TX: Jurisprudence and Ethics for Nurses

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Contact hours: 2

Course price: $19

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Course Summary

This course covers legal and ethical issues for Texas nurses. It includes a historical look at the recognition of nursing as a profession and the Texas Nurse Practice Act, the Texas Board of Nursing Rules, and the Texas Statutes and Administrative Code as it relates to nursing.

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80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Course Objectives

When you finish this course you will be able to:

1. Explain how the Texas Nursing Practice Act came about.
2. Discuss the provisions of the Texas Statutes and the Administrative Code.
3. Explain Texas Board of Nursing (BON) Rules, especially Rule §217.11,
4. Standards of Nursing Practice.
5. Describe Texas BON Position Statements and their purpose.
6. State the six Principles of Bioethics.
7. Define professional boundaries and their potential threats.

Nursing and the Texas Nursing Practice Act

Before 1900 no state had a nurse practice act and nurses were neither registered nor licensed. The vast majority of working nurses had no formal education and most worked in unregulated, crowded workplaces or as private nurses in homecare settings.

The Civil War (1861–1865) had a profound effect on the development of the nursing and medical professions and in many ways laid the foundation for modern nursing in the United States. Around the time of the war there were only about 150 hospitals in the United States, and there were no formal schools of nursing, no nursing credentials, and no "trained" nurses (Egenes, 2009). In England, Florence Nightingale had only just succeeded in establishing the world's first professional nurse training school at St. Thomas's Hospital in London; the first class launched on July 9, 1860.

The hundreds of thousands of casualties during the Civil War created a need for caregivers and tens of thousands of women offered their services, mostly on a volunteer basis. In the beginning, nurse volunteers were inexperienced, untrained, and disorganized. The situation changed quickly as the volunteer nurses gained experience and training. When the war ended, the sacrifices made by nurses and other female volunteers succeeded in changing public opinion about women working in healthcare. In 1868, only three years after the end of the Civil War, Samuel Gross, president of the American Medical Association, strongly endorsed the formation of training schools for nurses (Egenes, 2009).

Just five years later, in 1873, the first educational programs for nurses in the United States were established in New York, Massachusetts, and Connecticut. Writing in 1935, Registered Nurse Isabel Stewart noted that "The immediate problem was not to build a finished educational structure, but to clear the ground, to provide decent conditions for both patients and nurses, and to lay the foundations of an adequate nursing service" (Stewart, 1935). The new nursing schools were so popular and successful that soon every hospital wanted a school of nursing.

The emergence of germ theory in the late 1800s was another event that had a profound effect on medicine. As medical doctors expanded their education and training, nurses also recognized the need for more comprehensive training. Thus began a period of significant increase in the number of nursing schools throughout the United States, and shortly thereafter the fight for nursing licensure (then referred to as "nursing registration"). As the nineteenth century drew to a close, nurses themselves, along with many women's organizations and their leaders, lobbied for nurse registration, the development of standards for nursing education, and establishment of nurse practice acts.

The First Registrations and Practice Acts

In 1902 members of the newly formed New York Nurses Association met at the Rochester City Hospital to discuss the establishment of the nation's first nurse practice act. In attendance was an elderly and frail Susan B. Anthony, who urged the attendees to remember the influence and power of their work. Anthony predicted in a speech to the group that "The day is coming when trained nurses will be required to possess a college education before being admitted to training" (Willis et al., 2011).

Just one year later, in 1903, North Carolina passed the first "permissive" registration law for nurses. Permissive licensure allowed nurses who met certain standards (such as graduating from a nursing school and passing a comprehensive exam) to work as a nurse but did not allow the use of the title "registered nurse."

In addition to a registration law for nurses, North Carolina became the first state to pass a nurse practice act, signed into law by the governor on March 2, 1903, it read in part:

At meetings it shall be their duty to examine all applicants for license as registered nurse, of good moral character, in the elements of anatomy and physiology, in medical, surgical, obstetrical and practical nursing, invalid cookery and household hygiene, and if on such examination they be found competent, to grant each applicant a license authorizing her or him to register, as hereinafter provided, and to use the title 'Registered Nurse' signified by the letters R.N. The said Board of Examiners may in its discretion, issue license without examination to such applicants as shall furnish evidence of competency entirely satisfactory to them. Each applicant before receiving license, shall pay a fee of $5.00 which shall be used for defraying the expenses of the Board. (NCNH, 2015)

New York, New Jersey, and Virginia succeeded in passing nurse registration laws by the end of 1903 and by 1921, 48 states, the District of Columbia, and the Territory of Hawaii had enacted laws that regulated the practice of professional nursing (Egenes, n.d.). Mandatory licensure laws for nurses were not passed by the states until the late 1940s (Egenes, n.d.). The terms **Registered Nurse** and **Licensed Practical Nurse**(vocational) are now legally protected titles in all states.

Nursing in Texas

[This section taken from Tschirch & Crowder, 2010.]

In Texas, as elsewhere in the United States, care of the ill or injured and assistance in childbirth were part of the traditional and expected role of women. On the Texas frontier, settlements were often few and far between, as were physicians. Accidents, however, were not uncommon, and the hot Texas climate often contributed to outbreaks of disease (Tschirch & Crowder, 2010).

From the early 1820s there are records of Texas women nursing others through illness, injuries, and childbirth. The challenges of the frontier and the sometimes daunting climate meant they received a lot of practice even though there was no formal recognition or training for their work (Tschirch & Crowder, 2010).

The first groups in Texas to make an important impact on nursing outside of the home were lay nurses from Catholic congregations of women. In 1866 three sisters from the Incarnate Word Convent in Lyons, France, came to Galveston and opened St. Mary's Infirmary. The following year Galveston was struck with a devastating yellow fever epidemic and more than a thousand people were treated in and out of the hospital. After the Civil War, in 1869, several sisters left to open a hospital in San Antonio. In later years others would be opened in Beaumont, Texarkana, Fort Worth, and Amarillo, and all would open schools of nursing (Tschirch & Crowder, 2010).

In 1890 the first formal school of nursing in Texas was established at John Sealy Hospital in Galveston, just 17 years after the first ones in the East. In 1896 the school became a regular department of the University of Texas Medical Branch. Nursing schools were financially dependent for many years on hospitals or medical schools (Tschirch & Crowder, 2010).

Nurses cared for patients in hospital wards and operating rooms and assisted at home surgeries. They were concerned with understanding and providing effective treatments for their patients. Nurses also had responsibility for equipment and supplies in an era without plastics and disposable products (Tschirch & Crowder, 2010).

Hospitals were mainly staffed by student nurses who were supervised by a head nurse and the head of the nursing school. Until the Great Depression most graduate nurses worked in private-duty settings. Some also worked as visiting nurses or in occupational medicine. Hospitals did not begin to hire more graduate nurses until the late 1930s and especially after World War II (Tschirch & Crowder, 2010).

The First Nurses Association in Texas

With nursing registration and nurse practice acts becoming law in several states, nurses saw the need for professional organizations to represent their needs. In Texas as elsewhere, employment difficulties and the lack of educational and practice standards motivated trained nurses to organize and push for improvements. In 1907 nineteen nurses met in Fort Worth to form the association that would rename itself the Texas Nurses Association (TNA) in 1964, but was first called the Graduate Nurses' Association of Texas. One year later it became the Texas Graduate Nurses Association (TGNA) and it petitioned to join the forerunner of the American Nurses Association.

The TGNA helped influence the Texas legislature to pass a nurse registration and practice law in March 1909. The law did not provide any mechanism for inspecting or accrediting nursing schools so the TGNA undertook to study the means to improve standards in these schools. Finally, in 1923, a law was passed that provided an educational secretary to visit nursing schools annually and prepare a written report (Brown, 2010; BON, 2013).

The Texas Nurses Association is today the oldest and largest nursing association in the state. It is a membership-based professional association of licensed nurses who volunteer their time to the organization. They represent all parts of nursing from administration to practice in a wide variety of settings, but they share the common purpose of "advancing excellence in nursing" (TNA, n.d.).

The Texas Nursing Practice Act

The original **Nursing Practice Act (NPA)** was passed in March 1909, and has been revised and updated many times since, reflecting changes in healthcare and nursing practice (BON, 2013).

The NPA created the Board of Nurse Examiners, now known as the **Board of Nursing** (BON), and it met immediately to establish standards, but was not originally given authority over nursing education. It also had other weaknesses in that it only applied to individuals using the title *Registered Nurse*, it did not define "professional nursing," and it did not specify educational requirements for nurse licensure (BON, 2013).

In 1923 the Board was given authority over nursing education, and in 1925 all Texas statutes were re-codified and the professional nursing laws were incorporated in Vernon's Civil Statutes. Over the years changes were made to the Board's responsibilities and to nursing licensure and education. In 1999, the NPA was codified as **Chapter 301 of the Texas Occupations Code** (discussed in detail in the next section)**.** Today, the Texas Board of Nursing (BON) is responsible for licensing, regulating, and monitoring the status of approximately 260,000 licensed Registered Nurses and 98,000 Licensed Vocational Nurses. The BON approves 114 nursing education programs for registered nurses and 98 programs for licensed vocational nurses (BON, 2013).

Texas Statutes and Administrative Code

Many nursing professionals know less than they should about the rules and laws that govern their profession. Certainly, as nurses take on more responsibilities within the healthcare system, it is imperative that they know where to find information about their practice act and their scope of practice. They also must know what to do if a complaint is filed against them, what is involved when a nurse is disciplined, and what is considered incompetent or unethical practice.

Texas Statutes

The Texas Legislature convenes every two years in odd-numbered years. Bills that are passed and signed by the governor, are codified as law in the Texas Statutes. During the 2013 session, the Legislature passed four bills that amended the Nursing Practice Act (NPA), and in the introduction to the current version of the NPA, available online, the Board of Nursing notes:

> As you continue to practice as a nurse in Texas, it is your responsibility to be aware of changes to the law and the Board's rules and regulations. Changes are reported in the Board's quarterly newsletter mailed to all nurses licensed in Texas as well as posted on the BON website.

Chapter 301 of the Texas Occupations Code (TOC) contains the Nursing Practice Act (NPA) which creates the BON and defines its responsibility for regulating nursing education, licensure and practice. Chapter 303 relates to Nursing Peer Review and Chapter 304 relates to the Nurse Licensure Compact. These chapters of the TOC define nursing practice and give the Board the authority to make rules which implement and interpret the NPA. Licensees are required to comply with the NPA and the Board's rules. The NPA and the Rules are amended from time to time. Only the Legislature can change the NPA, so statutory changes only occur every two years. The Board makes rule changes as needed to assist in the application of the NPA to evolving practice conditions and settings. It is necessary, therefore, that you keep up with the changes (BON, 2013).

The subchapters of the Nursing Practice Act comprise the following:

A. General Provisions
B. Texas Board of Nursing
C. Executive Director and Personnel
D. General Powers and Duties of Board
E. Public Interest Information and Complaint Procedures
F. License Requirements
G. License Renewal
H. Practice by License Holder
I. Reporting Violations and Patient Care Concerns
J. Prohibited Practices and Disciplinary Actions
K. Administrative Penalty
L. Other Penalties and Enforcement Provisions
M. Anesthesia in Outpatient Setting
N. Corrective Action Proceeding and Deferred Action

Subchapter G. License Renewal contains the requirements for continuing competency, including the new requirement on Nursing Jurisprudence and Ethics by which: **"all nurses are required to complete at least two contact hours in nursing jurisprudence and ethics prior to the end of every third licensure renewal cycle"** (BON, 2014; 2013).

Chapters 303, 304, and 305 of the Texas Occupations Code address additional material for nurses, which are:

- 303, Nursing Peer Review
- 304, Nurse Licensure Compact
- 305, Advanced Practice Registered Nurse Compact

Chapter 303 addresses peer review and requires employers of ten or more vocational or professional nurses to establish a peer review committee. It provides guidance for establishing and utilizing the committee, and specifies when a nurse or group can or must avail themselves of a peer review determination.

Chapter 304 governs Texas' participation in the Nurse Licensure Compact (NLC), which "allows nurses to have one multistate license, with the ability to practice in both their home state and other compact states" (NCSBN, 2015).

Texas put Chapter 305 in place in 2007 in anticipation of the NCSBN Advanced Practice Registered Nurse (APRN) Compact, which is expected to become operational on January 1, 2016 (NCSBN, 2012).

Texas Administrative Code

The Texas Administrative Code (TAC) is a compilation of all state agency rules in Texas. There are sixteen titles in the TAC. Each title represents a subject category, and related agencies are assigned to the appropriate title. The Office of the Secretary of State compiles, indexes, and makes the Code available online.

The organization, structure, and responsibilities of the Texas Board of Nursing are contained in Title 22, Part 11, Chapters 211–228. Generally referred to as the **BON Rules**, they will be discussed in the next section, most notably **Rule 217.11**.

Texas Board of Nursing (BON) Rules

In the preface to *Texas Board of Nursing Rules and Regulations relating to Nurse Education, Licensure and Practice*, the Board makes its role and responsibilities clear: The Nursing Practice Act of Texas provides for the creation of a Board of Nursing (Board) empowered with the responsibility and legal authority for ensuring competent practitioners of nursing. The Board fulfills this responsibility by licensing qualified practitioners, controlling the practice of nursing in the interest of society by licensure, by investigation of violations of the Act, by initiating appropriate legal action when necessary, and by establishing minimum standards for educational programs in nursing. Without legal regulation of nursing practices, the public has no assurance that the nurses who provide nursing care as a part of the total healthcare plan are qualified to do so.

It is the responsibility of the Board to establish standards for nursing education in the State of Texas. The Board shall approve such nursing education programs that meet its requirements, and shall deny or withdraw approval from schools of nursing and educational programs which fail to meet the prescribed course of study or other standards. The intent of the approval process is to improve the educational programs and stimulate continuous self-study, evaluation, innovation, and appropriate changes within the programs. The Board provides guidance to nursing programs so that a high quality education for the preparation of practitioners is ensured (BON, 2013a).

The Rules

- Chapter 211, General Provisions
- Chapter 213, Practice and Procedure
- Chapter 214, Vocational Nursing Education
- Chapter 215, Professional Nursing Education
- Chapter 216, Continuing Competency
- Chapter 217, Licensure, Peer Assistance and Practice
- Chapter 219, Advanced Practice Nurse Education
- Chapter 220, Nurse Licensure Compact
- Chapter 221, Advanced Practice Nurses
- Chapter 222, Advanced Practice Registered Nurses with Prescriptive Authority
- Chapter 223, Fees
- Chapter 224, Delegation Of Nursing Tasks By Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments
- Chapter 225, RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions
- Chapter 226, Patient Safety Pilot Programs on Nurse Reporting Systems
- Chapter 227, Pilot Programs for Innovative Applications to Vocational and Professional Nursing Education
- Chapter 228, Pain Management

Rule 217.11* Standards of Nursing Practice

The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse’s license even if no actual patient injury resulted.

(1) **Standards Applicable to All Nurses.** All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:

- (A) Know and conform to the Texas Nursing Practice Act and the board’s rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse’s current area of nursing practice;
- (B) Implement measures to promote a safe environment for clients and others;
- (C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same;
- (D) Accurately and completely report and document:
  - (i) the client’s status including signs and symptoms;
  - (ii) nursing care rendered;
  - (iii) physician, dentist or podiatrist orders;
  - (iv) administration of medications and treatments;
  - (v) client response(s); and
  - (vi) contacts with other health care team members concerning significant events regarding client’s status;
- (E) Respect the client’s right to privacy by protecting confidential information unless required or allowed by law to disclose the information;
- (F) Promote and participate in education and counseling to a client(s) and, where applicable, the family/significant other(s) based on health needs;
- (G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices;
- (H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations;
- (I) Notify the appropriate supervisor when leaving a nursing assignment;

(J) Know, recognize, and maintain professional boundaries of the nurse-client relationship;

(K) Comply with mandatory reporting requirements of Texas Occupations Code Chapter 301 (Nursing Practice Act), Subchapter I, which include reporting a nurse:

(i) who violates the Nursing Practice Act or a board rule and contributed to the death or serious injury of a patient;

(ii) whose conduct causes a person to suspect that the nurse's practice is impaired by chemical dependency or drug or alcohol abuse;

(iii) whose actions constitute abuse, exploitation, fraud, or a violation of professional boundaries; or

(iv) whose actions indicate that the nurse lacks knowledge, skill, judgment, or conscientiousness to such an extent that the nurse's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior.

(v) except for minor incidents (Texas Occupations Code §§301.401(2), 301.419, 22 TAC §217.16), peer review (Texas Occupations Code §§301.403, 303.007, 22 TAC §217.19), or peer assistance if no practice violation (Texas Occupations Code §301.410) as stated in the Nursing Practice Act and Board rules (22 TAC Chapter 217).

(L) Provide, without discrimination, nursing services regardless of the age, disability, economic status, gender, national origin, race, religion, health problems, or sexual orientation of the client served;

(M) Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;

(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;

(O) Implement measures to prevent exposure to infectious pathogens and communicable conditions;

(P) Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care;

(Q) Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care; 106

(R) Be responsible for one's own continuing competence in nursing practice and individual professional growth;

(S) Make assignments to others that take into consideration client safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made;

(T) Accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability;

(U) Supervise nursing care provided by others for whom the nurse is professionally responsible; and

(V) Ensure the verification of current Texas licensure or other Compact State licensure privilege and credentials of personnel for whom the nurse is administratively responsible, when acting in the role of nurse administrator.

(2) **Standards Specific to Vocational Nurses.** The licensed vocational nurse practice is a directed scope of nursing practice under the supervision of a registered nurse, advanced practice registered nurse, physician's assistant, physician, podiatrist, or dentist. Supervision is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity. The licensed vocational nurse shall assist in the determination of predictable healthcare needs of clients within healthcare settings and:

(A) Shall utilize a systematic approach to provide individualized, goal-directed nursing care by:

(i) collecting data and performing focused nursing assessments;

(ii) participating in the planning of nursing care needs for clients;

(iii) participating in the development and modification of the comprehensive nursing care plan for assigned clients;

(iv) implementing appropriate aspects of care within the LVN's scope of practice; and

(v) assisting in the evaluation of the client's responses to nursing interventions and the identification of client needs;

(B) Shall assign specific tasks, activities and functions to unlicensed personnel commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made and shall maintain appropriate supervision of unlicensed personnel.

(C) May perform other acts that require education and training as prescribed by board rules and policies, commensurate with the licensed vocational nurse's experience, continuing education, and demonstrated licensed vocational nurse competencies.

(3) **Standards Specific to Registered Nurses.** The registered nurse shall assist in the determination of healthcare needs of clients and shall:

(A) Utilize a systematic approach to provide individualized, goal-directed, nursing care by:

(i) performing comprehensive nursing assessments regarding the health status of the client;

(ii) making nursing diagnoses that serve as the basis for the strategy of care;

(iii) developing a plan of care based on the assessment and nursing diagnosis;

(iv) implementing nursing care; and

(v) evaluating the client's responses to nursing interventions;

(B) Delegate tasks to unlicensed personnel in compliance with Chapter 224 of this title, relating to clients with acute conditions or in acute are environments, and Chapter 225 of this title, relating to independent living environments for clients with stable and predictable conditions.

(4) **Standards Specific to Registered Nurses with Advanced Practice Authorization**. Standards for a specific role and specialty of advanced practice nurse supersede standards for registered nurses where conflict between the standards, if any, exist. In addition to paragraphs (1) and (3) of this subsection, a registered nurse who holds authorization to practice as an advanced practice nurse (APN) shall:

(A) Practice in an advanced nursing practice role and specialty in accordance with authorization granted under Board Rule Chapter 221 of this title (relating to practicing in an APN role; 22 TAC Chapter 221) and standards set out in that chapter.

(B) Prescribe medications in accordance with prescriptive authority granted under Board Rule Chapter 222 of this title (relating to APNs prescribing; 22 TAC Chapter 222) and standards set out in that chapter and in compliance with state and federal laws and regulations relating to prescription of dangerous drugs and controlled substances.

*The provisions of this §217.11 adopted to be effective September 28, 2004, 29 TexReg 9192; amended to be effective November 15, 2007, 32 TexReg 8165.

In addition, the Board has adopted **position statements** and interpretive guidelines that are intended to clarify §217.11 or address specific practice-related issues. These can be found on the Board's website in the "Nursing Practice" section (BON, 2013a).

Other parts of Rule 217 as well as other rules—eg, Rule 216—Continuing Competency, or Rule 220—Nursing Licensure Compact—apply to all nurses, while some of the rules may apply only to Registered Nurses or Licensed Vocational Nurses or Advanced Practice Nurses, or to nurses working only in specific practice settings or with specific job duties. It is your responsibility to familiarize yourself with all applicable rules and to consult BON Position Statements and other supplementary material whenever necessary. This material can be obtained from the Board of Nursing and on its website.

Board of Nursing Position Statements

Board Position Statements do not have the force of law, but are a means of providing direction for nurses on issues of concern to the Board relevant to protection of the public. Board position statements are reviewed annually for relevance and accuracy to current practice, the Nursing Practice Act, and Board rules. The Board's last review was performed January 2014.

A brief summary of the BON Position Statements is available online and in PDF form, but the Board emphasizes that the summary does not provide any of the details that are found in each Position Statement. The summary is best used to obtain a glimpse of the content in order to decide which Position Statement is applicable to the topic or topics you are seeking information about.

Texas BON Position Statement Synopsis (2014)

The current summary list of BON Position Statements contains 28 items (numbered 15.1–15.29, although 15.21 has been deleted). All items are listed below with summary information given for some widely applicable issues as examples.

15.1 Nurses Carrying Out Orders from Physician's Assistants

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

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

15.4 Educational Mobility

15.5 Nurses with Responsibility for Initiating Physician Standing Orders

15.6 Board Rules Associated with Alleged Patient "Abandonment"

Differentiates employment vs. licensure issues; addresses relevant Board rules when a nurse engages in unprofessional conduct with regard to being unavailable to provide care to assigned patients (such as sleeping on the job). New for 2014: guidance related to emergency preparedness and workplace violence.

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

15.8 The Role of the Nurse in Moderate Sedation

15.9 Performance of Laser Therapy by RNs or LVNs

15.10 Continuing Education: Limitations for Expanding Scope of Practice

Clarifies that expansion of an individual nurse's scope of practice has licensure-related limitations. Informal continuing education or on-the-job training cannot be substituted for formal education leading to the next level of practice/licensure.

15.11 Delegated Medical Acts

Specifies criteria which must be met for a nurse to carry out a delegated medical act. This includes documentation of individual training and competency, procedures to be performed, physician order to initiate, and appropriate medical and nursing back up.

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

15.13 Role of LVNs and RNs in School Health

15.14 Duty of a Nurse in Any Practice Setting

Establishes that a nurse has a responsibility and duty to a patient to provide and coordinate the delivery of safe, effective nursing care, through the NPA and Board Rules. This duty supersedes any facility policy or physician order.

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

If an RN or LVN functions in role lower than that for which licensed, or in another area with an overlapping scope of practice, the nurse is still held to the level of education and competency of their highest licensure. Also restricts use of the titles LVN or RN or any designation implying nursing licensure by non-nurses (Rule 217.10 and NPA Section 301.351 and new NPA Section 301.004(a) (5))

15.16 Development of Nursing Education Programs

Judicious development of new nursing programs is urged, as adding programs alone will not address the growing nursing shortage. Key considerations are delineated.

15.17 BON/ Board of Pharmacy Joint Position Statement on Medication Errors

15.18 Nurses Carrying Out Orders from Advanced Practice Registered Nurses (APRN)

15.19 Nurses Carrying Out Orders from Pharmacists for Drug Therapy Management

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

15.21 [Deleted 01/2005]

15.22 APRNs Providing Medical Aspects of Care for Others with Whom There is a Close Personal Relationship

The BON is concerned that when APRNs provide medical aspects of care for other individuals with whom they have a close personal relationship the APRNs risk allowing their personal feelings to cloud their professional judgment. Thus APRNs should not provide medical treatment or prescribe medications for individuals with whom they have a close personal relationship.

15.23 The RN's Use of Complementary Modalities

Regardless of practice setting, RNs who incorporate complementary modalities into their practice are accountable and responsible for adherence to the NPA and BON Rules and Regulations. Specific regulations of particular relevance are identified in the position statement, including a reference to the BON's Six-Step Decision-Making Model for Determining Nursing Scope of Practice. Also, a list of criteria is included in order for RNs to show accountability for the care they provide. Lastly, RNs are accountable to hold proper credentials (eg, license, certification, registration) to safely engage in specific practices, where applicable.

15.24 Nurses Engaging In Reinsertion of Permanently Placed Feeding Tubes

15.25 Administration of Medication & Treatments by LVNs

15.26 Simulation in Prelicensure Nursing Education

15.27 The Licensed Vocational Nurse Scope of Practice

The LVN scope of practice is a directed scope of practice and requires appropriate supervision. The LVN is responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable healthcare needs.

15.28 The Registered Nurse Scope of Practice

The RN takes responsibility and accepts accountability for practicing within the legal scope of practice and is prepared to work in all healthcare settings, and may engage in autonomous nursing practice without supervision by another healthcare provider. The RN is responsible for providing safe, compassionate, and comprehensive nursing care to patients and their families with complex healthcare needs.

15.29 Use of Social Media by Nurses

The use of social media can be of tremendous benefit to nurses and patients alike. However, nurses must be aware of the potential consequences of disclosing patient-related information via social media. Nurses must always maintain professional standards, boundaries, and compliance with state and federal laws as stated in Board Rule 217.11, Standards of Nursing Practice. All nurses have an obligation to protect their patient's privacy and confidentiality [as required by Board Rule 217.11(E)] which extends to all environments, including the social media environment.

Ethical and Legal Practice

Ethics is a branch of philosophy that deals with right and wrong. It is a system of principles and rules of conduct recognized and accepted by a specific group or culture. **Bioethics** covers a broad set of possible topics, such as ethical standards and moral problems created by the practice of medicine, ethical issues in neuroscience, protection of research participants, privacy issues raised by genome sequencing, and research with children.

Clinical ethics is a discipline or methodology for considering the ethical implications of medical technologies, policies, and treatments, with special attention to determining what ought to be done (or not done) in the delivery of healthcare (Brock & Mastroianni, 2013).

Law is the set of enforced rules under which a society is governed. Laws can be created either through legislation, which is called *statutory law*, or by opinions written by judges in court cases, which is called *case law* (Center for Bioethics, n.d.).

The law establishes the rules that define a person's rights and obligations. Law also sets out penalties for those who violate these rules. Laws are changed frequently to reflect societal needs. In every society laws often have a strong moral standard (Porter, 2001). Two of the most common types of potential legal actions against healthcare providers for injuries resulting from healthcare involve lack of informed consent and violation of the standard of care (Brock & Mastroianni, 2013).

Nursing Code of Ethics

Ethical practice guidelines have been around since the early days of nursing. An ethical pledge for nurses—a modified version of the Hippocratic Oath called the Nightingale Pledge—was developed by Lystra Gretter in 1893. The first code of ethics for nurses was suggested by the American Nurses Association in 1926 and adopted in 1950 (Lyons, 2011).

The American Nurses Association maintains the current code of ethics for the nursing profession; it is called *A Code of Ethics for Nurses with Interpretive Statements*; last modified in 2015, it contains nine provisions, which detail "the ethical obligations of all nurses." It "addresses individual as well as collective nursing intentions and actions; it requires each nurse to demonstrate ethical competence in professional life" (ANA, 2015).

Codes of ethics are broadly written and are not meant to serve as a blueprint for ethical decision making. They are intended to provide a reminder of standards of conduct: that the nurse has a duty to keep confidentiality, maintain competence, and safeguard patients from unethical practice (Lyons, 2011).

The Language of Bioethics

The language of biomedical ethics is applied across all practice settings, and four basic principles are commonly accepted by bioethicists. These principles include (1) autonomy, (2) beneficence, (3) nonmaleficence, and (4) justice. In health fields, veracity and fidelity are also spoken of as ethical principles but they are not part of the foundational ethical principles identified by bioethicists.

The Principle of Autonomy: Personal Freedom

Autonomy is an American value. We espouse great respect for individual rights and equate freedom with autonomy. Our system of law supports autonomy and, as a corollary, upholds the right of individuals to make decisions about their own healthcare.

Respect for autonomy requires that patients be told the truth about their condition and informed about the risks and benefits of treatment. Under the law, adult patients are permitted to refuse treatment even if the best and most reliable information indicates that treatment would be beneficial, unless their action may have a negative impact on the well-being of another individual. These conflicts can set the stage for ethical dilemmas.

The concept of autonomy has evolved from paternalistic physicians who held ethical decision-making authority, to patients empowered to participate in making decisions about their own care, to patients heavily armed with Internet resources who seek to prevail in *any* decision making. This transition of authority has been slower to evolve in the geriatric population, but, as the baby boomers age, they are asserting this evolving standard of independence. Autonomy, however, does not negate responsibility. Healthcare at its foundation is a partnership between the provider and the recipient of care. Each owes the other responsibility and respect.

The Principle of Beneficence: Kindness

Beneficence is the act of being kind. The beneficent practitioner provides care that is in the best interest of the patient. The actions of the healthcare provider are designed to bring about a positive good. Beneficence always raises the question of subjective and objective determinations of benefit versus harm. A beneficent decision can only be objective if the same decision would be made regardless of who was making it.

Traditionally the ethical decision making process and the ultimate decision were the purview of the physician. This is no longer the case; the patient and other healthcare providers, according to their specific expertise, are central to the decision-making process (Valente & Saunders, 2000).

The Principle of Nonmaleficence: Do No Harm

Nonmaleficence means doing no harm. Providers must ask themselves whether their actions might harm the patient either by omission or commission. The guiding principle of *primum non nocere*, "first of all, do no harm," is based in the Hippocratic Oath. Actions or practices of a healthcare provider are "right" as long as they are in the interest of the patient and avoid negative consequences.

Florence Nightingale spoke of nonmaleficence more than 150 years ago when she reminded us that "the very first requirement in a hospital is that it should do the sick no harm"—and proceeded to set up systems and practices that are still being used today to enhance the quality and safety of patient care (Hughes, 2008).

Patients with terminal illnesses are often concerned that technology will maintain their life beyond their wishes; thus, healthcare providers are challenged to improve care during this end stage of life. Patients may even choose to hasten death if options are available (Phipps et al., 2003). The right of the individual to choose to “die with dignity” is the ultimate manifestation of autonomy, but it is difficult for healthcare providers to accept death when there may still be viable options.

Here we see the principle of nonmaleficence conflicting with the principle of autonomy as the healthcare providers desire to be beneficent or, at the least, cause no harm. The active choice to hasten death versus the seemingly passive choice of allowing death to occur requires that we provide patients with all the information necessary to make an informed choice about courses of action available to them.

A complicating factor in end-of-life decisions is patients’ concern that, even if they make their wishes clear (eg, through an advance directive), their family members or surrogates will not be able to carry out their desires and permit death to occur (Phipps et al., 2003). Treating against the wishes of the patient can potentially result in mental anguish and subsequent harm.

The Principle of Justice: Equity and Fairness

Justice speaks to equity and fairness in treatment. Hippocrates related ethical principles to the individual relationship between the physician and the patient. Ethical theory today must extend beyond individuals to the institutional and societal realms (Gabard & Martin, 2003).

Justice may be seen as having two types: distributive and comparative. **Distributive justice** addresses the degree to which healthcare services are distributed equitably throughout society. Within the logic of distributive justice, we should treat similar cases similarly, but how can we determine if cases are indeed similar? Beauchamp & Childress (2001) identify six material principles that must be considered, while recognizing that there is little likelihood all six principles could be satisfied at the same time.

Principles of Justice

To each person:

- An equal share
- According to need
- According to effort
- According to contribution
- According to merit
- According to free market exchanges

Looking at the principles of justice as they relate to the delivery of care, it is apparent that they do conflict in many circumstances; for example, a real-life system that attempts to provide an equal share to each person is distributing resources that are not without limit. When good patient care demands more than the system has allocated, there may be a need for adjustments within the marketplace.

Comparative justice determines how healthcare is delivered at the individual level. It looks at disparate treatment of patients on the basis of age, disability, gender, race, ethnicity, and religion. Of particular interest currently are the disparities that occur because of age. In 1975 Singer related bias as a result of age to gender and race discrimination and referred to the practice as **ageism** (Gabard & Martin, 2003). In a society where equal access to healthcare does not exist, there is a continuing concern about the distribution of resources, particularly as the population ages and the demand for services increases.

The first wave of baby boomers is signing up for Medicare now, and the health spending projections for the next decade are significant (Keehan et al., 2008). Thorpe & Howard (2006) found that there has been an increase in medication use of 11.5% in the past decade just for the medical management of metabolic syndrome, an age-associated complex of diseases. McWilliams and colleagues (2007) found that Medicare beneficiaries who were previously uninsured, and who enrolled in Medicare at age 65, may have greater morbidity, requiring more intensive and costlier care, than they would have had they been previously insured. The cost to the system of low levels of care is extensive. Recognizing the number of uninsured Americans who will ultimately come into the Medicare program with potentially greater morbidity, it appears that the demands of justice in the healthcare system will continue to increase.

Equitable allocation of resources is an ever-increasing challenge as technology improves and lives are extended through natural and mechanical means. All of these factors place greater stress on an already inefficient and overburdened healthcare system and results in more difficult ethical decisions about workforce allocation and equitable distribution of financial resources.

The Principle of Veracity: Truthfulness

Veracity is not a foundational bioethical principle and is granted just a passing mention in most ethics texts. It is at its core an element of respect for persons (Gabard, 2003). Veracity is antithetical to the concept of medical paternalism, which assumes patients need to know only what their physicians choose to reveal. Obviously there has been a dramatic change in attitudes toward veracity because it forms the basis for the autonomy expected by patients today. **Informed consent,** for example, is the ability to exercise autonomy with knowledge.

Decisions about withholding information involve a conflict between veracity and deception. There are times when the legal system and professional ethics agree that deception is legitimate and legal. Therapeutic privilege is invoked when the healthcare team makes the decision to withhold information believed to be detrimental to the patient. Such privilege is by its nature subject to challenge.

The Principle of Fidelity: Loyalty

Fidelity is faithfulness, or loyalty. It speaks to the special relationship developed between patients and their healthcare provider. Each owes the other loyalty; although the greater burden is on the medical provider, increasingly the patient must assume some of the responsibility (Beauchamp & Childress, 2001). Fidelity often results in a dilemma, because a commitment made to a patient may not result in the best outcome for that patient. At the root of fidelity is the importance of keeping a promise, or being true to your word. Individuals see this differently. Some are able to justify the importance of the promise at almost any cost, and others are able to set aside the promise if an action could be detrimental to the patient.

The Relationship of Ethics and the Law

> The moral conscience is a precursor to the development of legal rules for social order.
>
> Brock & Mastroianni, 2013

Ethics has been described as beginning where the law ends. Both share the goal of creating and maintaining social good (Brock & Mastroianni, 2013). Ethics never stands alone, nor does the law. Some issues that have both ethical and legal components include:

- Access to medical care
- Informed consent
- Confidentiality and exceptions to confidentiality
- Mandatory reporting
- Mandatory drug testing
- Privileged communication with healthcare providers
- Advance directives
- Reproductive rights/abortion
- Physician-assisted suicide

The Carnegie Foundation describes the educational components needed for work as a professional as involving three essential areas: (1) intellectual training to learn the academic knowledge base and the capacity to think in ways important to the profession; (2) a skill-based apprenticeship of practice; and (3) an apprenticeship to the ethical standards, social roles, and responsibilities of the profession, through which the novice is introduced to the meaning of an integrated practice of all dimensions of the profession, grounded in the profession's fundamental purposes (Hughes, 2008).

The Affordable Care Act is an example of a set of laws developed with a number of ethical issues in mind. Due to pre-existing conditions or simple unavailability, tens of millions of people have been unable to purchase health insurance at any cost. The law addresses this inequity by requiring most U.S. citizens and permanent residents to purchase health insurance (Lachman, 2012). The law also addresses insurances choices and costs, and puts into place certain rights and protections for consumers.

Recall the ethical concept of *distributive justice* discussed in the previous section, which addresses the degree to which healthcare services are distributed equitably throughout society. The Affordable Care Act was developed largely in response to this ethical concept, namely the situation in which many millions of people have no insurance and up to $100 billion of care is cost-shifted onto patients who are able to pay or who are on an existing insurance plan. This shift raised the average annual health insurance premium roughly $1,000 for every insured family (Lachman, 2012), which raises additional ethical issues of equity and fairness.

The Affordable Care Act also touches on the ethical principles of *beneficence* (kindness) and *nonmaleficence* (do no harm) by setting up affordable healthcare exchanges and plans. The exchanges are an integral part of the complicated issue that is created when healthcare is mandated. It is based on the concept that mandating health insurance without addressing affordability would cause significant harm to individuals and families who are struggling financially (Lachman, 2012).

Although ethics attempts to identify all available options to a given problem and consider the implications of each option, the law often places limits on those options. This intersection of the law and ethic often creates conflict and raises these important questions:

- Which bioethical choices, if any, should be limited by laws?
- Should laws make "immoral" activities illegal if there is no victim?
- How much weight should courts and legislators give to bioethical arguments when creating new laws?
- What is the proper balance between individual rights to treatment and the cost and efficacy of such treatment? (Porter, 2001)

Ethical Conflicts and Dilemmas

Ethical dilemmas arise when there are equally compelling reasons both for and against a particular course of action and a decision *must* be made. It is a dilemma because there is a conflict between the choices. Usually one action, though morally right, violates another ethical standard. A classic example is stealing to feed your family. Stealing is legally and ethically wrong, but if your family is starving it might be morally justified (Noel-Weiss et al., 2012).

Kidder calls this a "right vs. right" dilemma. When evaluating the alternatives, both courses of action have positive and negative elements. Right vs. right is an *ethical dilemma*, whereas right vs. wrong is identified as a *moral temptation* (Kidder, 1996).

Working through an ethical dilemma until a satisfactory conclusion is reached, making decisions that lead to good actions, and avoiding negative consequences and regret are the foundational principles of ethical practice (Noel-Weiss et al., 2012).

Sources of Ethical Conflict

Research suggests that ethical conflicts are on the rise in the nursing field, due both to the increasing complexity of care and to scientific and technological advances. Several studies that sought to analyze ethical conflicts that arise in critical care units noted that the ethical conflicts experienced by critical care nurses stem from three main sources:

- Relationships with patients and their families
- The provision of certain treatments
- The characteristics of the setting in which the clinical team works (Falcó-Pegueroles et al., 2013)

In the first area, the decision-making process comes up against issues such as the difficulty of ensuring informed consent, a failure to respect confidentiality, and failure to protect the patient's interests. The second area involves the provision of certain treatments in which nurses experience conflict when asked to administer treatment they regarded as overly aggressive, when pain management seemed to be deficient, or when it became necessary to limit the use of life support procedures. In the third area—workplace dynamics—conflict arises when nurses were not fully involved in the decision-making process or if they feel the work environment made it difficult to consider questions of a bioethical nature (Falcó-Pegueroles et al., 2013).

Making the Right Decision

Situations that create ethical conflicts highlight the difficulty involved in making the right decision. Andrew Jameton identified three types of ethical conflicts that nurses may experience in the clinical setting that can cause distress:

1. Moral uncertainty
2. Moral dilemma
3. Moral distress (Falcó-Pegueroles et al., 2013)

In a situation of *moral uncertainty* the professional is unsure whether an ethical problem exists, or recognizes that there is such a problem but is unclear about the ethical principles involved. A *moral dilemma* can arise when the professional must choose between two or more morally correct principles, each of which would lead to a distinct course of action (Falcó-Pegueroles et al., 2013).

Finally, *moral distress* is felt when the professional recognizes the ethical principles involved and knows the right thing to do but is constrained by something or somebody from acting accordingly. Judith Wilkinson has described an additional type of ethical conflict, which she calls *moral outrage*, a type of ethical conflict in which the professional experiences a sense of impotence in the face of an immoral action performed by others (Falcó-Pegueroles et al., 2013).

The Ethical Decision-Making Process

The primary function of a decision is to commit to some sort of action: a decision reduces to zero the uncertainty about what to do. **Primary uncertainty** is the uncertainty associated with "what to do."

To arrive at a decision, called **secondary uncertainty**, the decision maker must be motivated by some sort of pressure and must work to reduce uncertainty about the pros and cons of a selected course of action. Secondary uncertainty includes uncertainty about the situation, goals to be achieved, and available options or courses of action. Once secondary uncertainty has been reduced, commitment to a chosen option can occur. As soon as a commitment is made, a decision is made, and uncertainty falls to zero (Breck & Garcia, 1998).

While exploring how to improve a person's decision-making skills, researchers have categorized decision makers as novice, advanced, competent, or expert:

Novice

- Able to solve simple decision-making problems
- Slow and unreliable in recognizing problems needing decisive action
- Unable to identify a decision window
- Rudimentary ability to discern between important and unimportant features of a situation
- Unable to identify options in a hierarchical manner

Advanced

- Proficient in using, finding, and defining decision-making concepts
- Can invent their own way of doing things
- Recognizes the need to make a decision in a timely and reliable manner
- Able to solve moderately complex decision-making problems
- Only able to develop incomplete options

Competent

- Able to use principles and achieve competence in finding procedures and rules
- Capable of focusing on situation and context and can modify options to fit these features
- Recognizes decision problems
- Manages time well
- Develop well-ordered and complete options
- Can solve complex decision-making problems
- Fully competent in reducing uncertainty

Expert

- Decision-making is automatic, fast, and reliable
- Recognition and timing is no longer a problem
- Able to judge and apply context intuitively and instinctively
- Able to quickly identify the "first, best" option—satisfactory option simply "comes to mind"
- Very efficient at reducing uncertainty
- Able to see the situation, goal, and options based on minimal cues
- Able to probe available information for a perceived pattern (Breck & Garcia, 1998)

Professional Boundaries

Provision 2 of the American Nurses Association Code of Ethics states that "The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population." A nurse must always be guided by that primary commitment to the patient. Certain situations may offer particular challenges to nurses, including conflicts of interest, collaborative situations, and issues of professional boundaries (ANA, 2015).

Conflicts of interest may present themselves in direct care settings, in working with a patient within a family context, and even in administrative settings. They may present themselves as conflicts between a patient's values and those of the nurse (ANA, 2015).

In today's complex healthcare system, collaboration among many parties is often critical. Nurses can help ensure participation and "facilitate informed decision-making by assisting patients to secure the information that they need to make choices consistent with their own values" (ANA, 2015).

Professional boundaries are essential because of the personal nature of nursing relationships and the need to keep the patient's needs primary. Boundaries may be tested by anything from whether or not to accept a gift from a patient, which may be acceptable in certain situations, to dating and sexually intimate relationships with patients [which] are always prohibited" (ANA, 2015).

As practitioners in one of the most widely respected and trusted professions, nurses must be knowledgeable regarding professional boundaries and vigilant in their observation of those boundaries (NCSBN, 2015).

The Continuum of Professional Behavior

Professional boundaries may be viewed in light of a **continuum of professional behavior** model that views the **therapeutic relationship** between nurse and patient as the ideal in the center and **under-involvement** and **over involvement** as the usually undesirable positions to either side.

Over-involvement includes boundary crossings, boundary violations, and professional sexual misconduct. Under involvement can include distancing, disinterest, and neglect, and be damaging to both the patient and the nurse (NCSBN, 2014). The continuum model represents a situation in which definite lines do not exist between over- or under-involvement and a therapeutic relationship; it is usually a gradual transition (NCSBN, 2014).

The National Council of State Boards of Nursing (NCSBN) defines professional boundaries as "the spaces between the nurse's power and the client's vulnerability" (NCSBN, 2014). Maintaining professional boundaries is critical to open and professional communication and it supports trust, compassion, mutual respect, and empathy, which are key elements of the nurse-patient relationship (Hanna & Suplee, 2012). A nurse's responsibility to keep the patient's needs at the forefront and to always treat them with dignity and respect preclude many of the behaviors that constitutes crossings or violations of boundaries. Sometimes, however, it is not clear cut and details of context can be important. It is always advisable to consult a trusted colleague or supervisor when questions arise.

Boundary Crossings and Boundary Violations

[This section from Hanna & Suplee, 2012.]

Boundary crossings are generally defined as deliberate decisions to cross an otherwise established boundary for a therapeutic reason. These could include going out of one's way to give a patient a more convenient appointment time or a home health nurse performing some non-healthcare-related task such as washing dishes or doing laundry. Accepting gifts, exchanges of personal information in order to reassure someone, or calling to check on someone who has been discharged would also fall into this category. Touch is another problematic issue in relation to boundaries. All of these have the potential to be unclear and to be interpreted differently according to personal and cultural factors.

Boundary violations, on the other hand, should send out danger signals and are usually more clear-cut because they are not being done for any reason that could be justified as "therapeutic" for the patient. These might include refusing to discharge a patient when a qualified caregiver is available, or releasing patient information in violation of HIPAA privacy regulations.

Sexual misconduct is the most extreme form of boundary violation and is always forbidden. The NCSBN defines sexual misconduct as "engaging in contact with a patient that's sexual or may reasonably be interpreted by the patient as sexual, and verbal behavior that's seductive or sexually demeaning, or engaging in sexual exploitation of a patient or former patient." Other activities such as kissing or discussing possible dating activity would also fall under the sexual misconduct label.

Even these activities can fall into gray areas at times, especially when a nurse-patient relationship has technically ended. However, nurses have a professional responsibility to know and understand their own boundaries as well as rules and laws applicable in their institution and state. Never be afraid to consult a trusted colleague, a supervisor, or your state board for guidance if in doubt.

Vulnerable Populations

Patients who are most at risk for boundary violations tend to have these characteristics:

- Female gender
- A diagnosis of bipolar disorder and/or other personality disorders
- Complain of emptiness or boredom
- Are articulate and have reasonable social skills
- A history of childhood or physical abuse
- Like to keep secrets with staff
- May wish to be touched, hugged, and reassured that they're liked

Certain practice situations such as long-term care and rehabilitation care settings may provide greater opportunities for inappropriate boundary crossings or violations.

Boundary crossing behavior can be initiated by nurses, patients, or family members, and nurses must be alert to warning signs for themselves and for colleagues. It can be difficult to confront or report a colleague, but most institutions and states have requirements and procedures for doing so. Blatant sexual misconduct that is witnessed must always be reported to supervisors, the state board, and possibly local law enforcement.

Resources and References

Resources

Texas Resources
Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, TX 78701-3944
Phone: 512 305 7400
Fax: 512 305 7401
https://www.bon.texas.gov/index.asp

Texas Nurses Association
Office Address for TNA and all Affiliates:
8501 N. MoPac Expy., Suite 400
Austin, TX 78759-8396
tna@texasnurses.org
Toll free: 800 862 2022
Local: 512 452 0645
Fax: 512 452 0648

National Resources
American Nurses Association
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910
800 274 4ANA
http://www.nursingworld.org/

National Council of State Boards of Nursing
https://www.ncsbn.org/index.htm
Numerous resources on nursing education, licensure, practice, and discipline, including written guidelines and video material on professional boundaries.

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Post Test

Use the answer sheet following the test to record your answers.

1. The nation’s first nurse practice act was signed into law:

    a. In North Carolina in 1903.
    b. In California in 1850.
    c. In Ohio in 1915.
    d. In Puerto Rico in 1897.

2. The purpose of the Texas Nurses Association is:

    a. Unionizing to represent nurses.
    b. Advancing excellence in nursing.
    c. Mediating between hospitals and staff.
    d. Enforcing the nurse practice act.

3. Texas signed its first nurse practice act into law in:

    a. 1809.
    b. 1899.
    c. 1909.
    d. 1919.

4. All nurses are now required to complete at least two contact hours in nursing jurisprudence and ethics:

    a. At every license renewal.
    b. Once in a lifetime.
    c. Only if they work in hospitals or public clinics.
    d. Prior to the end of every third licensure renewal cycle.

5. The Texas Administrative Code is:

    a. A compilation of all state agency rules in Texas.
    b. A set of guidelines for nursing practice.
    c. A permanent collection of state laws updated annually.
    d. Laws amended every five years as needed by the State of Texas.

6. Texas Board of Nursing (BON) Rule 217.11 covers standards:

a. Applicable only to certain groups of nurses.

b. Applicable to all nurses.

c. Applicable to nurses and physicians.

d. Applicable only to nurses trained in other states.

7. Failure to meet the standards in BON Rule 217.11:

a. May result in action against the nurse’s license only if actual patient injury resulted.

b. May result in action against the nurse’s license only if the nurse is sued by the patient or a family member.

c. May result in action against the nurse’s license even if no actual patient injury resulted.

d. May result in action against the nurse’s license only if a crime was committed.

8. Texas Board of Nursing (BON) Position Statements:

a. Have the force of law.

b. Do not contain any information on scope of practice.

c. Do not include any statements on ethical issues.

d. Include a statement on the use of social media by nurses.

9. An evolving standard of autonomy supports patients but must be balanced with:

a. Demonstrated skills in ethical decision making.

b. A willingness to partner responsibly with their provider.

c. Effective use of the Internet to gather facts about their care.

d. Absence of mental or emotional issue.

10. Beneficence means:

a. Being kind.

b. Doing little harm.

c. Ensuring services for all.

d. Encouraging independence.

11. Nonmaleficence means:

a. First of all, assess your patient.

b. Not being malicious.

c. Doing no harm.

d. Avoiding malpractice.

12. Veracity means:

a. Paternalism, based on the need for hierarchical decision making.

b. Therapeutic privilege founded on a practitioner's right to privacy.

c. Legitimacy and the concept of moral relativism.

d. Truthfulness founded on a respect for persons.

13. In ethics, "right vs. right" is an ethical dilemma. What is "right vs. wrong"?:

a. A moral temptation.

b. An ethical morass.

c. An easy choice.

d. A stark divide.

14. Ethical conflicts are on the rise in the nursing field due to:

a. Society in general is exhibiting a decline in ethical standards.

b. Patients are more aggressive and demanding due to the Internet.

c. Increasing complexity of care and advances in technology.

d. Nursing education fails to address potential ethical conflicts that may arise.

15. The primary function of a decision is to commit to some sort of action. To arrive at an ethical decision, you must:

a. Weigh the ethical principles involved no matter how long it takes.

b. Assess the situation, goals to be achieved, and options for action, then commit.

c. Explore your uncertainties to look for possible hidden motivations.

d. Look over the situation and then make your move. It's better to act than to wait.

16. The continuum of professional behavior as a model for the nurse-patient relationship refers to:

a. Nurse practice acts.

b. Professional boundaries.

c. Registered nurse practice settings.

d. Legal decisions.

Answer Sheet

TX: Jurisprudence and Ethics for Nurses

Name (Please print your name): ____

Date: ______________

Passing score is 80%

1. _______
2. _______
3. _______
4. _______
5. _______
6. _______
7. _______
8. _______
9. _______
10. _______
11. _______
12. _______
13. _______
14. _______
15. _______
16. _______

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks * are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

* Upon completion of the course, I was able to:

a. Explain how the Texas Nursing Practice Act came about.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. Discuss the provisions of the Texas Statutes and the Administrative Code.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. Explain Texas Board of Nursing (BON) Rules, especially Rule §217.11, Standards of Nursing Practice.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. Describe Texas BON Position Statements and their purpose.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. State the six Principles of Bioethics.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Define professional boundaries and their potential threats.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* This course contained no discriminatory or prejudicial language.

○ Yes ○ No

* The course was free of commercial bias and product promotion.

○ Yes ○ No

* As a result of what you have learned, do you intend to make any changes in your practice?

○ Yes ○ No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- ○ Yes, within the next 30 days.
- ○ Yes, during my next renewal cycle.
- ○ Maybe, not sure.
- ○ No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- ○ Yes, definitely.
- ○ Possibly.
- ○ No, not at this time.

* What is your overall satsfaction with this learning activity?

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* Navigating the ATrain Education website was:

- ○ Easy.

- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour
- 40-49 minutes per contact hour
- 30-39 minutes per contact hour
- Less than 30 minutes per contact hour

I heard about ATrain Education from:

- Government or Department of Health website.
- State board or professional association.
- Searching the Internet.
- A friend.
- An advertisement.
- I am a returning customer.
- My employer.
- Other
- Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- 18 to 30
- 31 to 45
- 46+

I completed this course on:

- My own or a friend's computer.
- A computer at work.
- A library computer.
- A tablet.
- A cellphone.
- A paper copy of the course.

Please enter your comments or suggestions here: ______________________________

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Please print and answer all of the following questions (* required).

* Name: ____________________

* Email: ____________________

* Address: ____________________

* City: ____________________ * State: ________ * Zip: ________

* Country: ____________________

* Phone: ____________________

* Professional Credentials/Designations:

____

Your name and credentials/designations will appear on your certificate.

* License Number and State: ____________________

* Please email my certificate:

○ Yes ○ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

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You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
2 contact hours: $19

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* Name: ____________________

Address (if different from above): ____________________

* City: ____________________ * State: ________ * Zip: ________

* Card type:

○ Visa ○ Master Card ○ American Express ○ Discover

* Card number: ____________________

* CVS#: ____________________

* Expiration date: ____________________