# ARKANSAS STATE BOARD OF NURSING
## POSITION STATEMENTS

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Updated 4/2/21
Position Statement

94-1

Role of the Registered Nurse in the Management of Patients Receiving Moderate Sedation, Anesthetic Agents or Neuromuscular Blocking (paralytic) Agents For Therapeutic or Diagnostic Procedures

The Arkansas State Board of Nursing has determined that it is within the scope of practice of a registered nurse (RN) who has demonstrated competency to administer pharmacologic agents under direct supervision of a physician or advanced practice registered nurse (APRN) to produce moderate sedation and to assist in rapid sequence intubation (RSI). Air and surface transport RNs in the field may administer pharmacologic agents under the direction of the physician or APRN. Consistent with state law, the attending physician, APRN, or a qualified provider must order the drugs, dosages, and concentrations of medications to be administered to the patient. Optimal anesthesia care is best provided by anesthesiologists and certified registered nurse anesthetists (CRNAs). The Board recognizes that the demand in the practice setting necessitates non-APRN RNs to administer anesthetic agents or neuromuscular blocking (paralytic) agents in specific circumstances. The RN shall have the educational preparation and clinical competence to administer anesthetic agents or neuromuscular blocking (paralytic) agents to assist in moderate sedation, RSI, therapeutic, or diagnostic procedures.

These specific circumstances include:

1. The RN administering a continuous infusion of an anesthetic agent or neuromuscular blocking (paralytic) agent to a hospitalized patient who is intubated and ventilated in an acute care setting for the purposes of maintaining comfort, stable oxygenation and ventilation, and a viable airway. A physician qualified in the administration of anesthetics or an APRN shall determine the continuous infusion dosage. Dose titrations and boluses of subsequent anesthetic agents or neuromuscular blocking (paralytic) agents to be administered to the intubated and ventilated patient may be administered by the RN upon specific orders or protocols by a physician or APRN.
2. The RN administering sedation for comfort care in the final hours of life under the direction of a physician or APRN.
3. The RN administering sedation for procedure where the physician or APRN is present but unable to personally inject the agents because the physician or APRN is performing the critical procedure of emergent intubation.
4. The air and surface transport RN administering sedation for a procedure in the field setting under the direction of a physician or APRN.
5. The RN administering anesthetic agents in placement of peripheral nerve blocks that may require the use of both hands of the physician or APRN to not compromise patient safety.

6. The RN administering anesthetic agents for therapeutic care including pain management or treatment of agitated delirium.

As with all areas of nursing practice, the RN shall apply the *Nurse Practice Act and Rules* to the specific practice setting, and shall utilize good professional judgment in determining whether to engage in a given patient-care related activity.

Employing facilities shall have policies and procedures to guide the RN. The Arkansas State Board of Nursing has adopted the attached guidelines.

Adopted November, 1994
Revised September 17, 2009
Revised September 12, 2014
Revised May 11, 2017
Position Statement 94-1 Guidelines

Position Statement on the Role of the Registered Nurse (RN) in the Management of Patients Receiving Moderate Sedation, Anesthetic Agents or Neuromuscular Blocking (paralytic) agents For Therapeutic or Diagnostic Procedures

Position Statement 94-1 Guidelines

A. Definition of Moderate Sedation.

The American Society of Anesthesiologists (ASA) defines the various levels of sedation and anesthesia that are now incorporated into this statement. (ASA Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who are Not Anesthesia Professionals, Approved by ASA House of Delegates on October 25, 2005, and amended on October 19, 2011).

“Moderate Sedation/Analgesia” is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Also, note that procedural sedation involves the use of sedative and analgesic agents to reduce the anxiety and pain suffered by patients during procedures (American College of Emergency Physicians [ACEP] Policy Statement, Sedation in the Emergency Department, Approved by the ACEP Board January 13, 2011).

“Deep Sedation/Analgesia” is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in anesthesia care, proficient in airway management, and trained in advanced life support. The qualified anesthesia practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation.

“General Anesthesia” is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

B. Position Statement 94-1 Guidelines for Management and Monitoring

It is within the scope of practice of a registered nurse to manage the care of patients receiving moderate sedation during therapeutic or diagnostic procedures provided the following criteria are met:

1. Administration of moderate sedation medications by non-anesthetist RNs is allowed by state laws and institutional policy, procedures, and protocol.
2. An anesthesia provider or attending physician selects and orders the medications to induce moderate sedation.

3. Guidelines for patient monitoring, drug administration, and protocols for dealing with potential complications or emergency situations are available and have been developed in accordance with accepted standards of anesthesia practice.

4. The RN managing the care of the patient receiving moderate sedation shall have no other responsibilities that would leave the patient unattended or compromise continuous monitoring.

5. The RN managing the care of the patient receiving moderate sedation is able to:
   a. Demonstrate the acquired knowledge of anatomy, physiology, pharmacology, cardiac dysrhythmia recognition and complications related to moderate sedation and medications.
   b. Assess total patient care requirements during moderate sedation and recovery. Physiologic measurements should include, but not be limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate and rhythm, and patient’s level of consciousness.
   c. Understand the principles of oxygen delivery, respiratory physiology, transport and uptake, and demonstrate the ability to use oxygen delivery devices.
   d. Anticipate and recognize potential complications of moderate sedation in relation to the type of medication being administered.
   e. Possess the requisite knowledge and skills to assess, identify and intervene in the event of complications or undesired outcomes and to institute nursing interventions in compliance with orders (including standing orders) or institutional protocols or guidelines.
   f. Demonstrate skill in airway management resuscitation.
   g. Demonstrate knowledge of the legal ramifications of administering moderate sedation or monitoring patients receiving moderate sedation, including the RN’s responsibility and liability in the event of an untoward reaction or life threatening complication.

6. The institution or practice setting has in place an education and competency validation mechanism that includes a process for evaluating and documenting the RNs demonstration of the knowledge, skills, and abilities related to the management of patients receiving moderate sedation. Evaluation and documentation of competence occurs on a periodic basis according to institutional policy.

C. Additional Guidelines

1. Intravenous access must be continuously maintained in the patient receiving moderate sedation.

2. All patients receiving moderate sedation will be continuously monitored throughout the procedure as well as the recovery phase by physiologic measurements including, but not limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate and rhythm, and patient’s level of consciousness.

3. Supplemental oxygen will be immediately available to all patients receiving moderate sedation and administered per order (including standing orders).

4. An emergency cart with a defibrillator must be immediately accessible to every location where moderate sedation is administered. Suction and a positive pressure breathing
device, oxygen, and appropriate airways must be in each room where moderate sedation is administered.

5. Provisions must be in place for back-up personnel who are experts in airway management, emergency intubation, and advanced cardiopulmonary resuscitation if complications arise.

D. Definitions/Implications for Rapid Sequence Intubation

The American College of Emergency Physicians (ACEP) defines Rapid Sequence Intubation (RSI) as an airway management technique in which a potent sedative or anesthetic induction agent is administered simultaneously with a paralyzing dose of a neuromuscular blocking agent to facilitate rapid tracheal intubation. The technique includes specific protection against aspiration of gastric contents, provides access to the airway for intubation, and permits pharmacologic control of adverse responses to illness, injury, and the intubation itself.

Additionally, the American College of Emergency Physician claims the licensed provider who is managing the patient’s airway is to have no other responsibilities or duties at that time. To require the licensed provider to leave the patient’s airway in order to administer medications for the purpose of RSI compromises patient safety (ACEP, 2006)

E. Guidelines for Management and Monitoring of RSI

It is within the scope of practice of a RN who has completed special education and demonstrated evidence of competency and skill to administer anesthetic agents or neuromuscular blocking (paralytic) agents to the non-intubated patient for the purpose of RSI, as well as manage and monitor the patient receiving RSI, provided specific criteria are met.

1. Administration of anesthetic agents or neuromuscular blocking (paralytic) agents by non-anesthetist RN is allowed by state laws and institutional policy, procedure, and protocol.
2. Medications for RSI are ordered by a physician or APRN.
3. The RN managing the care of the patient receiving RSI shall have no other responsibilities that would leave the patient unattended or compromise continuous patient monitoring.
4. The RN managing the care of the patient receiving RSI shall be able to:
   a. Demonstrate knowledge of airway management, arrhythmia recognition, and emergency resuscitation appropriate to the age of the patient, utilizing Advanced Cardiopulmonary Life Support (ACLS), Pediatric Advanced Life Support (PALS), and/or Neonatal Resuscitation Program (NRP) guidelines.
   b. Understand principles of pharmacology related to sedation, anesthetic induction, and neuromuscular blocking (paralytic) agents, including drug actions, side effects, and reversal agents.
   c. Demonstrate knowledge of physiologic parameters that are to be monitored during medication administration and RSI such as respiratory rate, oxygen saturation, blood pressure, cardiac rhythm, heart rate, and patient’s level of consciousness.
d. Assess the total patient care requirements before and during the administration of anesthetic agents or neuromuscular blocking (paralytic) agents, including the recovery phase.
e. Demonstrate knowledge of the appropriate nursing interventions in the event of a complication, unsuccessful RSI, or untoward outcome.
f. Demonstrate knowledge of the legal ramifications of administering medications for the purpose of RSI and patient monitoring, including the RNs responsibility and liability in the event of an untoward reaction or life threatening complication.

F. Practice Setting/Agency Responsibilities for RSI

Based on agency standards, regulations, accreditation requirements, personnel, and equipment, each employing agency may determine if medication administration by RNs for the purpose of RSI is authorized in their setting. If medication administration by non-anesthetist RNs for the purpose of RSI is permitted, the following shall be in place:

1. Written policy and procedure to address RSI.
2. Credentialing requirements for non-anesthesiologist physicians.
3. Documentation of required and ongoing education and competency for RNs administering medications for the purpose of RSI.
4. Requirement that the physician or APRN be physically present at the bedside throughout the time RSI medications are being administered by a RN to ensure the physician or APRN performs the intubation and is readily available in the event of an emergency, except when administration occurs in the field by air and surface transport RNs. In the field setting, a second provider who will perform intubation must be physically present and ready to intubate as soon as possible once the medications have been administered.
5. Emergency Equipment
   a. Age and size appropriate emergency supplies must be immediately accessible at every location where RSI is performed. Required supplies include emergency resuscitative drugs, basic and advanced airway and ventilator adjunct equipment, cardiac monitor and defibrillator, and source for 100% oxygen administration.
   b. Suction devices
   c. Positive pressure breathing device/bag-valve mask (BVM)
   d. Supplemental oxygen
   e. Blood pressure cuff(s)
   f. Stethoscope
   g. Pulse oximetry
Position Statement 94-1 Guidelines

References


American Association of Critical-Care Nurses
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Spinal Cord Injury Nurses
American Association of Occupational Health Nurses
American Nephrology Nurses Association
American Nurses Association
American Radiological Nurses Association
American Society of Pain Management Nurses
Position Statement 94-1 Guidelines

American Society of Plastic and Reconstructive Surgical Nurses
American Society of Post Anesthesia Nurses
American Urological Association, Allied
Association of Operating Room Nurses
Association of Pediatric Oncology Nurses
Association of Rehabilitation Nurses
Dermatology Nurses Association
NAACOG, The Organization for Obstetric, Gynecologic, and Neonatal Nurses
National Association of Orthopaedic Nurses
National Flight Nurses Association
National Student Nurses Association
Nurse Consultants Association, Inc.
Nurses Organization of Veterans Affairs
Nursing Pain Association

Adopted November 1994
Revised September 17, 2009
Revised September 12, 2014
Revised May 11, 2017
Position Statement

95-2

Transmission and Acceptance of Verbal Orders

The Arkansas State Board of Nursing acknowledges that the best interests of all members of the health care team are served by having authorized prescribers holding active prescriptive authority write all orders on the patient's medical record. Although a licensed nurse relating verbal and telephonic orders to a licensed nurse may have become accepted practice, neither the Arkansas Nurse Practice Act nor the Arkansas State Board of Nursing Rules and Regulations specifically address this issue. Verbal orders transmitted over the phone place the licensed nurse at greater risk. Employing facilities should have policies and procedures to guide the licensed nurse.

However, the Rules and Regulations of the Arkansas State Board of Nursing do prohibit a licensed nurse from receiving or transmitting verbal orders to or from unlicensed personnel.

Adopted December 7, 1995
Revised: May 12, 2012
Position Statement

97-1

The Performance of Stapling, Suturing, or Application of Tissue Adhesive, for Superficial Wound Closure by Nurses in the Operating Room

Statutory Definition

Arkansas Code Annotated §17-87-102 defines "Practice of professional nursing" as: "...the performance for compensation of any acts involving the observation, care, and counsel of the ill, injured, or infirm; the maintenance of health or prevention of illness of others; the supervision and teaching of other personnel; the delegation of certain nursing practices to other personnel as set forth in regulations established by the Board; or the administration of medications and treatments as prescribed by practitioners authorized to prescribe and treat in accordance with state law, where such acts require substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical, and social sciences.".

"...the Practice of practical nursing” means the performance for compensation of acts involving the care of the ill, injured, infirm or the delegation of certain nursing practices to other personnel as set forth in regulations established by the board under the direction of a registered professional nurse, an advanced practice nurse, a license physician, or a licensed dentist, which acts do not require the substantial specialized skill, judgment, and knowledge required in professional nursing;”

“Practice of psychiatric technician nursing” means the performance for compensation of acts involving the care of the physically and mentally ill, retarded, injured, or infirm or the delegation of certain nursing practices to other personnel as set forth in regulations established by the board, and the carrying out of medical orders under the direction of registered professional nurse, and advanced practice nurse, a licensed physician, or a licensed dentist, where such activities do not require the substantial specialized skill, judgment, and knowledge required in professional nursing.”

Position Statement

Numerous inquiries regarding the roles of nurses in the performance of stapling, suturing, or application of tissue adhesive has been received by the Arkansas State Board of Nursing. After study of the issues and concerns, the Arkansas State Board of Nursing issued the following position statement:
Stapling and Suturing

The performance of stapling, suturing or application of tissue adhesive for superficial wound closure, as delegated by the attending surgeon in the operating room, is within the scope of nursing practice; however, the suturing of muscle, nerve, fascia, or tendon is not within the scope of their practice.

Nurses who perform stapling, suturing or application of tissue adhesive for superficial wound closure are responsible for having adequate preparation and experience to perform such acts and shall have documented competency with performance of such procedures. The nurse is responsible for documentation of educational preparation and for maintaining continuing competency.

In the performance of stapling, suturing, or application of tissue adhesive for superficial wound closure, the nurse should:

1) Have knowledge of the potential complications and adverse reactions, which may result from the procedure(s),

2) Have the knowledge and ability to recognize adverse reactions and to take appropriate nursing intervention as indicated, and

3) Perform the procedure(s) in accordance with the established written agency policies and procedures, which are consistent with the definition of "professional nursing practice", “practice of practical nursing” and “licensed psychiatric technician nurse” as stated in Arkansas Code Annotated §17-87-102.

Determining Scope of Practice

Arkansas Code Annotated § 17-87-309 and ASBN Rules, Chapter 9, Section XV.A.6.f. holds all nurses individually responsible and accountable for the individual's acts based upon the nurse's education and experience. Each nurse must exercise professional and prudent judgment in determining whether the performance of a given act is within the scope of practice for which the nurse is both licensed and clinically competent to perform.

Adopted March 13, 1997
Revised November 2001
Reviewed: September 11, 2013
Position Statement

97-2

Assistance with Self Medication for Unlicensed Persons

DEFINITIONS

Assistance with Medication—Ancillary aid needed by an individual to self-administer oral medication, such as reminding the individual to take a medication at the prescribed time, opening and closing a medication container, returning a medication to the proper storage area, and assisting in reordering such medications from a pharmacy. Such ancillary aide shall not include calculation of medication dosage, or altering the form of the medication by crushing, dissolving, or any other method.

Setting:—Location in which the purpose of the setting is other than the provision of health care such as an individual’s residence which may include a group home or foster home as well as other settings including, but not limited to school, work or church where the individual participates in activities.

Cognitively Able:—Awareness with perception, reasoning, intuition and memory.

Stable:—A situation where the individual’s clinical and behavioral status and care needs are non-fluctuating and consistent.

POSITION

The Arkansas State Board of Nursing is authorized by ACA § 17-87-203 to regulate nurses, and nursing education and practice and to promulgate regulations in order to assure that safe and effective nursing care is provided by nurses to the public. Pursuant to ACA § 17-87-101, any person practicing nursing for compensation is required to hold nursing licensure. ACA § 17-87-102 allows the licensed nurse to delegate certain nursing practices to other personnel as set forth in regulations established by the Board.

Effective September 25, 1995 the Board promulgated Chapter Five of the Rules-entitled Delegation. Delegation is defined in Chapter One as entrusting the performance of a selected nursing task to an individual who is qualified, competent and able to perform such tasks. The nurse retains the accountability for the total nursing care of the individual.

This position statement provides a guideline to nurses who supervise and delegate tasks to unlicensed persons who provide assistance in order to assure that care is provided in a safe and effective manner.

A licensed nurse shall not delegate to any unlicensed person the administration of medication. An unlicensed person is not precluded from assisting an individual with the self administration of oral medications in a setting where the purpose of the setting is other than the provision of health care. Assistance with self medication by an unlicensed person may occur only as directed by physically impaired, cognitively able individuals with stable conditions. An unlicensed person assisting with the self
administration of medication may only do the following:

(1) Remind an individual when to take the medication and observe to ensure that the individual follows the directions on the container;

(2) Assist an individual in the self administration of medication by taking the medication in its container from the area where it is stored and handing the container with the medication in it to the individual. If the individual is physically unable to open the container, the unlicensed person may open the container for the individual; and

(3) Assist, upon request by or with the consent of, a physically impaired but cognitively able individual, in removing oral medication from the container and in taking the medication. If an individual is physically unable to place a dose of oral medicine in the individual’s mouth without spilling or dropping it, an unlicensed person may place the dose in another container and place that container to the mouth of the individual.

As set forth above, the assistance with self administration of oral medication shall not constitute the practice of nursing in a setting where the purpose of the setting is other than the provision of health care.

Adopted May 7, 1997
Reviewed May 9, 2012
The Arkansas State Board of Nursing has determined that, under the following conditions, it is within the scope of practice of the registered nurse, licensed practical nurse, and licensed psychiatric technician nurse to provide care to patients receiving analgesia by a specialized catheter.

A. Catheter Placement, Initial Test Dosing, and Establishment of Analgesic Dosage Parameters.

Placement of a catheter or infusion device, administration of the test-dose or initial dose of medication to determine correct catheter or infusion devise placement, and establishment of analgesic dosage parameters by written order for patients who need acute or chronic pain relief or for the woman during labor is to be done only by professionals who are educated and licensed in the specialty of anesthesia and physicians in other specialties who have been granted clinical privileges by the institution. A qualified anesthesia provider must be readily available as defined by institutional policy.

B. Monitoring of the woman in labor who is receiving epidural analgesia.

1. The registered nurse may monitor the woman in labor who is receiving epidural analgesia, Monitoring may include:
   a. Replacement of empty infusion containers with new pre-prepared solutions containing the same medication and concentration;
   b. Stopping infusions;
   c. Initiating emergency therapeutic measures under standing orders if complications arise;
   d. Removing the catheter upon written provider order;
   e. Monitoring the effectiveness of therapy and identification of complications.

2. Monitoring does not include the administration of subsequent bolus doses or adjusting the drug infusion rates.

C. Management of patients with catheters or devices for analgesia to alleviate acute post surgical, pathological, or chronic pain.

1. A registered nurse may manage the care of patients with catheters or devices for analgesia to alleviate acute post surgical, pathological, or chronic pain. Management may include:
   a. Administration of a bolus dose through bolus feature of a continuous infusion pump, following establishment of appropriate therapeutic range as set by the professional who is educated and licensed in the specialty of anesthesia or physicians in other specialties who have been granted clinical privileges by the institution;
   b. Adjustment of drug infusion rate in compliance with the anesthesia provider or physician’s patient-specific written orders;
c. Replacement of empty infusion containers with new pre-prepared solutions;
d. Stopping infusions;
e. Initiating emergency therapeutic measures under standing orders if complications arise;
f. Removing the catheter upon written order;
g. Accessing implanted ports with percutaneous access; and
h. Monitoring the effectiveness of therapy and identification of complications.

2. A licensed practical nurse or licensed psychiatric technician nurse may provide the care to patients with catheters or devices for analgesia to alleviate acute post surgical, pathological, or chronic pain. Care may include:

a. Replacement of empty infusion containers with new pre-prepared solutions;
b. Monitoring the effectiveness of therapy and identification of complications; and
c. Stopping infusions.

D. Standing orders, Education, and Competency

It is within the scope of practice of the registered nurse, licensed practical nurse, or licensed psychiatric technician nurse to manage and/or provide the care of patients receiving analgesia by catheter as defined above only when the following criteria are met.

1. Management and/or monitoring of analgesia by catheter technique are allowed by institutional policy, procedure, or standing orders.
2. The attending physician or the qualified anesthesia provider placing the catheter or infusion device selects and orders the medications, doses and concentrations of opioids, local anesthetics, steroids, alpha-agonists, or other documented safe medications or combinations thereof.
3. Guidelines for patient monitoring, medication administration and standing orders for dealing with potential complications or emergency situations are available and have been developed in conjunction with the anesthesia or physician provider.
4. The registered nurse providing care for patients receiving analgesia by catheter or infusion device for acute post surgical, pathological, or chronic pain relief or for the woman during labor is able to:

a. Demonstrate the acquired knowledge of anatomy, physiology, pharmacology and complications related to the analgesia technique (catheter and site specific) and medication.
b. Assess the patient’s total care needs during analgesia.
c. Utilize monitoring modalities, interpret physiological responses, and initiate nursing interventions to ensure optimal patient care.
d. Anticipate and recognize potential complications of the analgesia in relationship to the type of catheter/infusion device and medication being utilized.
e. Recognize emergency situations and institute nursing interventions in compliance with the anesthesia provider’s or attending physician’s guidelines and orders as allowed by this position statement.
f. Demonstrate the cognitive and psychomotor skills necessary for use of the analgesic catheter or mechanical infusion devices.
g. Demonstrate knowledge and skills required for catheter removal.
h. Demonstrate knowledge of the legal ramifications of managing and/or monitoring analgesia by catheter techniques, including the registered nurses responsibility and liability in the event of untoward reaction or life-threatening complication.
5. The licensed practical nurse/licensed psychiatric technician nurse providing care for patients receiving analgesia by catheter or infusion device for acute post surgical, pathological, or chronic pain relief is able to:

a. Demonstrate the acquired knowledge of anatomy, physiology, pharmacology and complications related to the analgesia technique medication.
b. Anticipate and recognize potential complications of the analgesia in relationship to the type of catheter/infusion device and medication being utilized.
c. Recognize emergency situations and institute nursing interventions in compliance with the anesthesia provider’s or attending physician’s guidelines and orders.
d. Demonstrate the cognitive and psychomotor skills necessary for use of the analgesic catheter or mechanical infusion devices.

6. An educational/competency validation mechanism is developed by the institution, and documentation of the successful demonstration of knowledge, skills, and abilities related to the management of the care of persons receiving analgesia by catheters and pain control infusion devices for all nurses who will be providing such care is maintained by the institution. Education/competency validation is specific to type catheter, device, and site being used. Evaluation and documentation of competence occurs on a periodic basis.

Adapted from the American Nurses Association’s “Position Statement on the Role of the Registered Nurse (RN) In the Management of Analgesia by Catheter Techniques (Epidural, Intrathecal, Intrapleural, or Peripheral Nerve Catheters)” 1991, and Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) “Role of the Registered Nurse (RN) in the Care of the Pregnant Woman Receiving Analgesia/Anesthesia by Catheter Techniques (Epidural, Intrathecal, Spinal, PCEA Catheters)” Reapproved by the AWHONN Board of Directors June 2007.

Adopted March 14, 1998
Revised: May 12, 2011
The Arkansas State Board of Nursing has determined that it is not within the scope of practice of the registered nurse, licensed practical nurse, and licensed psychiatric technician nurse to insert intrauterine pressure catheters.

Adopted: May 14, 1998
Reviewed: May 9, 2013
Position Statement

98-6

Decision Making Model

The attached Decision Making Model has been adopted by the Arkansas State Board of Nursing:

Arkansas State Board of Nursing

The mission of the Arkansas State Board of Nursing is to protect the public and act as their advocate by effectively regulating the practice of nursing.

The profession of nursing is a dynamic discipline. Practice potentials change and develop in response to health care needs of society, technical advancements, and the expansion of scientific knowledge. All licensed nurses share a common base of responsibility and accountability defined as the practice of nursing. However, competency based practice scopes of individual nurses may vary according to the type of basic licensure preparation, practice experiences, and professional development activities.

The parameters of the practice scopes are defined by basic licensure preparation and advanced education. Within this scope of practice, all nurses should remain current and increase their expertise and skill in a variety of ways, e.g., practice experience, in-service education, and continuing education. Practice responsibility, accountability, and relative levels of independence are also expanded in this way.

The licensed nurse is responsible and accountable, both professionally and legally, for determining his/her personal scope of nursing practice. Since the role and responsibilities of nurses, and consequently the scope of nursing practice, is ever changing and increasing in complexity, it is important that the nurse makes decisions regarding his/her own scope of practice.
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<th>The Practice of Professional (Registered) Nursing:</th>
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<td>The delivery of health care services which require assessment, diagnosis, planning, intervention, and evaluation fall within the professional nurse scope of practice.</td>
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<td>The performance for compensation of any acts involving:</td>
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<td>• the observation, care and counsel of the ill, injured or infirm;</td>
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<td>• the maintenance of health or prevention of illness of others;</td>
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<td>• the supervision and teaching of other personnel;</td>
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<td>• the delegation of certain nursing practices to other personnel;</td>
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<td>• administration of medications and treatments where such acts require substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social sciences.</td>
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<tr>
<td>ACA § 17-87-102 (6) (A-E)</td>
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<td>The advanced practice nurse shall practice in accordance with the scope of practice defined by the appropriate national certifying body and the standards set forth in the ASBN Rules and Regulations. The advanced practice nurse may provide health care for which the APN is educationally prepared and for which competence has been attained and maintained.</td>
</tr>
<tr>
<td>The delivery of health care services for compensation by professional nurses who have gained additional knowledge and skills through successful completion of an organized program of nursing education that certifies nurses for advanced practice roles as advanced nurse practitioners, certified nurse anesthetists, certified nurse midwives, and clinical nurse specialists.</td>
</tr>
<tr>
<td>ACA § 17-87-102 (4)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>The Practice of Registered Nurse Practitioner Nursing:</th>
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<tbody>
<tr>
<td>The delivery of health care services for compensation in collaboration with and under the direction of a licensed physician or under the direction of protocols developed with a licensed physician. ACA § 17-87-102 (8) (A)</td>
</tr>
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<tr>
<th>The Practice of Practical Nursing:</th>
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<tr>
<td>The delivery of health care services which are performed under the direction of the professional nurse, licensed physician, or licensed dentist, including observation, intervention, and evaluation, fall within the LPN/LPTN scope of practice.</td>
</tr>
<tr>
<td>The performance for compensation of acts involving:</td>
</tr>
<tr>
<td>• the care of the ill, injured, or infirm;</td>
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<tr>
<td>• the delegation of certain nursing practices to other personnel under the direction of a registered professional nurse, an advanced practice nurse, a licensed physician or a licensed dentist, where such activities do not require the substantial specialized skill, judgement, and knowledge required in professional nursing.</td>
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<tr>
<td>ACA § 17-87-102 (5)</td>
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<tr>
<th>The Practice of Psychiatric Technician Nursing:</th>
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<tr>
<td>The performance for compensation of acts involving:</td>
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<tr>
<td>• the care of the physically and mentally ill, retarded, injured, or infirm;</td>
</tr>
<tr>
<td>• the delegation of certain nursing practices to other personnel the carrying out of medical orders under the direction of a registered professional nurse, an advanced practice nurse, a licensed physician or a licensed dentist, where such activities do not require the substantial specialized skill, judgment, and knowledge required in professional nursing.</td>
</tr>
<tr>
<td>ACA § 17-87-102 (7)</td>
</tr>
</tbody>
</table>
Decision Making Process

1. Define the Activity/Task:
   Clarify what is the problem or need?
   Who are the people involved in the decision?
   What is the decision to be made and where (what setting or organization) will it take place?
   Why is the question being raised now?
   Has it been discussed previously?

2. Is the activity permitted by Arkansas Nurse Practice Act?
   NO – Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Go to Question # 5 – Special education needed?
   Unsure – Go to Question # 3 – Precluded by other law, rule, or policy?

3. Is activity/task precluded under any other law, rule or policy?
   No – Go to Question #4 – Consistent with....
   Yes – Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.

4. Is the activity consistent with:
   Pre-licensure/post-basic education program
   National Nursing Standards
   Nursing Literature/Research
   Institutional policies and procedures
   Agency Accreditation Standards
   Board Position Statements
   Community Standards?
   No -- Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Go to Question # 5 – Special education needs?

5. Has the nurse completed special education if needed?
   No -- Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Go to Question # 6 – Possess appropriate knowledge?

6. Does nurse possess appropriate knowledge?
   No -- Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Go to Question #7—Documented competency?

7. Is there documented evidence of competency & skill?
   No -- Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Go to Question # 8 – Reasonable & prudent nurse?

8. Would a reasonable & prudent nurse perform the act?
   No -- Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Go to Question #9 – Prepared to accept consequences?

9. Is nurse prepared to accept the consequences of action?
   No -- Stop. Defer the activity/task to a professional qualified to do the activity/task or to the Arkansas State Board of Nursing for a decision.
   Yes – Nurse may perform the activity/task according to acceptable and prevailing standards of nursing care.

Guidelines for Decision Making

The nurse is constantly involved in the decision-making and problem solving process, whether as a staff nurse or a manager, regardless of the practice setting. Although their perspectives are different the process is the same. The following steps are basic to the process.

Clarify: What is the problem or need?
Who are the people involved in the decision?
What is the decision to be made and where (what setting or organization) will it take place?
Why is the question being raised now?
Has it been discussed previously?

Assess: What are your resources?
What are your strengths?
What skills and knowledge are required?
What or who is available to assist you?

Identify What are possible solutions?
Options: What are the characteristics of an ideal solution?
Is it feasible?
What are the risks?
What are the costs?
Are they feasible?
What are the implications of your decision?
How serious are the consequences?

Point of Decision: What is the best decision?
When should it be done?
By whom?
What are the implications or consequences of your decision?
How will you judge the effectiveness of your decision?
Clarify what it is you are being asked to do:
- Gather facts that may influence the decision.
- Are there written policies and procedures available to describe how and under what conditions you will perform this task?
- Does the new responsibility require professional judgment or simply the acquisition of a new skill?
- Is this a new expectation for all RNs? LPNs? LPTNs?
- Has this been done before by others in your unit or health care facility?
- Is it just new to you?
- What about the other facilities in your community or region?
- What are the nurse manager’s expectations about you or other RNs, LPNs, LPTNs, becoming responsible for this procedure?
- When will this become effective?
- Will there be an opportunity to help you attain the needed clinical competency?
- Who will be responsible for the initial supervision and evaluation of this newly performed task?
- Will you be given additional time to learn the skill if you need it?

Assess:
- Are you clinically competent to perform this procedure?
- Do you currently have the knowledge and skills to perform the procedure?
- Have you had experience in previous jobs with this procedure?
- Who is available to assist you who has that skill and knowledge?
- Is that person accessible to you?
- Do you believe you will be able to learn the new skill in the allotted time?
- How can you determine that you are practicing within your scope of nursing?
- What is the potential outcome for the patient if you do or do not perform the procedure?

Identify options and implications of your decision. The options include:
- The responsibility/task is not prohibited by the Nurse Practice Act.

If you believe that you can provide safe patient care based upon your current knowledge base, or with additional education and skill practice, you are ready to accept this new responsibility.
You will then be ethically and legally responsible for performing this new procedure at an acceptable level of competency.
If you believe you will be unable to perform the new task competently, then further discussion with the nurse manager is necessary.
At this point you may also ask to consult with the next level of management or nurse executive so that you can talk about the various perspectives of this issue.

It is important that you continue to assess whether this is an isolated situation just affecting you, or whether there are broader implications. In other words, is this procedure new to you, but nurses in other units or health care facilities with similar patient populations already are performing? To what do you relate your reluctance to accept this new responsibility? Is it a work load issue or is it a competency issue?

At this point, it is important for you to be aware of the legal rights of your employer. Even though you may have legitimate concerns for patient safety and your own legal accountability in providing competent care, your employer has the legal right to initiate employee disciplinary action, including termination, if you refuse to accept an assigned task. Therefore, it is important to continue to explore options in a positive manner, recognizing that both you and your employer share the responsibility for safe patient care. Be open to alternatives.

In addition, consider resources which you can use for additional information and support. These include your professional organization, both state and national, and various publications. The American Nurses Association Code for Nurses, standards on practice, and your employer’s policies and procedures manuals are valuable resources. The Nurse Practice Act serves as your guide for the legal definition of nursing and the parameters that indicate deviation from or violation of the law.

Point of decision/Implications.
Your decision may be:
- Accept the newly assigned task. You have now made an agreement with your employer to incorporate this new responsibility, under the conditions outlined in the procedure manual. You are now legally accountable for its performance.
- Agree to learn the new procedure according to the plans established by the employer for your education, skills practice and evaluation. You will be responsible for letting your nurse manager know when you feel competent to perform this skill. Make sure that documentation is in your personnel file validating this additional education. If you do not believe you are competent enough to proceed after the initial inservice, then it is your responsibility to let the educator and nurse manager know you need more time. Together you can develop an action plan for gaining competency.
- Refuse to accept the newly assigned task. You will need to document your concerns for patient safety as well as the process you use to inform your employer of your decisions. Keep a personal copy of this documentation and send a copy to the nurse executive. Courtesy requires you also send a copy to your nurse manager. When you refuse to accept the assigned task, be prepared to offer options such as transfer to another unit (if this new role is just for your unit) or perhaps a change in work assigned tasks with your colleagues. Keep in mind though, when you refuse an assignment you may face disciplinary action, so it is important that you be familiar with your employer’s grievance procedure.

For additional information on the Nurse Practice Act, Rules and Regulations, and Position Statements see the ASBN web page: www.state.ar.us/nurse

Approved: November 1998
Revised: January 1999
Reviewed: January 10, 2013
ADVANCED PRACTICE REGISTERED NURSE (APRN) SCOPE OF PRACTICE DECISION MAKING MODEL

1. Identify, describe or clarify the task/function under consideration.

2. Review the scope of practice for the APRN role based on the ASBN Nurse Practice Act and ASBN Rules, Chapter 4.

3. Is the task/function expressly prohibited by ASBN Nurse Practice Act, ASBN Rules, or any other law, rule or policy?
   - **YES**: STOP
   - **NO**: Proceed to the next step.

4. Is the task/function included in the scope of practice based on your educational preparation and national certification specialty area?
   - **YES**: Proceed to the next step.
   - **NO**: STOP
   - **UNSURE**: Proceed to the next step.

5. Is the task/function consistent with your APRN education, certification, population foci, national standards of practice, current APRN competencies, current nursing literature and research, policies and procedures, institution, accreditation standards, information on certification test content outline, or role delineation study?
   - **YES**: Proceed to the next step.
   - **NO**: STOP

6. Is the performance of the task/function within the accepted “standard of care” which would be provided in similar circumstances by reasonable and prudent APRNs who have similar training and experience?
   - **YES**: Proceed to the next step.
   - **NO**: STOP

7. Do you have the required knowledge, skill, education and experience to do the activity or task? Can you produce documentation/evidence that you have the knowledge, current skills, education and experience to do the activity or task?
   - **YES**: Proceed to the next step.
   - **NO**: STOP

8. Are you prepared to manage the consequences and accept accountability for your actions? Can you defend yourself if an adverse event occurs?
   - **YES**: Proceed to the next step.
   - **NO**: STOP

9. Is it reasonable to expect the patient will be safe/without harm as a result of your actions?
   - **YES**: You now must make a decision to perform or decline to perform the activity or task according to the currently accepted standards of care and in accordance with your institution’s policies and procedures. STOP
   - **NO**: STOP

Acknowledgements: Adapted with permission from Kentucky Board of Nursing Scope of Practice Decision-Making Model for APRNs, 2/88; Iowa Board of Nursing Scope of Practice Decision Making Model for Advanced Registered Nurse Practitioners; American Nurses Association Scope-of-Practice Decision Making Model for CNPs and CNSs.
Position Statement

99-1

Registered Nurse Deployment of Extravascular Collagen Plugs

The Arkansas State Board of Nursing has determined that, under the following conditions, it is within the scope of practice of the registered nurse to deploy extravascular collagen plugs for hemostasis.

1. Successful completion of an organized program of study which is approved by a nationally recognized accrediting body and provides didactic classroom instruction followed by supervised clinical practice which includes but is not limited to:
   a. Anatomy and physiology
   b. Patient screening
   c. Patient teaching
   d. Equipment
   e. Sterile technique
   f. Complication identification and management
   g. Documentation of pre/post teaching, procedure and follow-up
   h. Cognitive and psychomotor skills necessary to deploy an extravascular collagen plug
   i. Legal ramifications of deploying an extravascular collagen plug including the RN's responsibility and liability in the event of untoward reaction or life-threatening complications
   j. A mechanism for quality assurance and periodic review for competency
   k. Supervised clinical practice on a minimum of ten (10) successful deployments

2. Deployment of extravascular collagen plugs by RNs is allowed by institutional policy, procedure, or protocol.

3. A consent form designating the RN as the person performing the procedure is signed by the patient or their legally authorized representative.

4. A physician writes the order for the RN to deploy the extravascular collagen plug and is readily accessible to manage complications which may occur.

5. A periodic educational/competency validation mechanism is developed, and documentation of the successful demonstration of knowledge, skills, and abilities related to the management and care of persons receiving an extravascular collagen plug are on file for each nurse performing the procedure.

Approved: January 14, 1999
Reviewed: May 9, 2013
Telenursing is defined as the practice of nursing care over distance using telecommunications technology\(^\text{i}\).

The Arkansas State Board of Nursing (ASBN) has determined that the nurse must hold an active Arkansas license or a valid multistate license to practice Telenursing in the State of Arkansas. ASBN “Position Statement 98-6 Decision Making Model” shall be followed to determine if a particular act of Telenursing is within the scope of practice of the nurse, with emphasis on completion of special education, possession of appropriate knowledge, and documented evidence of competency and skill in the nurse’s personnel file.

*Adopted: November 16, 2000*
*Revised: September 11, 2013*

Position Statement

03-1

School Nurse Guidelines in Patient Care
Settings other than Schools

It is the Board’s opinion that the Arkansas State Board of Nursing School Nurse Roles and Responsibilities Practice Guidelines may be applied to settings other than schools provided they are used as a whole and not taken out of context. Further it is the opinion of the Board that it is inappropriate to use these guidelines to approve or deny services to clients.

In May 2000 the Arkansas State Board of Nursing approved practice guidelines for school nurses. These guidelines were developed to assist the school nurse in determining the nursing care activities that could safely be delegated when certain conditions were met. The guidelines may be applied to other similar settings if:

1. Nursing care is NOT the primary purpose of the client being in the setting,
2. The parent/guardian would do the same nursing task(s) if they were present, and
3. The parent/guardian has given their consent for the unlicensed person to perform the nursing tasks.

In addition, the nurse who delegates nursing care to an unlicensed person must apply the following criteria in determining if it is appropriate to delegate the care:

1. A licensed nurse responsible for the client’s nursing care and qualified to determine the appropriate application of delegation to an unlicensed person must assess the client. Periodic reassessment must confirm that the nursing care being delegated to an unlicensed person continues to be appropriate.
2. The client’s nursing care needs must be stable.
3. The performance of the nursing care by an unlicensed person must not pose a potential harm to the client.
4. No or little modification can be made in the nursing care provided the client.
5. The nursing care being provided for the client cannot involve ongoing assessments, interpretations, or decision-making.
6. The competency of the unlicensed person to perform the required nursing care is validated and documented. This requires the nurse who is delegating the nursing care to be familiar with the client’s needs and with the unlicensed person’s skills.
7. Supervision that is required for the individual unlicensed person performing the specific task(s) for a specific client is readily available.
8. The facilities’ policies and procedures identify the task(s) that may be delegated to an unlicensed person. The policies and procedures must also recognize that the nurse who is delegating the task(s) is responsible for determining that a task is appropriate to delegate in a specific situation.

Nurses who delegate nursing tasks are responsible and accountable for ensuring that the delegation was appropriate. Unlicensed persons are responsible and accountable for competent performance of the nursing care that is delegated to them which includes calling the delegating nurse for assistance if the client’s condition or needs change.

*Adopted: February 12, 2003*
Position Statement

03-2

Assistive Personnel Applying and Measuring Tuberculin Skin Tests

Assistive personnel may apply and measure tuberculin skin tests provided the following requirements are met.

1. The assistive personnel work under the supervision of a Registered Nurse employed by the Arkansas Department of Health.

2. The assistive personnel satisfactorily completes a course in applying and measuring tuberculin skin tests that includes:
   a. Five rights of medication administration
   b. Criteria for tuberculin testing
   c. Technique for administering antigen
   d. Measuring & documenting negative and reactive skin tests
   e. Criteria for immediate reporting of results to the nurse
   f. Minimum of 20 observed applications and 20 observed test measurements & documentations.

3. The assistive personnel contact the RN for direction in determining if a tuberculin test is warranted when new contacts are identified.

4. The assistive personnel notify the RN of any reaction.

5. Competency is periodically re-evaluated and documented by the supervising RN.

Approved November 13, 2003
Reviewed: May 9, 2013
The Arkansas State Board of Nursing has determined that based on educational and skills preparation, it is within the scope of practice of the Advanced Practice Nurse and Registered Nurse to pronounce death. The Advanced Practice Nurse and Registered Nurse must adhere to other Arkansas statutes regarding pronouncement of death.

Approved: September 13, 2006
Revised: January 11, 2007
Reviewed: May 9, 2013
Expedited Partner Therapy (EPT) is “the practice of treating the sex partners of persons with sexually transmitted diseases (STDs) without an intervening medical evaluation or professional prevention counseling” (Centers for Disease Control, 2006).

The Arkansas State Board of Nursing has determined that it is within the scope of practice of the Advanced Practice Nurse (APN) with Prescriptive Authority to prescribe EPT to their patients’ heterosexual partner(s) with suspected gonorrhea and/or chlamydia. The prescription shall be in the partner’s name.

*Adopted: May 15, 2008*
*Revised: June 14, 2012*
The Arkansas State Board of Nursing has determined that, registered nurses may perform stapling, suturing or application of tissue adhesive for superficial wound closure, as delegated by the attending provider in the emergency department; however, the suturing of muscle, nerve, fascia, or tendon is not within the scope of their practice.

Registered nurses who perform stapling, suturing or application of tissue adhesive for superficial wound closure are responsible for having adequate preparation and experience to perform such acts and shall have documented competency with performance of such procedures. The registered nurse is responsible for documentation of educational preparation and for maintaining continuing competency. The registered nurse should use the Decision Making Model as a tool in determining if the task is within his or her scope of practice.

The Arkansas Nurse Practice Act, A.C.A. § 17-87-309 and Rules, Chapter 7, Section IV, A.6.f., holds all nurses individually responsible and accountable for the individual's acts based upon the nurse's education and experience. Each nurse must exercise professional and prudent judgment in determining whether the performance of a given act is within the scope of practice for which the nurse is both licensed and clinically competent to perform.

Adopted May 8, 2014
The Arkansas State Board of Nursing has determined that to ensure public safety of the citizens of Arkansas and others seeking medical care in this state and to provide guidance for licensed nurses as recommended by the National Academy of Medicine’s vision of team-based diagnosis to allow Nurse Driven Standing Orders. Implementation of Nurse Driven Standing Orders allows institutions to adopt policies and procedures developed by medical staff and the hospital’s nursing and pharmacy leadership team. Nurse Driven Standing Orders promotes team-based diagnosis, specifically calling for the patient and nursing staff to be integral members of the team and contribute to the diagnostic process.

In May 2012, the Centers for Medicare and Medicaid Services (CMS) adopted 77 FR 29002 and 77 FR 29034, which included provisions for hospitals: Revisions of the Conditions of Participation (CoPs) concerning governing body, patient’s rights, medical staff, nursing services, medical records, pharmaceutical services, infection control, outpatient services, and transplant center organ recovery and receipt. Drugs and biologicals may be prepared and administered on the orders contained in pre-printed and electronic standing orders only if the standing orders meet the requirements of the medical records CoP. Hospitals may use pre-printed and electronic standing orders for patient orders concerning situations where hospital policy permits treatment to be initiated by a nurse without a prior specific order from the treating practitioner. Such treatment is typically initiated when a patient’s condition meets certain pre-defined clinical criteria. For example, standing orders may be initiated as part of an emergency response or as part of an evidence-based treatment regimen where it is not practical for a nurse to obtain either a written, authenticated order or a verbal order from a hospital credentialed practitioner prior to the provision of care.

Evidence-based standing orders approved by hospitals per CMS guidelines would allow the licensed nurse to initiate medications and treatments when the patient’s condition meets certain pre-defined clinical criteria. Ordering medications or treatments under the standing order would not be construed to be prescribing which may only be done by practitioners authorized to prescribe and treat.

For each approved standing order, there must be specific criteria clearly identified in the protocol for the order for a nurse to initiate the execution of a particular standing order, for example, the specific clinical situations, patient’s conditions, or diagnoses by which initiation of the order would be justified.

Policies and procedures should also address the instructions that the medical, nursing, and other applicable professional staff receive on the conditions and criteria for using standing orders as well as any individual staff responsibilities associated with the initiation and execution of standing orders. An order that has been initiated for a specific patient must be added to the patient’s medical record at time of initiation or as soon as possible thereafter.
Likewise, standing orders policies and procedures must specify the process whereby the physician or other practitioner responsible for the care of the patient acknowledges and authenticates the initiation of all standing orders after the fact, with the exception of influenza and pneumococcal vaccines, which do not require such authorization in accordance with § 482.23(c)(2).

Licensed nurses working in hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:

1. Has adopted and are in compliance in the provisions for hospitals included in the Conditions of Participation (77 FR 29002 and 77 FR 29034);
2. Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital’s nursing and pharmacy leadership;
3. Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;
4. Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital’s nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and
5. Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

References


Conditions of Participation for Hospitals, 42 C.F.R. § 482.24(c)(3) (2012).


Adopted: May 6, 2020
Position Statement

21-1

Role Of The Licensed Nurse In The Practice Of Aesthetics

The performance of aesthetic procedures is within the scope of practice of a trained Advanced Practice Registered Nurse (APRN) or Registered Nurse (RN) as part of a medically prescribed plan of care for treatment of various dermatological conditions or as a part of a health maintenance and health promotion regime. The performance of aesthetic procedures is not within the scope of practice of a licensed practical nurse (LPN) or a licensed psychiatric technician nurse (LPTN).

A. EDUCATIONAL PREPARATION
   The nurse shall have documented educational preparation, supervised clinical practice experience and competency validation appropriate to responsibilities, treatment provided and patient population served. The delegating physician or supervising APRN shall document competency for the RN. The collaborating physician shall document competency for the APRN.

B. Documentation of ongoing competence should be readily available in the APRN or RN’s personnel file. To ensure patient safety, the APRN and RN should gain and demonstrate the following knowledge and skill before engaging in aesthetics procedures:
   1. Anatomy, physiology, and pathophysiology regarding the integumentary system as well as systems specific to the procedure(s) being performed.
   2. Proper technique for each dermatologic procedure and nursing care required.
   4. Pharmacology including drug actions/interactions, side effects, contraindications, and untoward effects.
   5. Proper selection, maintenance and utilization of equipment.
   6. Realistic and expected outcomes of the procedure(s).
   7. Potential complications and side effects of the procedure(s).
   8. Management of complications or adverse reactions.
   9. Infection control.
   10. Safety precautions.
   11. Documentation appropriate to the type of the procedure being performed.
   13. Competency validation.

C. PRACTICE SETTINGS
   Aesthetic procedures shall be prescribed by a qualified physician or an APRN with a collaborative practice agreement with a qualified physician.
D. RNs shall practice under a patient specific order written by the delegating physician or supervising APRN. The use of standing orders for aesthetic cosmetic procedures is acceptable, provided the standing orders are documented in the patient’s medical record. Standing orders shall be reviewed by the prescriber on an annual basis. The standing orders shall contain the following:
   1. Patient name;
   2. Patient specific diagnosis;
   3. Procedure(s);
   4. Treatment site;
   5. Drug (when applicable);
   6. Dosage (when applicable);
   7. Frequency;
   8. Instructions for emergency and follow-up care; and
   9. Prescriber signature and date.

E. The APRN or physician shall be available to the RN in person or through electronic communications during a procedure. Such provisions shall be contained in the practice setting’s standard procedures and protocols.

F. In addition to these requirements, the Arkansas Board of Nursing has published Position Statement 98-6, Scope of Practice Decision Making Model that contains a decision tree chart providing guidance to nurses in determining whether a selected act is within an individual nurse’s scope of practice and if education and training are adequate to perform a specified procedure or treatment.

Sources:

