

The LPN and Assessment Functions

POSITION STATEMENT

The Mississippi Board of nursing is a consumer protection agency with the authority to regulate the practice of nursing provided for by Mississippi Code of 1972, Annotated, Title 73, and Chapter 15.

A position statement is a scope of practice determination made by the Board, as to whether performance of an action by a licensed nurse is within acceptable standards. Position statements are administrative and educational tools that can be used to assist providers, licensed nurses, and other interested parties in scope of practice determinations. Position statements of the Mississippi Board of Nursing are formulated in response to the Board's legally mandated charge to protect the public through safe nursing practice.

ASSESSMENT

Assessment is the first step of the nursing process and an essential component of nursing practice. Assessment is an ongoing process. Nursing assessment is the gathering of information about a patient's biological, physical, behavioral, psychological, and sociological status. The Mississippi Board of Nursing has reviewed the scope of practice of the LPN in performing assessments and has incorporated the use of descriptive terms as adopted by the National Council of State Boards of Nursing in identifying the role of the LPN with assessments.

SCOPE OF PRACTICE

The Mississippi Nursing Practice Law §73-15-5 describes the scopes of practice for the registered nurse (RN) and the licensed practical nurse (LPN) differently. The RN functions at an independent nursing level while the LPN functions at a dependent nursing level. Beginning with the initial encounter and continuing throughout the episode(s) of care, assessment is the basis for nursing judgments, decisions, and interventions. Registered nurses conduct comprehensive nursing assessments of the health status of clients. A comprehensive nursing assessment is an extensive data collection (initial and ongoing) for individuals, families, groups and communities in addressing anticipated changes in client conditions, as well as emergent changes in a client's health status; recognizing alterations to previous client conditions; synthesizing the biological, psychological, spiritual and social aspects of the client's condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnoses; plan nursing interventions; evaluate need for different interventions; and assess the need to communicate and consult with other health team members. The licensed practical nurse has a directed scope of practice and conducts focused nursing assessments of the health status of clients. A focused assessment is an appraisal of an individual's status and situation at hand, contributing to comprehensive assessment by the RN, supporting ongoing data collection, and deciding who needs to be informed of the information and when to inform.

ROLE & ACCOUNTABILITY

Part 2830, Rule 1.2, of 30 Miss. Admin. Code pursuant to the Mississippi Nursing Practice Law states, "The registered nurse shall be held accountable for the quality of nursing care given to patients. This includes assessing the patient's needs,

formulating a nursing diagnosis, planning for, implementing and evaluating the nursing care in the promotion and the maintenance of health..." It is further stated that the licensed practical nurse "may assist the registered nurse in the planning, implementation and evaluation of nursing care by," in part, "observing, recording and reporting to the appropriate person the signs and symptoms that may be indicative of change in the patient's condition." Part 2830, Rule 1.3, also indicates, "The registered nurse shall be held accountable for the quality of nursing care given by self or others being supervised." Therefore, it is the responsibility of the registered nurse to perform the initial assessment of the patient. An initial assessment is considered to be a comprehensive assessment.

The licensed practical nurse may assist the registered nurse with both initial and comprehensive assessments by collecting data through performing a focused nursing assessment. The collection of data may consist of observing, recording and reporting basic information about the biological, physical, behavioral, psychological and sociological. This also includes responses to interventions and reactions to illness. The LPN's participation in assessment is limited to the direction or delegation of a RN, APRN, licensed physician, or licensed dentist; recognition of existing relationships between data gathered and the client's current health status; and determining the need for immediate nursing interventions and who should be informed. The RN retains overall responsibility for verifying data collected, interpreting data, and formulating nursing diagnoses. The registered nurse and/or licensed practical nurse should document and sign the portion of the assessment which he/she completed per facility policy and procedure.

The interval/frequency of nursing assessments is dependent upon the patient's status and accepted standards of practice. The registered nurse may delegate the observation and recording of a patient's ongoing or subsequent status to the appropriately prepared licensed practical nurse. Thus the registered nurse is responsible for knowing the patient's status and therefore must be informed on an ongoing basis of signs and symptoms indicative of change. The licensed practical nurse assisting with the initial and/or comprehensive assessment should be educated and competent. This education and competence must be documented initially and on an ongoing basis. This education/competence must be specific to the tasks being assigned. The facility/agency must have policies and procedures in place addressing all aspects of this issue including policies and procedures which assure that the patient's needs are met should a patient be admitted and the registered nurse is not immediately available.

Restraint/Seclusion Assessment

In April 2003, The Board of Nursing reviewed a request to expand the scope of practice of the licensed practical nurse to include the assessment and evaluation of patients during or immediately after restraint or seclusion. The Board determined it is not within the scope of practice of the licensed practical nurse to independently initiate seclusion and/or restraint of a patient/client or to complete the mandated assessments. The licensed practical nurse may not make independent decisions regarding the care of the patient and gives patient care under the direction of the registered nurse, physician, or licensed dentist which does not require the specialized skill, judgment and knowledge required of a registered nurse.

Although the determination of medical procedures and the patient's medical status is a medical decision, the Registered Nurse or Licensed Practical Nurse has the right and the obligation to question orders and

decisions which are contrary to acceptable standards and to refuse to participate in procedures which may result in harm to the patient.

SOURCES

1. National Council State Boards of Nursing, "Model Nursing Practice Act", revised 2010. Retrieved February 2011 from www.ncsbn.org.
2. North Carolina Board of Nursing, "LPN Scope of Practice – Clarification Position Statement for LPN Practice", original 1/2010. Retrieved from www.ncbon.com.
3. Texas Board of Nursing, "Interpretive Guideline for LVN Scope of Practice", revised 1/24/2006. Retrieved February 2011 from www.bon.state.tx.us.
4. Mississippi Community College Board, "2008 Mississippi Curriculum Framework Postsecondary Practical Nursing". Retrieved March 2011 from www.sbcjc.cc.ms.us.
5. Corazzini K.N., et al., (2011). Regulation of LPN Scope of Practice in Long-Term Care. *Journal of Nursing Regulation*, 2(2), 30-35.

HISTORY

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