AM I WITHIN MY SCOPE?

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CE 1 CONTACT HOUR

Learning Outcome:

Nurses will increase their knowledge of the legal scope of practice and Board of Nursing resources (decision trees and Position Statements) to effectively recognize and prevent situations that may exceed legal scope.

Disclosure:

The authors and planners of this CE activity have disclosed that there are no conflicts of interest related to the content of this activity. See the last page of the article to learn how to earn CE credit.

I'll just do this first and then call Dr. Smith later, I'm sure he won't mind… We do this all the time… I know how to do this, it's no big deal. Have you ever said something like this? Upon further reflection, you may find that you have done this more frequently than you would have imagined. This could be the signal for you to ask yourself, "Am I exceeding my scope of practice?"

In this article, common examples seen by the Board will be discussed to help nurses recognize subtle actions which can lead to at-risk practice. We will review the importance of scope of practice and how to ensure you are practicing safely. Discussion questions are provided to encourage nurses to think about their own practice and common situations they may have encountered.

Scope of Practice History

The Nursing Practice Act (NPA) originated in North Carolina, in 1903. North Carolina was the first state to enact a nurse registration law to protect the title "nurse" and to improve the practice of nursing (Russell, 2017). It is the responsibility of each state and US territory to enact an NPA to govern the practice of nursing, providing laws and rules.

While the role of an RN or LPN may vary between facilities and employers, the fundamentals of nursing practice are outlined in each state's NPA. According to the American Nurses Association (ANA), the method to define nursing scope of practice is a two-step process (Scope of Practice, n.d.). First, a law known as a "nurse practice act" must be passed in the state, then regulatory bodies create and implement the rules and regulations (Scope of Practice, n.d.). The Nursing Practice Act (law) and related rules define and regulate a variety of areas within in nursing, including scope of practice.

Scope of Practice in North Carolina

The scope of nursing practice is defined in the North Carolina Nursing Practice Act under §90-171.20 (7) for the registered nurse and (8) for the licensed practical nurse. The Board offers a variety of resources for nurses that have questions regarding their scope of practice. Nurses are encouraged to review the Practice Act, which can be accessed at, https://www.ncleg.net/enactedlegislation/statutes/html/byarticle/chapter_90/article_9a.html. The NCBON website https://www.ncbon.com/ provides useful links, contacts, and resources. Additionally, nurses and employers are able to contact the Board of Nursing and speak with a Practice Consultant to determine whether a task is within the scope of practice.

The Board of Nursing frequently receives complaints where a nurse has exceeded his or her scope of practice. Some exceeding scope of practice situations seem obvious, while others are not as clear and should cause the nurse to stop and analyze the situation. Exceeding scope can evolve from a slippery slope of risk-taking decisions and behaviors. Disciplinary actions can be imposed for exceeding scope of practice and may range from a letter of concern up to suspension of a license.

The Board of Nursing encourages all nurses to review the Scope of Practice Decision Tree, the RN and LPN Scope of Practice Components Comparison Chart, and the Board's position statements on both RN and LPN Scope of Practice. Comparing and contrasting the similarities and differences between RN and LPN Scopes will clarify practice parameters for all nurses.

- https://www.ncbon.com/vdownloads/position-statements-decision-trees/scope-of-practice-decision-tree-rn-lpn.pdf
- https://www.ncbon.com/vdownloads/position-statements-decision-trees/color-rn-lpn-scope-comparison-chart.pdf
- https://www.ncbon.com/vdownloads/position-statements-decision-trees/lpn-position-statement.pdf
- https://www.ncbon.com/vdownloads/position-statements-decision-trees/rn-position-statement.pdf

"This is how we have always done it"

Frequently nurses will run into a situation where they are asked to perform a task that they have never performed or be told it is alright to perform a task or sign an order because "this is how we have always done it." The culture of a unit or facility can play a key role in nursing scope of practice. Exceeding scope can be disguised as "bending the rules." There are a number of reasons that nurses may bend the rules, for example, unfamiliarity with policies and regulations or believing that their professional judgement is in the best interest of the patient (Bending the Rules, 2016). Regardless of patient outcomes, exceeding your scope or bending the rules could jeopardize your employment and your ability to practice.

Believing that it is alright to complete a task, fail to notify a physician, write an order without permission, or accept an assignment because this is the norm on a unit can lead to at-risk practice. Hahtela, et al. (2017) found that unit characteristics were associated with adverse events and nurses' perception of autonomy. Nurses are encouraged to follow their chain of command, speak with risk management, and utilize the Board's website to ensure that they are practicing within their scope and not drifting beyond scope by following the unit culture.

How can I be sure I am staying within my scope?

The best way to be sure you are practicing within your scope of practice is to stay informed, take advantage of educational opportunities, and familiarize yourself with both organizational policies and Board scope documents.

Olin (2012) describes factors for nurses to ask themselves when faced with the question if they are within their scope. For example, did I learn this skill in nursing school or clinical experience, is this task so commonplace that it can be "reasonably and prudently" assumed within scope; is this skill or task in your facility policy/procedure manual; does this skill pass the "reasonable and prudent" standard of nursing" (Olin, 2012)?

Think about your practice. Do you bend the rules? Do you "assume" something is correct because it is the way it has always been done? Chastain (2016) reported that "if left unquestioned, the rule-bending action then tacitly becomes acceptable practice not only by that individual but may be adopted by others in the unit or facility and many times leads to what is referred to as a cultural norm."

You are encouraged to review the following discussion questions, based on common Board complaints, and think about how they apply to your practice.

Discussion Questions

In the first scenario, Julia, a wound care nurse, is called by a staff nurse for a phone consultation regarding a patient's wound because the patient does not seem to be responding favorably to the current treatment. Nurse Julia makes a recommendation based on what the staff nurse reports, without actually assessing the wound or reviewing the chart, and writes the order. She assumes that the physician will agree because he always has. In fact, he will usually ask Nurse Julia what she suggests for wound therapy.

STOP: What is the correct action at this time?

a) The nurse should not write the order until she actually speaks with the physician or office nurse communicating on behalf of the physician and receives confirmation.

b) The nurse should write the order and have staff begin the new wound care with the next scheduled dressing change.

c) The nurse should write the order but not have staff implement the order.

Discussion:

Answer is (a). The nurse should not write a verbal or telephone order unless he/she has received the order. Additionally, no change in wound care treatment should ever be implemented until it is approved by the physician.

In scenario #2, Kate, a nursing supervisor administers a particular commonly used medication to a patient after assessing the patient with respiratory distress. The nurse assumes that the patient has a standing order protocol in place which includes an order for the medication. The nurse does not stop to go check the computer or chart to ascertain what current orders exist.

STOP: What is the correct action at this time?

a) The nurse should go on and administer the medication because she is certain after assessment that the patient needs the medication.

b) The nurse should check

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with another supervisor and make sure the medication is appropriate based on the patient assessment.
c)..The nurse should not administer the medication without speaking with the physician and obtaining an order.

Discussion:
Answer is (c). The nurse should not administer any medication without a current order for the medication from the physician. The nurse should not assume that an order was present without actually checking the medical record and verifying the orders first.

In scenario #3, Mary, a nurse working at a home care agency is preparing a recertification packet for an existing patient that has received the same basic care and orders for a few months. The nurse has been on vacation and realizes that the packet is overdue, and the new certification period should begin today. The nurse assumes the physician wants the patient to continue receiving home care and just updates the orders and prepares the paperwork for the physician to sign.

STOP: What is the correct action at this time?
a) The nurse should just send the paperwork and instruct the staff assigned to this patient to continue to make visits as usual, so the patient's services are not disrupted.
b) The nurse should contact the physician and obtain the order to continue home care services before any additional visits are made.
c) The nurse should ask the agency Administrator to approve the continuation of care.

Discussion:
Answer is (b). The nurse should contact the physician prior to the expiration of existing orders and obtain a verbal order to continue services. If the current orders have expired, the nurse must obtain new orders prior to staff making any additional visits. Staff cannot continue to make visits to a patient for which no current orders exist.

In scenario #4, Good Care Nursing Home has an open position for Director of Nursing and has had difficulty finding qualified applicants in the rural area. A day shift LPN has been employed at this facility nearly 20 years and knows everything about this facility. The LPN approached the Administrator and said she would be willing to take the position because, after all, she has the most knowledge and seniority and would love a promotion with more money.

STOP: What should the Administrator do?
a) Ask the corporate office because they deal with this all the time.
b) Praise the LPN for her previous work but explain that in NC, an LPN cannot manage the delivery of nursing care and administration of nursing service. This function is within the RN scope of practice only.
c) Allow the LPN to be the interim DON for as long as it takes to hire and train an RN.

Discussion:
Answer is (b). It is beyond the scope of practice for an LPN to be responsible for nursing unit or facility management and nursing administration.

In scenario #5, Jeff, a nurse working on a hospital unit is caring for a patient that has a physician's order for Zolpidem 10mg at bedtime. When the nurse goes in to administer the medication, the patient states that she only wants to take half of the pill. The nurse breaks the pill in half, administers it to the patient and wastes the other half. The nurse stated that he didn't want to bother the physician for something like this.

STOP: What should the nurse have done?
a) Inform the nurse witnessing the waste that only half of the ordered dose was given.
b) Tell the patient that it's fine to give her only half.
c) Contact the physician and request a change in the order.

Discussion:
Answer is (c). It is not within the scope of the RN or LPN to change the dosage of a medication unless there are parameters included in the order authorizing the discretion. The nurse needs to contact the provider and receive new orders before giving a different dosage.

In scenario #6, Susan, a LPN working in a long term care facility is assigned to a patient that has orders for Valium 2mg twice daily. The medication is scheduled to be given at 10 am and 10 pm. Susan notes that the patient is agitated around 5 am and knows the patient has Valium ordered and decides to administer the scheduled Valium early as a prn dose. Susan signs the medication out on the controlled substance form, however she does not report this to oncoming shift.

STOP: What would be the appropriate action by the nurse?
a) Give the medication at 5 am because the patient was agitated and clearly needed it.
b) Give the medication at 5 am and report to oncoming nurse.
c) Contact the provider for prn order.

Discussion:
Answer is (c). It is not appropriate for

the nurse to administer a scheduled medication early because the patient needs it. The medication was ordered q 12 hours in this case and the medication was not yet due. The provider should have been contacted for further orders.

In scenario #7, Thomas works in an emergency department and is a charge nurse. Getting patients through the ED efficiently is a major quality focus of the department. Thomas enters basic lab orders indicating "based on protocol" on a patient with minor symptoms that's been triaged. There is no protocol for routine labs in the ED. Thomas does this to make sure the patient gets moved through quickly and the ED doesn't get backed up.

STOP: What is the correct action?
a) Contact the ED provider and obtain orders for the labs.
b) Contact the ED provider when the results come back.
c) There is no need to contact the provider because the labs returned normal and now the patient can be seen and discharged more quickly.

Discussion:
Answer is (a). There was no protocol in the ED for Thomas to use. Thus, the provider had to write an order for any lab work. Thomas should have contacted the provider and asked if any labs should be ordered.

In scenario #8, Anna, a Women's Health Nurse Practitioner is seeing a patient for an annual well check visit. The patient's husband accompanies her and asks Anna if she can write him a prescription for some Adderall because he is having trouble focusing at work. He tells Anna he was on Adderall years ago but hasn't taken it recently.

STOP: What should the NP do?
a) Write the prescription for the patient's husband because he seems like he is truthful.
b) Tell the patient's husband she cannot treat him for this problem because her specialty is Women's Health.
c) Tell the patient's husband to make an appointment and she'll be glad to treat his ADHD.

Discussion:
Answer is (b). Anna would be practicing outside her scope as a WHNP by prescribing Adderall for the patient's husband.

In scenario #9, Beth comes in for her morning shift in the emergency department after a late night at a New Year's Eve party. Because Beth has been counseled about too many absences, she goes into work really sick even though she knows she shouldn't. Beth asks a coworker to start an IV and give her some fluids and Zofran. Beth has seen other staff do this before and thinks it's no big deal.

STOP: What should the coworker do?
a) Tell Beth that she needs to speak to ED provider and be seen if she's that sick.
b) Take Beth to an empty room and give her the fluids and Zofran because they need her to be able to work and she's not really a patient so it should be fine.
c) Tell Beth to just get some Zofran out of the Pyxis and take it.

Discussion:
Answer is (a). The coworker should not administer medication to Beth as it's not within a nurse's scope of practice to order IV fluids and medication.

In scenario #10, George, an ICU nurse, is caring for a patient that is intubated and has an order for Fentanyl 50 mcg every 20 minutes. The patient starts to wake up and is grimacing and agitated. George removes 100 mcg Fentanyl and begins to push the medication slowly while he monitors the patient. He gives the full 100 mcg in about 5 minutes and the patient calms downs and appears to be resting comfortably. George documents that he gave the Fentanyl as two separate doses but tells the oncoming nurse that he gave a "nursing dose" of Fentanyl to the patient and it seemed to help.

STOP: What was the correct action?
a) Report to oncoming nurse what medication was given so that nurse will have complete information on the patient's status.
b) Contact the physician after giving the Fentanyl and tell the physician that the patient is requiring more Fentanyl than what was ordered.
c) Administer 50 mcg Fentanyl and wait 20 minutes before administering another 50 mcg.

Discussion:
Answer is (c). The nurse should have followed the order as it was written. The nurse could have contacted the physician after the first dose if the patient did not improve.

As you can see from the discussion questions, the concept of scope of practice reaches further than the RN and LPN role. It encompasses advanced practice nursing, nurse managers, nurse leaders, and should be considered when delegating nursing tasks. Additional information on delegation can be found at https://www.ncbon.com/vdownloads/position-statements-decision-trees/decision-tree-delegation-to-uap.pdf Our hope is that this article and the discussion questions have caused you to reflect on your practice and provided resources for you to access throughout

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your career.

Are you exceeding your scope?

Are you practicing safely?

What steps can you take to ensure you are providing safe care to your patients?

Please consider utilizing the resources, websites, and decision trees described in this article. If you have further questions, please contact the NCBON at (919) 782-3211 and ask to speak to a practice consultant.

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INSTRUCTIONS

Read the article, online reference documents (if applicable), and reflect on the questions under the "Discussion Questions" section of this article.

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Go to www.ncbon.com and scroll over "Nursing Education"; under "Continuing Education," select "Board Sponsored Bulletin Offerings," scroll down to the link, "Am I Within My Scope?". When you register, please write down your confirmation number, complete, and submit the evaluation; and print your certificate immediately.

If you experience issues with printing your CE certificate, please email practice@ncbon.com. In the email, please provide your full name and the name of the CE offering (Am I Within My Scope?).

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The North Carolina Board of Nursing will award 1 contact hour for this continuing nursing education activity.

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The following disclosure applies to the NCBON continuing nursing education article entitled "Am I Within My Scope?".

Participants must read the article, online reference documents (if applicable), and reflect on the questions under the "Discussion Questions" section of this article in order to be awarded CE contact hours. Verification of participation will be noted by online registration, and the completion and submission of the online evaluation form. Neither the author or members of the planning committee have any conflicts of interest related to the content of this activity.