Minnesota Medical Association Task Force Report on Delegation to Licensed Practical Nurses (LPNs) in a Clinic or Physician Office Setting

This report provides guidance to physicians and clinic managers regarding the medical functions that might appropriately be delegated to a licensed practical nurse (LPN) within a clinic or physician office setting.

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MMA
Minnesota Medical Association

LPN ISSUES TASK FORCE

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History of the Issues

The impetus for examining LPN scope of practice issues was a request from members of the Minnesota Academy of Family Physicians (MAFP) who asked the MMA to review several issues related to LPN practice in the non-acute setting. MAFP members were concerned because opinions issued by the Minnesota Board of Nursing (MBON) in its publications were interpreted by the MAFP to mean that LPNs could no longer perform the skills/tasks/activities that they had routinely been delegated in the physician office or clinic setting.

Several physician offices and clinics began considering an LPN hiring freeze and contemplated hiring and training non-nurses such as medical technicians or medical aides to carry out delegated medical functions that are performed in a clinic and office setting. Concerned about the impact on the quality of patient care, many physicians questioned the advisability of hiring non-nurses. Physicians believe that LPN staff are capable of providing the care needed by clinic patients and that LPNs are more qualified to provide nursing care and carry out delegated medical orders than unlicensed assistive personnel such as an aide or technician.

Because of physicians' concerns, in August 2000 the MMA House of Delegates passed the following resolution introduced by the MAFP:

> RESOLVED that the MMA draft legislation amending MN Statute 151.37, Subd. 2 (a), the Pharmacy Act, to allow for physicians to direct a licensed practical nurse to administer legend drugs under practice guidelines or protocols, and be it further RESOLVED that the MMA work with appropriate nursing and other organizations to develop guidelines for the supervision of LPNs by RNs or physicians that will support the provision of quality patient care.

In response, the MMA created the Ad Hoc LPN Issues Task Force to study the topics addressed in the resolution. Invited to join the task force were several Minnesota nursing organizations including the Minnesota Board of Nursing, the Minnesota Nurses Association, the Minnesota LPN Association, Service Employees International Union, and the Minnesota Practical Nurse Directors and Educators Association. The task force met for several months. During this time, the nursing organizations also met separately to discuss and work out various issues that were brought up by physician members of the task force.

The Minnesota Nurse Practice Act (MNPA) and the Authority of the Minnesota Board of Nursing (MBON)

The MNPA (Minnesota Statutes section 148.171-148.285) is the statute or law that governs nursing practice in Minnesota. Nurses are also governed by Minnesota Rules Chapter 6301-6330.

As agents of state government, boards of nursing through statutes and rules are empowered to regulate activities related to nursing education, licensure and practice within their respective jurisdictions to meet the states' constitutional obligations of protecting their citizens. The State Board of Nursing confers a license to a qualified registered nurse (RN) or licensed practical nurse (LPN) authorizing the individual to engage in professional or practical nursing and certifying that the individual has attained the minimal degree of competency to ensure that public health, safety and welfare will be reasonably well protected.

The Minnesota Nurse Practice Act (MNPA)

(Please note, for the purposes of this report, only those portions of the statutes and rules that apply to RNs and LPNs will be discussed.)

The Minnesota Nurse Practice Act defines RN practice as the practice of *professional* nursing [emphasis added]. The Act states, "the practice of professional nursing means the performance for compensation or personal profit of the professional interpersonal service of (1) providing a nursing assessment of the actual or potential needs of individuals, families, or communities; (2) providing nursing care supportive to or restorative of life by functions such as skilled ministration of nursing care, supervising and teaching nursing personnel, health teaching and counseling, case finding, and referral to other health resources; and (3) evaluating these actions. The practice of professional nursing includes both independent nursing functions and delegated medical functions that may be performed in collaboration with other health team members, or may be delegated by the professional nurse to other nursing personnel. Independent nursing function may also be performed autonomously. The practice of professional nursing requires that level of special education, knowledge, and skill ordinarily expected of an individual who has completed an approved professional nursing education program…" It is important to note that the RN is termed *professional* and the responsibilities are delineated much more specifically than those in the LPN definition that follows. Specifically, the responsibilities of assessment, delegation, evaluation, supervision and teaching of nursing personnel, and health teaching are clearly defined by the Minnesota Board of Nursing as responsibilities of an RN.

The Minnesota Nurse Practice Act defines practical nursing as the "performance for compensation or personal profit of any of those services in observing and caring for the ill, injured, or infirm, in applying counsel and procedure to safeguard life and health, in administering medication and treatment as prescribed by a licensed health professional, which are commonly performed by LPNs and which require specialized knowledge and skill such as are taught or acquired in an approved school of practical nursing, *but do not require the specialized education, knowledge, and skill of a registered nurse* [emphasis added]." The language that has been emphasized is the crux of the controversy about what tasks/activities can be assigned and delegated to an LPN. The Minnesota Nurse Practice Act does not offer examples of the activities an LPN is licensed to perform and those that should only be performed by an RN. For example, the nursing statute does not specify the specific medications and treatments that may be administered by an LPN.

What Activities Specifically Differentiate LPN and RN Practice?

A clear delineation between RN and LPN practice is difficult because the nursing profession as a whole has not developed consensus on what makes a nursing skill, task, or activity one that can only be performed by an RN versus a nursing skill, task, or activity that can be delegated to an LPN. Although it would seem logical that LPN skills, tasks, and activities delineated in statute and rules would be comparable from state to state and the specifics of their scope of practice reflected in state's statutes, this is not the case. Some state's statutes are very specific about an LPN's scope of practice, but others, such as Minnesota statutes, are vague and open to interpretation.

Although there are some recent studies that validate the positive outcomes of care provided by RNs (NEJM, Vol 345, No.22. May 30, 2002), there is little, if any, research that differentiates the outcomes of care provided by LPNs versus RNs, particularly in the outpatient setting such as a clinic or physician office. A detailed review of the literature on this subject reveals a notable lack of research and information about the effectiveness of care provided by RNs versus care provided by LPNs.

It is important that persons who develop nursing policies, procedures and protocols or who delegate to an LPN understand the differences and similarities between LPN and RN education and training and the functions that can only be delegated to an RN. Arguably, an apt analogy might be the similarities and differences between the scope of practice of a physician and an advanced practice registered nurse (APRN). Both have overlapping areas within their scope of practice, yet physicians also have a scope of practice that goes beyond that of an APRN because of their education and training and the provisions of their state license. Similarly, because RNs receive more extensive and in-depth education and training than LPNs, they are licensed to practice beyond the scope of practice of an LPN.

LPN and RN Educational Preparation and Training

A nurse must be licensed in a state in order to work as an RN or LPN and the exams for these two levels are separate and distinct, as are the qualifications that must be met before a candidate can sit for the examination. The differences in the education and training of LPNs and RNs are important to consider when determining what an LPN is able to do and what responsibilities must be assigned to an RN. Other considerations might include the client's/patient's condition, the complexity of the task, the ability of the RN or LPN to carry out the care that has been delegated, the amount of supervision, if any, that is required, the expertise and training that has been acquired since licensure, and the risk of liability for the delegator and the delegatee. The following information describes the basic differences between LPN and RN education.

LPN Education

Educational preparation for an LPN is usually nine to 15 months in a community college or technical college, and a high school diploma or the equivalent is required prior to enrollment. Becoming an LPN requires completion of a formal training program plus supervised clinical instruction. The curriculum includes the study of nursing, body structure and function, basic psychology, pharmacology, math and communication skills. Graduates of an approved program take a licensing examination for practical nursing. Upon passing the NCLEX-PN examination the graduate is eligible for state licensure by the Minnesota Board of Nursing and is allowed to use the title of licensed practical nurse (LPN).

Upon graduation from an approved program, an LPN is prepared to function as a member of the health-care team by exercising sound nursing judgment based on educational preparation, knowledge, skills, understanding and experiences in nursing situations. The LPN participates in the planning and implementation of nursing care in all settings; monitors changes in patients' symptoms and conditions; and performs more specialized nursing functions such as administering medications and therapeutic treatments prescribed by a licensed health professional, i.e., an advanced practice registered nurse, physician, or dentist.

RN Education

RNs can receive their education in several ways: a four-year baccalaureate degree program in nursing, a two-year associate degree program, or a three-year diploma program. Graduates of each program are able to use the title RN (registered nurse) after passing the National Council of State Boards of Nursing NCLEX-RN examination, the same exam taken by every RN candidate, regardless of their educational route.

Upon graduation, an RN is prepared to function as a member of the health-care team by exercising sound nursing judgment based on educational preparation, knowledge, skills, understanding and experiences in nursing situations. The RN practices both independently and by carrying out delegated medical functions. The RN is responsible for the planning, implementation and evaluation of nursing care; including developing, implementing and evaluating a plan of care, modifying the plan of care using evidence-based practice, analyzing nursing interventions, providing patient education and evaluating changes in patients' symptoms and conditions; performing more specialized nursing functions such as administering medications and therapeutic treatments; and performing other delegated medical functions as prescribed by a licensed individual such as a physician or dentist.

Associate Degree in Nursing (ADN)

Associate degree nurses (ADN) are prepared to function in various health care settings as providers of care, managers of care, and members of the discipline of nursing. The ADN provides care for individuals of all ages and performs patient care functions which require special knowledge in the psychological, biological, physical and social sciences. In 2001, 44 percent of registered nurses in Minnesota graduated from an ADN program.

Associate degree nursing programs are offered at universities, colleges and community colleges and require approximately two years of full-time study and include 60 to 72 college credit hours. The curriculum and clinical learning opportunities reflect current trends in health care and courses in the sciences and humanities. Upon completion of a registered nurse AD program, the graduate is eligible to take the NCLEX-RN examination. Upon completion of an approved program of registered nursing and after passing the exam, the candidate is entitled to apply for state licensure by the Minnesota Board of Nursing and to use the title of registered nurse (RN).

Three-Year Diploma Program

Although 19 states continue to offer a program resulting in a Diploma in Nursing, this type of nursing program is no longer offered in Minnesota. Twenty-three percent of RNs currently practicing received their education in a three-year diploma program. Programs were hospital based and required three years of full-time study and clinical experience. Upon completion of the diploma program, the graduate was eligible to take the NCLEX-RN, which upon passing entitled the candidate to apply for state licensure by the Minnesota Board of Nursing and to use the title of registered nurse (RN).

Baccalaureate of Science in Nursing (BSN)

Graduates of baccalaureate nursing programs are prepared to provide health promotion and health restoration care for individuals, families and populations in a variety of institutional and community settings. The program of study emphasizes courses in the natural sciences, social and behavioral sciences, humanities and nursing. Baccalaureate education emphasizes critical decision making skills, independent nursing judgment, and management and research skills.

These nursing education programs are offered by colleges and universities and are approximately four years in length (120 to 135 college credit hours). The usual degree awarded is the Bachelor of Science in Nursing (BSN). Upon completion of an approved program of registered nursing, the graduate is eligible to take the NCLEX-RN, which upon passing entitles the candidate to apply for state licensure by the Minnesota Board of Nursing and to use the title of registered nurse (RN). In 2001, 33 percent of registered nurses in Minnesota graduated from a BSN program.

Interpretation of the Statutes and Rules by the Minnesota Board of Nursing

As with many state statutes and rules, those governing the practice of RNs and LPNs in Minnesota are broad in definition and leave latitude in the exact interpretation of the statutory language. The Minnesota Board of Nursing has the authority to adopt and revise rules that are consistent with the law as deemed necessary to enable the Board to carry out its responsibility to safeguard the public's health. However, it must be noted that the actual statutory language governs nursing practice and it is always subject to judicial review and interpretation. The initial interpretation by the Board of Nursing may be challenged by a licensed individual and is subject to further interpretation by the courts. The Board may also issue general interpretations of the nursing statutes.

Through their nursing publications, most frequently in their newsletter, *For Your Information*, the MBON has provided interpretation of statutes and rules that apply to all settings where nurses practice. Although the MBON maintains that there is no difference in the interpretation of the law based on patient care setting, it is important to note that to adequately safeguard public health, the interpretations might appear to apply to the area of practice where patient care is the most acute, e.g., a hospital setting. In a setting where care provided to patients is less acute, e.g., a clinic/physician office/ambulatory care setting, it is important to balance patient needs with available nursing staff and ensure that nursing assignments correspond with the level of expertise required to provide quality patient care. In an outpatient setting such as a clinic, there might be little need for RNs to perform a comprehensive patient assessment or develop a detailed plan of nursing care, as is always the case in an acute care setting.

In the past several years, there have been several specific areas of nursing practice where the MBON has provided written interpretations regarding the responsibilities that fall into RN or LPN scope of practice. These areas have included the following activities: supervision, assessment, delegation and telephone triage.

Who Can Provide Supervision of Nursing Practice, According to the MBON?

Although some states' statutes, e.g., Alabama, Colorado, Kentucky, New Mexico and Maryland to name a few, specifically allow an LPN to "supervise," an article in the May 2000 MBON publication, *For Your Information*, "Who May Supervise Nursing Practice?" defined supervision as "the guidance by a *registered nurse* [emphasis added] for the accomplishment of a function or activity. The guidance consists of establishing the initial direction, delegating, setting expectations, directing activities and courses of action, critical watching, overseeing, evaluating and changing a course of action" [Minn. Rules Part 6321.010, subpart 3 (2001)].

Supervision is defined in Minnesota Rules 6321.0100 as "establishing direction, delegating, setting expectations, directing activities and courses of action, critical watching, overseeing, evaluating and changing a course of action." In the May 2000 advisory, the Board stated, "an LPN may not perform the activities defined as nursing supervision, e.g., delegate, plan, direct, or evaluate nursing practice." The advisory further stated, "an LPN is not legally authorized to supervise any nursing personnel, including RNs, other LPNs, or unlicensed assistive personnel, such as a nursing assistant or a medical assistant." The advisory also stated, "LPNs should not be employed in positions that require the LPN to delegate and supervise staff who perform nursing care." The Nurse Practice Act provides that only an RN may delegate independent nursing functions such as planning, directing, evaluating nursing practice, or changing a course of action.

It is important to note that although LPNs may not supervise, an LPN is allowed to *monitor* the practice of other LPNs or unlicensed assistive personnel. Minnesota Rules 6321.0100 defines monitoring as the "periodic inspection…of a directed function or activity and includes watching during the performance, checking, and tracking progress, updating a supervisor of progress or accomplishment by the person [that has been] monitored, and contacting a supervisor as needed for direction and consultation." LPNs may be directed by a physician to monitor another person by utilizing a checklist of items that must be observed when monitoring a specific task or employee. It is essential to indicate in the checklist that the LPN is expected to report to a physician or other licensed individual in regard to the actions that have been monitored.

A physician may direct an LPN to carry out medical functions including administering medication and treatments or following established protocols that are within the LPN's scope of practice. LPNs may also establish staff working schedules, order supplies and follow other established condition-specific protocols.

Who Can Perform an Assessment, According to the MBON?

Webster's Dictionary defines assessment as (1) the act or instance of appraising, (2) to determine the amount, and (3) to make an official valuation. The *Lexicon Dictionary of Health Care Terms* defines assessment as (1) the process of determining the value, significance, or extent of something, or (2) the systematic collection and analysis of patient-specific data necessary to determine patient care and treatment needs. In a Fall 1994 *For Your Information*, the MBON stated that the RN is responsible for the act of assessment and the LPN is responsible for observing, monitoring and reporting observations. In a clinic or outpatient setting, the LPN provides care under the supervision of an RN or a licensed practitioner.

In an acute care setting RNs are always available and responsible for deciding who will carry out medical or nursing directives. In a clinic or office setting where an RN might not be available or on-site, the physician has the authority to delegate medical directives to an LPN. A medical directive can be appropriately delegated to an LPN if the LPN has acquired the specialized knowledge and skills to carry out the directive, and the LPN follows the accepted standard of care that would be provided by a "reasonable and prudent" nurse.

As opposed to many states where statute specifically states that LPNs "provide care under the direction of a licensed professional nurse or physician or dentist," Minnesota law does not specifically state that an LPN work "under the direction of a physician." However, it does state that an LPN can "administer medication and treatment prescribed by a licensed health professional." The MBON interprets this to mean that the law provides for LPNs to accept delegation of medical functions directly from a physician, and the LPN is accountable for accepting delegation. The licensed health professional delegating to an LPN must ensure that the LPN has the knowledge and skill to carry out the directive. For instance, an LPN cannot, according to the MBON, be expected to interpret and analyze a patient's response to a medical directive. The ability to analyze, interpret and change the care provided to a patient can be done by an RN, physician, or APRN.

Who Can Participate in Telephone Nursing, According to the MBON?

It is important to note that after meeting with various nursing organizations involved with the MMA Ad Hoc LPN Issues Task Force regarding the issue of providing directions to patients via telephone, the nursing group came to consensus that the term "telephone triage" should be replaced by the term "telephone nursing." This decision was made because the word "triage" in its strictest interpretation means the sorting out or screening of patients to determine the type of medical service that is required and assigning a priority as to when and where the service should best be provided. Originally developed in military medicine to determine who needed immediate care and who could wait for care, triage is a term that is still used at disaster sites, in hospital emergency departments and at other sites where limited medical resources need to be allocated. By virtue of this strict definition, only an RN is licensed to carry out this function as triage calls for independent judgment that only the RN has been educated to provide.

The use of the term "telephone triage" as it is applied and utilized in a clinic or physician office is very different from the strict definition as explained previously. In a clinic or office setting, patients who telephone a clinic are "triaged" by clinic or office personnel based on predetermined protocols of care that have been developed by an RN or other licensed practitioner such as a physician, doctor of osteopathy, dentist, optometrist, podiatrist, or advanced practice registered nurse. Therefore, based on the pure and most frequent use of the term "triage", this activity has, instead, been termed "telephone nursing."

Telephone nursing by definition is an activity that involves responding to a patient's telephone inquiry and using a pre-determined protocol to direct the caller to the appropriate care. LPNs practice telephone nursing using protocols developed by a licensed practitioner. The protocols should provide clear statements regarding what information to request of the caller, and, depending on the caller's responses, how to direct the caller to proceed. If the caller's responses fall outside the protocol, the LPN needs to consult with the licensed practitioner who developed the protocol or refer the caller to an RN or other licensed practitioner who will make an assessment and determine the plan of care. As defined in Minnesota Statutes section 151.01, Subd.23, "practitioner" means a licensed doctor of medicine, a licensed doctor of osteopathy duly licensed to practice medicine, a licensed doctor of dentistry, a licensed doctor of optometry, licensed podiatrist, physician assistant authorized to prescribe, or an advanced practice registered nurse.

An LPN can respond to the caller by collecting data using established protocol questions; establishing the urgency of the call; referring the caller to a licensed practitioner if the caller presents multiple or complex problems or falls outside the protocol; implementing the interventions listed in the protocol; transmitting information to the patient's practitioner; recognizing deviations from protocol criteria; documenting implementation of the protocol; and reporting caller response and outcomes to the licensed practitioner.

Who Can Administer Legend Drugs and Vaccines Under Practice Guidelines or Protocols?

Prior to 2002, LPNs were inadvertently omitted from the statute that determined who could administer a vaccine in a flu clinic setting. During the 2001-2002 legislative session, Minnesota Nursing Statute, 148.235, Subd. 8, was amended to read as follows:

> Subd. 8. Vaccine by protocol. A nurse may implement a protocol that does not reference a specific patient and results in the administration of a vaccine that has been predetermined and delegated by a licensed practitioner as defined in section 151.01, subdivision 23 when caring for a patient whose characteristics fall within the protocol and when the protocol specifies the contraindications for implementation, including patients or populations of patients for whom the vaccine must not be administered and the conditions under which the vaccine must not be administered.

Also during the 2001-2002 legislative session, Minnesota Nursing Statute, 148.235, Subd. 9, was amended to read as follows:

> Subd. 9. Prescription by protocol. A registered nurse may, based on an assessment, implement a protocol that does not reference a specific patient and results in a prescription that has been predetermined and delegated by a licensed practitioner as defined under section 151.01, subdivision 23, when caring for a patient whose condition falls within the protocol and when the protocol specifies the circumstances under which the drug is to be prescribed or administered.

In addition to changes made in Minnesota Nursing Statutes, the Minnesota Pharmacy Statute, Section 151.37, Subd. 2, was changed to read as follows:

> Subd. 2. Prescribing and filing. (a) A licensed practitioner in the course of professional practice only may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, *by directing a nurse, pursuant to section 148.235, Subd. 8. and 9.*[emphasis added], physician assistant, medical student, or resident to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order as an agent of the prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of section 147A.18.

Suggested Guidelines for Patient Care Management by LPNs in the Clinic or Physician Office Setting

As with the practice of medicine, nursing - both practical and professional nursing - is not limited to skills acquired in formal education and training. Therefore, the tasks and responsibilities of an LPN should not be limited to those skills acquired as part of their formal education and training prior to licensure, but may also include other selected tasks/skills/activities in which the nurse has become competent.

Most employers in outpatient settings such as a clinic or physician office are not regulated by external organizations such as the Joint Commission on Accreditation of Hospital Organizations, the National Council on Quality Assurance, or the state health department. Although they are not regulated, employers have an obligation to provide quality care. One way to meet this obligation is to objectively determine employees' abilities and level of expertise. Another is to develop policies and procedures that adhere to standards and clearly define an LPN's scope of practice as described in Minnesota statute and rule.

To a large degree, the work setting will influence and dictate the need for the type of tasks/skills/activities in which the employee must demonstrate competence. Employers should ensure competence by the use of one or more of the following methods: a written examination, peer review, self assessment, supervised practice experience, practice evaluation, computer simulated and virtual reality testing, targeted continuing education with outcomes measurement, skills testing and practice evaluations. The responsibilities for which the LPN will be held accountable must correspond to the LPN's legal scope of practice and must follow accepted nursing standards and guidelines developed for the practice setting that ensure safe performance of patient care activities.

Some Suggested Standards for LPN Practice Within a Clinic or Physician Office Setting

Rationale: To establish minimal, acceptable levels of practice for the LPN, the employer through discussions with delegating licensed practitioners, i.e., physicians, advanced practice registered nurses, or RNs, must ensure the following:

> Any patient care activities that are delegated to an LPN are within the LPN scope of practice as described in the Minnesota Nurse Practice Act.
>
> The skill/task/activity is specifically delineated in the office/clinic policy and procedure manual as appropriate for an LPN to perform.
>
> The skill/task/activity passes the "reasonable and prudent" standard for nursing care that can safely be performed by an LPN.
>
> A licensed practitioner appropriately authorizes the skill/task/activity.
>
> The skill/task/activity is within accepted standards of care that would be provided in similar circumstances by LPNs with similar education, training and clinical skills.

The LPN possesses the knowledge, skill and clinical competence to perform the skill/task/activity safely as documented in the LPN's personnel file.

The LPN is accountable for clarifying any medical directive or order.

The skill/task/activity has not been deemed inappropriate for an LPN to perform by directives issued by the Minnesota Board of Nursing.

The skill/task/activity has been included in the LPN's basic nursing education or the LPN has acquired competence as demonstrated to an RN or other licensed practitioner.

Personal Responsibilities of the LPN

The LPN shall:

Demonstrate knowledge and understanding of Minnesota statutes and rules governing nursing and function within the legal boundaries of practical nursing practice.

Accept responsibility for individual nursing actions, competence and behavior.

Maintain competence in safe practical nursing practice and obtain instruction and supervision as necessary when implementing a medical directive or providing nursing care.

Consult with other health care team members and seek guidance as necessary.

Contribute to the formulation, interpretation, implementation and evaluation of the objectives and policies related to nursing practice within the clinic setting.

Participate in the evaluation of nursing practice through peer review.

Report unsafe nursing practice to licensed practitioner supervisors or the clinic manager.

Prior to delegating a task or activity to an LPN the following questions should be asked:

- What experience has the LPN had with the population being treated?
- What is the level of experience of the LPN with the task that has been delegated?
- What education, preparation and orientation have been provided to ensure that the LPN can safely carry out the delegated skill/task/activity?
- Does a mentor need to observe the LPN prior to the independent performance of the delegated skill/task/activity?
- Is a licensed practitioner, i.e., a physician or registered nurse, available if questions arise?
- Does the skill/task/activity require a written protocol?
- If so, have protocols been developed by appropriate practitioners, e.g., an RN or other licensed practitioner?
- Are there sufficient systems in place that will permit the LPN to decline to perform the delegated skill/task/activity without jeopardizing the LPN's employment status?

Development of Physician Office and/or Clinic-Based Policies, Procedures and Protocols

Every clinic or physician office setting should have policies, procedures and protocols that have been developed to provide guidance and clarity for the performance of quality patient care. The policy, procedure and protocol must not conflict with language found in state statute or rule. For instance, an LPN is not authorized and should not be directed to implement a protocol that results in the administration of a legend drug, except in the case of a vaccine.

At a minimum, policies, procedures and protocols should be developed to address the following issues:

Verbal and/or Telephone Orders

1. Define who can *give* verbal and/or telephone orders. The policy should be consistent with the legal scope of practice of all involved.
2. Define who can *accept* verbal and/or telephone orders.
3. Define the specific time frame when verbal or telephone orders must be signed by the prescriber.
4. Define the documentation that is necessary to validate that the order was followed appropriately.
5. Determine an appropriate timeframe whereby protocols are reviewed and updated.

Supervision of Unlicensed Staff, Nursing Personnel and Re-delegation of Orders

1. Define who can re-delegate to nursing staff. The MBON has stated that only the registered nurse may accept the delegation of medical care and then legally re-delegate to other nursing staff.
2. Define who can supervise licensed and unlicensed staff.

It is important to remember the differences between the definitions of supervising and monitoring. If a physician delegates a medical function to an LPN, the physician is responsible for determining whether his/her direct oversight is required, or if being available on site is sufficient. If a course of action needs to be changed, the LPN must communicate with the physician and receive appropriate direction.

Development of Nursing Policies, Procedures and Protocols

1. Nursing staff, including both LPNs and RNs, should be involved in developing patient care policies, procedures and protocols since they must implement the policies, procedures and protocols effectively and remain within the parameters specified in the Nurse Practice Act.
2. A nurse is responsible for declining to accept delegated medical functions if the nurse thinks the function is inappropriate or would result in unsafe provision of care.
3. A policy should be developed that designates how a nurse should decline a delegated medical order. The policy should stipulate that a nurse has a legitimate right to refuse a delegation that the nurse thinks is inappropriate or would result in unsafe patient care.

Other Issues that Could Be Addressed in Policies, Procedures, or Protocols

1. The availability of a written policy, procedure, or protocol for carrying out a delegated task or responsibility.
2. The proximity of the physician or other licensed practitioner when nurses are following a policy, procedure, or protocol.
3. The type of supervision, if any, that might be necessary to carry out a given protocol.
4. Development of a protocol for dealing with potential complications or emergency situations within the clinic or physician office setting.
5. A policy that addresses the liability of the nurse and the licensed practitioner in the performance of a task or responsibility that has been delegated to a nurse.