pronounce death may do so. If the RN does not have the authority

to pronounce death, upon assessment of death the RN must notify a person legally authorized to pronounce death.

Conclusion

This position statement is intended to guide registered nurses in long term care facilities who encounter an unwitnessed resident arrest without a DNR order. It is hoped that by clarifying the responsibility of the registered nurse, and through the use of supportive facility policies and procedures, that registered nurses will be better able to provide compassionate end of life care.

Qualifier to Position

The BON evaluates "failure to initiate CPR cases" based on the premise that in the absence of a physician's DNR order it is generally outside the standard of nursing practice not to initiate CPR. Consequently, RNs deciding not to initiate CPR when all seven signs of death are not present must assure themselves that not initiating CPR complies with their respective standards of practice. Depending on the circumstances, a nurse's failure to initiate CPR when all seven signs are not present may constitute failure to comply with standards of nursing care. This position statement is limited to situations when all seven signs are present and should not be construed as providing guidance on the appropriateness of not initiating CPR when all seven signs are not present.

References:

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

[American Heart Association \(2015\) 2015 American Heart Association \(AHA\) Guidelines Update for Cardiopulmonary Resuscitation \(CPR\) and Emergency Cardiovascular Care \(ECC\)](#)

(Approved by the Board of Nursing on October 24, 2002; Revised: 01/2005; 01/2007; 01/2008; 01/2011; 01/2012; 01/2013; 01/2014; 01/2016)
(Reviewed: 01/2006; 01/2009; 01/2010; 01/2015)

15.25 Administration of Medication & Treatments by LVNs

The definition of “Vocational Nursing” ~~as amended in the Texas Occupations Code by SB1000 (79th Regular Session, 2005)~~ states:

301.002(5): “Vocational Nursing” means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- (A) collecting data and performing focused nursing assessments of the health status of an individual;
- (B) participating in the planning of the nursing care needs of an individual;
- (C) participating in the development and modification of the nursing care plan;
- (D) participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual;
- (E) assisting in the evaluation of an individual’s response to a nursing intervention and the identification of an individual’s needs; and
- (F) engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse’s experience, continuing education, and demonstrated competency [\[TOC 301.002\(5\)\]](#).

Educational preparation leading to initial licensure as a nurse in Texas is described in the *Differentiated Essential Competencies (DECs) Of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgements, and Behaviors (Oct 2010)*. This document lists the minimum competency expectations for graduates of Vocational (VN), Diploma/Associate Degree (Diploma/ADN), and Baccalaureate (BSN) nursing programs. According to DECs, educational preparation for Vocational Nurses includes the following related to administration of medications:

Knowledge:

- Common medical diagnoses, drug and other therapies and treatments.

Clinical Behavior/Judgments:

- Administer medications and treatments and perform procedures safely, and
- Monitor, document, and report responses to medications, treatments, and procedures and communicate the same to other health care professionals clearly and accurately.

The Standards of Nursing Practice (22 TAC §217.11) applicable to LVNs (as well as RNs) includes the following standards that specifically relate to medication administration:

- (1)(C) Know the rationale for and effects of medications and treatments, and shall correctly administer the same;

(1) (D) Accurately and completely report and document...(iv) administration of medications and treatments;

(1) (N) Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment.

[Note that other standards may apply to administration of medications within a given practice circumstance.]

The Board's position, therefore, is that LVNs are educationally prepared to administer medications and treatments as ordered by a physician, podiatrist, dentist, or any other practitioner legally authorized to prescribe the ordered medication. LVNs may also administer medications and treatments ordered by PAs and APRNs as established under Position Statements 15.1 and 15.18, relating to nurses accepting orders from Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), respectively.

~~As with other practice tasks, the Board cannot provide a list of medications, routes of administration, or other specific information that may be relevant to determining whether or not a task is within the scope of practice for a LVN. What is within the scope of practice for one LVN may not be within the scope of practice for another LVN. Each LVN has different experiences, knowledge, level of competence, and abilities; therefore it is up to the individual LVN to use sound judgment when determining the individual LVN's scope of practice.~~ The following documents on the Board's web page may be helpful for a LVN concerned about his/her scope of practice for administration of medications or other nursing practices concerns:

- Six-Step Decision-Making Model for Determining Nursing Scope of Practice
- Rule 217.11, Standards of Nursing Practice
- Lists of Tasks a Nurse Can/Cannot Perform
- Position Statements
- Position Statement 15.3, LVNS Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
- Position Statement 15.8, Role of the Nurse in Moderate Sedation
- Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice

(Adopted: 10/2005; Revised 01/2009; 01/2011; 01/2012; 01/2013; [01/2016](#))

(Reviewed: 01/2007; 01/2008; 01/2010; 01/2014; 01/2015)

15.27 The Licensed Vocational Nurse Scope of Practice

The BON recommends that all nurses utilize the Six-Step Decision-Making Model for Determining Nursing Scope of Practice¹ when deciding if an employer's assignment is safe and legally within the nurse's scope of practice.

The Texas Board of Nursing (BON) is authorized by the Texas Legislature to regulate the nursing profession to ensure that every licensee is competent to practice safely. The Texas Nursing Practice Act (NPA) and the Board's Rules and Regulations define the legal scope of practice for licensed vocational nurses (LVN). The LVN scope of practice is a directed scope of practice and requires appropriate supervision. The LVN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws, rules, regulations, and policies, procedures and guidelines of the employing health care institution or practice setting. ***The LVN is responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable health care needs.***

The purpose of this position statement is to provide direction and recommendations for nurses and their employers regarding the safe and legal scope of practice for licensed vocational nurses and to promote an understanding of the differences between the LVN and RN levels of licensure. The RN scope of practice is interpreted in Position Statement 15.28.

Every nursing education program in the state of Texas is required to ensure that their graduates exhibit competencies outlined in the Board's Differentiated Essential Competencies (DECs) of Graduates of Texas Nursing Programs.² These competencies are included in the program of study so that every graduate has the knowledge, clinical behaviors and judgment necessary for LVN entry into safe, competent and compassionate nursing care. The DECs serve as a guideline for employers to assist LVNs as they transition from the educational environment into nursing practice. As LVNs enter the workplace, the DECs serve as the foundation for the development of the LVN scope of practice.

Completion of on-going, informal continuing nursing education offerings and on-the-job trainings in a LVN's area of practice serves to develop, maintain, and expand the level of competency. Because the LVN scope of practice is based upon the educational preparation in the LVN program of study, there are limits to LVN scope of practice expansion parameters. The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the next requires the completion of a formal program of education.³

The LVN Scope of Practice

The LVN is an advocate for the patient and the patient's family and promotes safety by practicing within the NPA and the BON Rules and Regulations. LVN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.⁴ The practice of vocational nursing must be performed under the

supervision of a RN, APRN, physician, physician assistant, podiatrist or dentist.⁵ Supervision is defined as the active process of directing, guiding, and influencing the outcome of an individual's performance of an activity.⁶ The LVN is precluded from practicing in a completely independent manner; however, direct and on-site supervision may not be required in all settings or patient care situations. Determining the proximity of an appropriate clinical supervisor, whether available by phone or physical presence, should be made by the LVN and the LVN's clinical supervisor by evaluating the specific situation, taking into consideration patient conditions and the level of skill, training and competence of the LVN. An appropriate clinical supervisor may need to be physically available to assist the LVN should emergent situations arise.

The setting in which the LVN provides nursing care should have well defined policies, procedures, and guidelines, in which assistance and support are available from an appropriate clinical supervisor. The Board recommends that newly licensed LVNs work in structured settings for a period of 12-18 months, such as nursing homes, hospitals, rehabilitation centers, skilled nursing facilities, clinics or private physician offices.⁷ This allows the new nurse sufficient practice experience in more structured settings in order to assimilate knowledge from their education. As competencies are demonstrated, if the LVN transitions to unstructured settings where the clinical supervisor may not be on-site, it is the LVN's responsibility to ensure he or she has access to an appropriate clinical supervisor and that the policies, procedures and guidelines for that particular setting are established to guide the LVN practice.

The LVN uses a systematic problem-solving process in the care of multiple patients with predictable health care needs to provide individualized, goal-directed nursing care. LVNs may contribute to the plan of care by collaborating with interdisciplinary team members, the patient and the patient's family. The essential components of the nursing process are described in a side by side comparison of the different levels of education and licensure (see Table).

Assessment

The LVN assists in determining the physical and mental health status, needs, and preferences of culturally, ethnically, and socially diverse patients and their families based on interpretation of health-related data. The LVN collects data and information, recognizes changes in conditions and reports this to the RN supervisor or another appropriate clinical supervisor to assist in the identification of problems and formulation of goals, outcomes and patient-centered plans of care that are developed in collaboration with patients, their families, and the interdisciplinary health care team. The LVN cannot perform independent assessments as the LVN has a directed scope of practice under supervision. The LVN participates in the nursing process by appraising the individual patient's status or situation at hand. Also known as a focused assessment, this appraisal may be considered a component of a more comprehensive assessment performed by a RN or another appropriate clinical supervisor. For example, a RN may utilize the data and information collected and reported by the LVN in the formation of the nursing process; however, the RN's comprehensive assessment lays the foundation for the nursing process. The LVN reports the data and information collected either verbally or in writing. Written documentation must be accurate and

complete, and according to policies, procedures and guidelines for the employment setting.⁸

Planning

The second step in which the LVN participates and contributes to the nursing process is planning. After the focused assessment, the LVN reports data and other information such as changes in patient conditions to the appropriate clinical supervisor, such as a RN. This information may be considered in planning, problem identification, nursing diagnoses, and formulation of goals, teaching plans and outcomes by the RN supervisor or another appropriate clinical supervisor. A nursing plan of care for patients is developed by the RN and thus the RN has the overall responsibility to coordinate nursing care for patients.

Implementation

Implementing the plan of care is the third step in the nursing process. The LVN is responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable health care needs. The LVN may implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors. The LVN organizes aspects of patient care based on identified priorities. Delegating tasks to unlicensed assistive personnel (UAPs) is beyond the scope of practice for LVNs; however, LVNs may make appropriate assignments to other LVNs and UAPs according to 22 TAC §217.11(2).⁶ The RN is generally responsible and accountable for supervising not only the LVN's practice but the UAP's performance of tasks as well. For example, the RN may have trained, verified competency and delegated the tasks to a UAP and the LVN may then proceed to assign those tasks that need to be accomplished for that day. Teaching and counseling are interwoven throughout the implementation phase of the nursing process and LVNs can participate in implementing established teaching plans for patients and their families with common health problems and well defined health learning needs.

Evaluation

A critical and fourth step in the nursing process is evaluation. The LVN participates in the evaluation process identifying and reporting any alterations in patient responses to therapeutic interventions in comparison to expected outcomes. The LVN may contribute to the evaluation phase by suggesting any modifications to the plan of care that may be necessary and making appropriate referrals to facilitate continuity of care.

Essential Skills Use in the Nursing Process

Communication

Communication is a fundamental component in the nursing process. The LVN must communicate verbally, in writing, or electronically with members of the healthcare team, patients and their families on all aspects of the nursing care provided to patients. Communications must be appropriately documented in the patient record or nursing care plan. Because LVNs are members of the healthcare team, provide nursing care, and contribute to the nursing process, collaboration is a quality that is crucial to the communication process. When patient conditions or situations have changed or exceeded the LVN's level of competency and scope of practice, the LVN must be

prepared to seek out his or her clinical supervisor and actively cooperate to develop solutions that ensure patient safety.

Clinical Reasoning

Clinical reasoning is another integral component in the nursing process. LVNs must use clinical reasoning and established evidence-based policies, procedures or guidelines as the basis for decision making in nursing practice. LVNs are accountable and responsible for the quality of nursing care provided and must exercise prudent nursing judgment to ensure the standards of nursing practice are met at all times.⁹

Employment Setting

When an employer hires a nurse to perform a job, the nurse must assure that it is safe and legal. For instance, the LVN must have a clinical supervisor who is knowledgeable and aware of his or her role. Caution must be exercised not to overstep the legal parameters of nursing practice when an employer may not understand the limits of the LVN scope of practice and makes an assignment that is not prudent or safe. The LVN must determine before he or she engages in an activity or assignment whether he or she has the education, training, skill, competency and the physical and emotional ability to safely carry out the activity or assignment.¹⁰ The LVN's duty is to always provide safe, compassionate, and focused nursing care to patients.

Making Assignments

The LVN's duty to patient safety when making assignments to others is to take into consideration the education, training, skill, competence and physical and emotional ability of the persons to whom the assignments are made.^{11 12} If the LVN makes assignments to another LVN or UAP, he or she is responsible for reasonable and prudent decisions regarding those assignments. It is not appropriate and is beyond the scope of practice for a LVN to supervise the nursing practice of a RN. However, in certain settings, i.e.: nursing homes, LVNs may expand their scope of practice through experience, skill and continuing education to include supervising the practice of other LVNs, under the oversight of a RN or another appropriate clinical supervisor. The supervising LVN may have to directly observe and evaluate the nursing care provided depending on the LVN's skills and competence, patient conditions and emergent situations. Timely and readily available communication between the supervising LVN and the clinical supervisor is essential to provide safe and effective nursing care.

Summary

The LVN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws, rules, regulations, and policies, procedures and guidelines of the employing health care institution or practice setting. The LVN functions under his or her own license and assumes accountability and responsibility for quality of care provided to patients and their families according to the standards of nursing practice.⁹ The LVN demonstrates responsibility for continued competence in nursing practice, and develops insight through reflection, self-analysis, self-care, and lifelong learning.

The table below offers a brief synopsis of how the scope of practice for nurses differs based on educational preparation and level of licensure. These are minimum

competencies, but also set limits on what the LVN or RN can do at his or her given level of licensure, regardless of experience.

¹Texas Board of Nursing (2010). Six-step decision-making model for determining nursing scope of practice

²Texas Board of Nursing (2010). Differentiated essential competencies (DECs) of graduates of Texas Nursing Programs.

³Texas Board of Nursing (~~2014~~[2015](#)). Position statement 15.10 Continuing education: Limitations for expanding scope of practice.

⁴Texas Nursing Practice Act, TOC § 301.002(5).

⁵Texas Nursing Practice Act, TOC § 301.353.

⁶Texas Administrative Code, 22 TAC §217.11(2).

⁷Texas Board of Nursing (~~2014~~[2015](#)). Rules and guidelines governing the graduate vocational and registered nurse candidates or newly licensed vocational or registered nurse.

⁸Texas Administrative Code, 22 TAC §217.11(1)(D).

⁹Texas Administrative Code, 22 TAC §217.11.

¹⁰Texas Administrative Code, 22 TAC §217.11(1)(T).

¹¹Texas Administrative Code, 22 TAC §217.11(1)(S).

¹²Texas Administrative Code, 22 TAC §217.11(2)(B).

Additional Resources

Idaho Board of Nursing (2010). Position on safety to practice.

Kentucky Board of Nursing. (2005). Components of licensed practical nursing practice (AOS #27 LPN Practice).

National Council of State Boards of Nursing. (2009). Changes in healthcare professions' scope of practice: Legislative considerations.

North Carolina Board of Nursing. (2010). LPN scope of practice: Clarification: Position statement for LPN practice.

North Carolina Board of Nursing. (2010). RN and LPN scope of practice components of nursing comparison chart.

North Carolina Board of Nursing. (2010). RN scope of practice: Clarification: Position statement for RN practice.

Texas Administrative Code, 22 TAC §224.

Texas Administrative Code, 22 TAC §225.

(Adopted: 07/2011)

(Revised: 01/2013; [01/2016](#))

(Reviewed: 01/2012; 01/2014; 01/2015)

Synopsis Of Differences in Scope Of Practice for Licensed Vocational, Associate, Diploma and Baccalaureate Degree Nurses

| Nursing Practice | LVN Scope of Practice Directed/Supervised Role | ADN or Diploma RN Scope of Practice Independent Role | BSN RN Scope of Practice Independent Role |
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| Education | <p>The curriculum for the VN education is in a clinically intensive certificate program of approximately one year in length. The Texas BON rules mandate a minimum of 558 theory and 840 clinical hours in the VN program of study.</p> <p>The VN curriculum includes instruction in five basic areas of nursing care: adults; mothers and newborns; children; elderly; and individuals with mental health problems. Clinical experience in a unit or a facility specifically designed for psychiatric care is optional.</p> <p>Required support courses should provide instruction in biological, physical, social, behavioral, and nursing sciences, including body structure and function, microbiology, pharmacology, nutrition, signs of emotional health, human growth and development, vocational adjustments, and nursing skills.</p> | <p>ADN programs require a minimum of two full years of study, integrating a balance between courses in liberal arts; natural, social, and behavioral sciences; and nursing. Academic associate degrees consist of 60-72 credit hours with approximately half the program requirements in nursing courses.</p> <p>The Texas BON approved curriculum includes requirements for didactic instruction and clinical experiences in four contents areas: medical-surgical, maternal/child health, pediatrics, and mental health nursing.</p> <p>Diploma programs are hospital-based, single purpose schools of nursing that consist of two-three years of general education and support courses.</p> | <p>The BSN program of study integrates approximately 60 hours from liberal arts and natural, social, and behavioral science courses and approximately 60-70 hours of nursing courses. In addition to the ADN/Diploma education requirements, BSN education includes instruction in community health, public health, research, nursing leadership, and nursing management with preparation and skills to practice evidence-based nursing.</p> |
| Supervision | Supervision is required for the LVN scope of practice. LVNs are not licensed for | Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN | Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is |

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| | <p>independent nursing practice. A LVN must ensure that he or she has an appropriate clinical supervisor, i.e. RN, APRN, Physician, PA, Dentist or Podiatrist. The proximity of a clinical supervisor depends on skills and competency of the LVN, patient conditions and practice setting. Direct, on-site supervision may not always be necessary depending on the LVN's skill and competence and should be determined on a case-by-case situation taking into consideration the practice setting laws. However, clinical supervisors must provide timely and readily available supervision and may have to be physically present to assist LVNs should emergent situations occur.</p> | <p>staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity.</p> | <p>defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity.</p> |
| Setting | <p>Provides focused nursing care to individual patients with predictable health care needs under the direction of an appropriate clinical supervisor.</p> <p>The setting may include areas with well defined policies, procedures and guidelines with assistance and support from appropriate clinical supervisors, i.e. nursing home, hospital, rehabilitation center, skilled nursing facility, clinic, or a private physician office. As competencies are</p> | <p>Provides independent, direct care to patients and their families who may be experiencing complex health care needs that may be related to multiple conditions. Provides healthcare to patients with predictable and unpredictable outcomes in various settings.</p> | <p>Provides independent, direct care to patients, families, populations, and communities experiencing complex health care needs that may be related to multiple conditions. Provides healthcare to patients with predictable and unpredictable outcomes in various settings.</p> |

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| | demonstrated, if the LVN transitions to other settings, it is the LVN's responsibility to ensure he or she has an appropriate clinical supervisor and that the policies, procedures and guidelines for that particular setting are available to guide the LVN practice. | | |
| Assessment | <p>Assists, contributes and participates in the nursing process by performing a focused assessment on individual patients to collect data and gather information. A focused assessment is an appraisal of the situation at hand for an individual patient and may be performed prior to the RN's initial and comprehensive assessment.</p> <p>The LVN reports and documents the assessment information and changes in patient conditions to an appropriate clinical supervisor.</p> | <p>Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party.</p> <p>Determines the physical and mental health status, needs, and preferences of culturally diverse patients and their families.</p> | <p>Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party.</p> <p>Determines the physical and mental health status, needs, and preferences of culturally diverse patients, families, populations and communities.</p> |
| Planning | <p>Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making.</p> <p>May assign specific daily tasks and supervise nursing care to other LVNs or UAPs.</p> | <p>Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making. Analyzes assessment data to identify problems, formulate goals and outcomes, and develops nursing plans of care for patients and their families.</p> <p>May assign tasks and</p> | <p>Uses clinical reasoning based on established evidence-based practice outcomes and research for decision-making and comprehensive care. Synthesizes comprehensive data to identify problems, formulate goals and outcomes, and develop nursing plans of care for patients, families, populations, and communities.</p> <p>May assign tasks and activities</p> |

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| | | activities to other nurses. May delegate tasks to UAPs. | to other nurses. May delegate tasks to UAPs. |
| Implementation | <p>Provides safe, compassionate and focused nursing care to patients with predictable health care needs.</p> <p>Implements aspects of the nursing care plan, including emergency interventions under the direction of the RN or another appropriate clinical supervisor.</p> <p>Contributes to the development and implementation of teaching plans for patients and their families with common health problems and well-defined health needs.</p> | <p>Provides safe, compassionate, comprehensive nursing care to patients, and their families through a broad array of health care services.</p> <p>Implements the plan of care for patients and their families within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles.</p> <p>Develops and implements teaching plans to address health promotion, maintenance, and restoration.</p> | <p>Provides safe, compassionate, comprehensive nursing care to patients, families, populations, and communities through a broad array of health care services.</p> <p>Implements the plan of care for patients, families, populations, and communities within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles.</p> <p>Develops and implements teaching plans to address health promotion, maintenance, restoration, and population risk reduction.</p> |
| Evaluation | <p>Participates in evaluating effectiveness of nursing interventions.</p> <p>Participates in making referrals to resources to facilitate continuity of care.</p> | <p>Evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice, and plans follow-up nursing care to include referrals for continuity of care.</p> | <p>Evaluates and reports patient, family, population, and community outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research, and plans follow-up nursing care to include referrals for continuity of care.</p> |

15.28 The Registered Nurse Scope of Practice

The BON recommends that all nurses utilize the Six-Step Decision-Making Model for Determining Nursing Scope of Practice¹ when deciding if an employer's assignment is safe and legally within the nurse's scope of practice.

The Texas Board of Nursing (BON) is authorized by the Texas Legislature to regulate the nursing profession to ensure that every licensee is competent to practice safely. The Texas Nursing Practice Act (NPA) defines the legal scope of practice for professional registered nurses (RN).² The RN takes responsibility and accepts accountability for practicing within the legal scope of practice and is prepared to work in all health care settings, and may engage in independent nursing practice without supervision by another health care provider. The RN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws; rules and regulations; and policies, procedures and guidelines of the employing health care institution or practice setting. ***The RN is responsible for providing safe, compassionate, and comprehensive nursing care to patients and their families with complex healthcare needs.***

The purpose of this position statement is to provide direction and recommendations for nurses and their employers regarding the safe and legal scope of practice for RNs and to promote an understanding of the differences in the RN education programs of study and between the RN and LVN levels of licensure. The LVN scope of practice is interpreted in Position Statement 15.27.

Every nursing educational program in the state of Texas is required to ensure that their graduates exhibit competencies outlined in the Board's Differentiated Essential Competencies (DECs) of Graduates of Texas Nursing Programs.³ These competencies are included in the program of study so that every graduate has the knowledge, clinical behaviors and judgment necessary for RN entry into safe, competent and compassionate nursing care. The DECs serve as a guideline for employers to assist RNs as they transition from the educational environment into nursing practice. As RNs enter the workplace, the DECs serve as the foundation for the development of the RN scope of practice.

Completion of on-going, informal continuing nursing education offerings and on-the-job trainings in a RN's area of practice serves to develop, maintain, and expand competency. Because the RN scope of practice is based upon the educational preparation in the RN program of study, there are limits to the expansion of the scope. The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the next requires the completion of a formal program of education.⁴

The RN Scope of Practice

The professional registered nurse is an advocate for the patient and the patient's family, and promotes safety by practicing within the NPA and the BON Rules and Regulations. The RN provides nursing services that require substantial specialized judgment and skill. The planning and delivery of professional nursing care is based on knowledge and application of the principles of biological, physical and social science as acquired by a completed course of study in an approved school of professional nursing. Unless licensed as an

advanced practice registered nurse, the RN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.² RNs utilize the nursing process to establish the plan of care in which nursing services are delivered to patients. The level and impact of the nursing process differs between the RN and LVN as well as between the different levels of RN education (see Table).

Assessment

The comprehensive assessment is the first step, and lays the foundation for the nursing process. The comprehensive assessment is the initial and ongoing, extensive collection, analysis and interpretation of data. Nursing judgment is based on the assessment process. The RN uses clinical reasoning and knowledge, evidence-based outcomes, and research as the basis for decision-making and comprehensive care. Based upon the comprehensive assessment the RN determines the physical and mental health status, needs, and preferences of culturally, ethnically, and socially diverse patients and their families using evidence-based health data and a synthesis of knowledge. Surveillance is an essential step in the comprehensive assessment process. The RN must anticipate and recognize changes in patient conditions and determines when reassessments are needed.

Planning

The second step in the nursing process is planning. The RN synthesizes the data collected during the comprehensive assessment to identify problems, make nursing diagnoses, and to formulate goals, teaching plans and outcomes. A nursing plan of care for patients is developed by the RN, who has the overall responsibility to coordinate nursing care for patients. Teaching plans address health promotion, maintenance, restoration, and prevention of risk factors. The RN utilizes evidence-based practice, published research, and information from patients and the interdisciplinary health care team during the planning process.

Implementation

Implementing the plan of care is the third step in the nursing process. The RN may begin, deliver, assign or delegate certain interventions within the plan of care for patients within legal, ethical, and regulatory parameters and in consideration of health restoration, disease prevention, wellness, and promotion of healthy lifestyles. The RN's duty to patient safety when making assignments to other nurses or when delegating tasks to unlicensed staff is to consider the education, training, skill, competence, and physical and emotional abilities of those to whom the assignments or delegation is made. The RN is responsible for reasonable and prudent decisions regarding assignments and delegation. The RN scope of practice may include the supervision of LVNs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity.⁵ The RN may have to directly observe and evaluate the nursing care provided depending on the LVN's skills and competence, patient conditions, and emergent situations.

The RN may determine when it is appropriate to delegate tasks to unlicensed personnel and maintains accountability for how the unlicensed personnel perform the tasks. The RN is responsible for supervising the unlicensed personnel when tasks are delegated. The proximity of supervision is dependent upon patient conditions and skill level of the

unlicensed personnel. In addition, teaching and counseling are interwoven throughout the implementation phase of the nursing process.

Evaluation and Re-assessment

A critical and fourth step in the nursing process is evaluation. The RN evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research findings, and plans any follow-up care and referrals to appropriate resources that may be needed. The evaluation phase is one of the times when the RN reassesses patient conditions and determines if interventions were effective and if any modifications to the plan of care are necessary.

Essential Skills Used in the Nursing Process

Communication

Communication is an essential and fundamental component used during the nursing process. The RN must communicate verbally, in writing, or electronically with members of the healthcare team, patients and their families in all aspects of the nursing care provided to patients. These communications must be appropriately documented in the patient record or nursing care plan. Because RNs plan, coordinate, initiate and implement a multidisciplinary team's approach to patient care, collaboration is a quality crucial to the communication process. When patient conditions or situations exceed the RN's level of competency, the RN must be prepared to seek out other RNs with greater competency or other health care providers with differing knowledge and skill sets and actively cooperate to ensure patient safety.

Clinical Reasoning

Clinical reasoning is another integral component in the nursing process. RNs use critical thinking skills to problem-solve and make decisions in response to patients, their families and the healthcare environment. RNs are accountable and responsible for the quality of nursing care provided and must exercise prudent and professional nursing judgment to ensure the standards of nursing practice are met at all times.

Employment Setting

When an employer hires a RN to perform a job, the RN must assure that it is safe and legal. Caution must be exercised not to overstep the legal parameters of nursing practice when an employer may not understand the limits of the RN scope of practice and makes an assignment that is not safe. The RN must determine before he or she engages in an activity or assignment whether he or she has the education, training, skill, competency and the physical and emotional ability to safely carry out the activity or assignment.⁶ The RN's duty is to always provide safe, compassionate, and comprehensive nursing care to patients.

Summary

The RN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws; rules and regulations; and policies, procedures and guidelines of the employing health care institution or practice setting. The RN functions under his or her own license and assumes accountability and responsibility for quality of care provided to patients and their families according to the standards of nursing practice.⁷ The RN demonstrates responsibility for

continued competence in nursing practice, and develops insight through reflection, self-analysis, self-care, and lifelong learning.

The table below offers a brief synopsis of how the scope of practice for nurses differs based on educational preparation and level of licensure. These are minimum competencies, but also set limits on what the LVN or RN can do at his or her given level of licensure, regardless of experience.

¹ Texas Board of Nursing (2010). Six-step decision-making model for determining nursing scope of practice.

² Texas Nursing Practice Act, TOC §301.002(2)

³ Texas Board of Nursing (2010). Differentiated essential competencies (DECs) of graduates of Texas Nursing Programs

⁴ Texas Board of Nursing (~~2011~~[2015](#)). Position statement 15.10. Continuing education: Limitations for expanding scope of practice.

⁵ Texas Administrative Code, 22 TAC §217.11(2)

⁶ Texas Administrative Code, 22 TAC §217.11(1)(T)

⁷ Texas Administrative Code, 22 TAC §217.11

Additional Resources

Idaho Board of Nursing (2010). Position on safety to practice.

Kentucky Board of Nursing. (2005). Components of licensed practical nursing practice (AOS #27 LPN Practice).

National Council of State Boards of Nursing. (2009). Changes in healthcare professions' scope of practice: Legislative consideration.

North Carolina Board of Nursing. (2010). LPN scope of practice: Clarification: Position statement for LPN practice.

North Carolina Board of Nursing. (2010). RN and LPN scope of practice components of nursing comparison chart.

North Carolina Board of Nursing. (2010). RN scope of practice: Clarification: Position statement for RN practice.

Texas Administrative Code, 22 TAC §224 (~~2011~~[2015](#)).

Texas Administrative Code, 22 TAC §225 (~~2011~~[2015](#)).

Texas Board of Nursing (2011). Rules and guidelines governing the graduate vocational and registered nurse candidates or newly licensed vocational or registered nurse.

(Adopted: 07/2011)

(Revised: 01/2013; [01/2016](#))

(Reviewed: 01/2012; 01/2014; 01/2015)

Synopsis Of Differences in Scope of Practice for Licensed Vocational, Associate, Diploma and Baccalaureate Degree Nurses

| Nursing Practice | LVN Scope of Practice <i>Directed/Supervised Role</i> | ADN or Diploma RN Scope of Practice <i>Independent Role</i> | BSN RN Scope of Practice <i>Independent Role</i> |
|------------------|---|--|---|
| Education | <p>The curriculum for the VN education is in a clinically intensive certificate program of approximately one year in length. The Texas BON rules mandate a minimum of 558 theory and 840 clinical hours in the VN program of study.</p> <p>The VN curriculum includes instruction in five basic areas of nursing care: adults; mothers and newborns; children; elderly; and individuals with mental health problems. Clinical experience in a unit or a facility specifically designed for psychiatric care is optional.</p> <p>Required support courses should provide instruction in biological, physical, social, behavioral, and nursing sciences, including body structure and function, microbiology, pharmacology, nutrition, signs of emotional health, human growth and development, vocational adjustments, and nursing skills.</p> | <p>ADN programs require a minimum of two full years of study, integrating a balance between courses in liberal arts; natural, social, and behavioral sciences; and nursing. Academic associate degrees consist of 60-72 credit hours with approximately half the program requirements in nursing courses.</p> <p>The Texas BON approved curriculum includes requirements for didactic instruction and clinical experiences in four contents areas: medical-surgical, maternal/child health, pediatrics, and mental health nursing.</p> <p>Diploma programs are hospital-based, single purpose schools of nursing that consist of two-three years of general education and support courses.</p> | <p>The BSN program of study integrates approximately 60 hours from liberal arts and natural, social, and behavioral science courses and approximately 60-70 hours of nursing courses.</p> <p>In addition to the ADN/Diploma education requirements, BSN education includes instruction in community health, public health, research, nursing leadership, and nursing management with preparation and skills to practice evidence-based nursing.</p> |
| Supervision | <p>Supervision is required for the LVN scope of practice. LVNs are not licensed for independent nursing practice.</p> <p>A LVN must ensure that he or she has an appropriate clinical supervisor, i.e. RN,</p> | <p>Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity.</p> | <p>Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity.</p> |

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| | <p>APRN, Physician, PA, Dentist or Podiatrist. The proximity of a clinical supervisor depends on skills and competency of the LVN, patient conditions and practice setting. Direct, on-site supervision may not always be necessary depending on the LVN's skill and competence and should be determined on a case-by-case situation taking into consideration the practice setting laws. However, clinical supervisors must provide timely and readily available supervision and may have to be physically present to assist LVNs should emergent situations occur.</p> | | |
| Setting | <p>Provides focused nursing care to individual patients with predictable health care needs under the direction of an appropriate clinical supervisor.</p> <p>The setting may include areas with well defined policies, procedures and guidelines with assistance and support from appropriate clinical supervisors, i.e. nursing home, hospital, rehabilitation center, skilled nursing facility, clinic, or a private physician office. As competencies are demonstrated, if the LVN transitions to other settings, it is the LVN's responsibility to ensure he or she has an appropriate clinical supervisor and that the policies, procedures and guidelines for that particular setting are available to</p> | <p>Provides independent, direct care to patients and their families who may be experiencing complex health care needs that may be related to multiple conditions.</p> <p>Provides healthcare to patients with predictable and unpredictable outcomes in various settings.</p> | <p>Provides independent, direct care to patients, families, populations, and communities experiencing complex health care needs that may be related to multiple conditions.</p> <p>Provides healthcare to patients with predictable and unpredictable outcomes in various settings.</p> |

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| | guide the LVN practice. | | |
| Assessment | <p>Assists, contributes and participates in the nursing process by performing a focused assessment on individual patients to collect data and gather information. A focused assessment is an appraisal of the situation at hand for an individual patient and may be performed prior to the RN's initial and comprehensive assessment.</p> <p>The LVN reports and documents the assessment information and changes in patient conditions to an appropriate clinical supervisor.</p> | <p>Independently performs an initial or ongoing comprehensive assessment (extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and/or a responsible party.</p> <p>Determines the physical and mental health status, needs, and preferences of culturally diverse patients and their families.</p> | <p>Independently performs an initial or ongoing comprehensive assessment (extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and/or a responsible party.</p> <p>Determines the physical and mental health status, needs, and preferences of culturally diverse patients, families, populations and communities.</p> |
| Planning | <p>Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making.</p> <p>May assign specific daily tasks and supervise nursing care to other LVNs or UAPs.</p> | <p>Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making. Analyzes assessment data to identify problems, formulate goals and outcomes, and develops nursing plans of care for patients and their families.</p> <p>May assign tasks and activities to other nurses. May delegate tasks to UAPs.</p> | <p>Uses clinical reasoning based on established evidence-based practice outcomes and research for decision-making and comprehensive care. Synthesizes comprehensive data to identify problems, formulate goals and outcomes, and develop nursing plans of care for patients, families, populations, and communities.</p> <p>May assign tasks and activities to other nurses. May delegate tasks to UAPs.</p> |
| Implementation | <p>Provides safe, compassionate and focused nursing care to patients with predictable health care needs.</p> | <p>Provides safe, compassionate, comprehensive nursing care to patients, and their families through a broad array of health care services.</p> | <p>Provides safe, compassionate, comprehensive nursing care to patients, families, populations, and communities through a broad array of health care services.</p> |

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| | <p>Implements aspects of the nursing care plan, including emergency interventions under the direction of the RN or another appropriate clinical supervisor.</p> <p>Contributes to the development and implementation of teaching plans for patients and their families with common health problems and well-defined health needs.</p> | <p>Implements the plan of care for patients and their families within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles.</p> <p>Develops and implements teaching plans to address health promotion, maintenance, and restoration.</p> | <p>Implements the plan of care for patients, families, populations, and communities within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles.</p> <p>Develops and implements teaching plans to address health promotion, maintenance, restoration, and population risk reduction.</p> |
| Evaluation | <p>Participates in evaluating effectiveness of nursing interventions.</p> <p>Participates in making referrals to resources to facilitate continuity of care.</p> | <p>Evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice, and plans follow-up nursing care to include referrals for continuity of care.</p> | <p>Evaluates and reports patient, family, population, and community outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research, and plans follow-up nursing care to include referrals for continuity of care.</p> |