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Contact Hours: **1**

Ohio Nurse Practice Act (1 Hour)

Law and Rules – Category A

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will have increased your knowledge of the standards of safe nursing practice as outlined in the Ohio Nurse Practice Act and the rules of the Ohio Administrative Code as written by the Ohio Board of Nursing in accordance with Section 4723 of the Ohio Revised Code. Specific learning objectives to address potential knowledge gaps include:

- Describe the Ohio Scope of Practice Decision-Making Model.
- Discuss the standards for competent nursing practice of RNs and LPNs in Ohio.
- Explain standards for the promotion of patient safety by licensed nurses in Ohio.
- Summarize the RN and LPN standards for applying the nursing process in Ohio.

The establishment of standards for nursing education and practice is the result of efforts by nursing associations that began over 100 years ago. Currently in each state or territory, a law known as the Nurse Practice Act designates an authoritative body that defines and regulates the nursing practice of every nurse in every role. This authoritative body, known as a board of nursing, is responsible for ensuring that nurses who practice in the state for which they have responsibility are competent, safe, skilled, and knowledgeable about the standards set forth in that state's scope of practice for nurses (NCSBN, 2018). This course presents those standards for the state of Ohio written by the Ohio Board of Nursing in accordance with the Nurse Practice Act.

OHIO BOARD OF NURSING AND OHIO ADMINISTRATIVE CODE

All licensed medical professionals work under accepted standards derived from local, state, and federal laws as well as professional guidelines. Licensed nurses are no exception. Their scope of practice is defined by the Nurse Practice Act (NPA) of the state in which they practice. In Ohio, the NPA is codified in Section 4723 of the Ohio Revised Code (ORC). It establishes an Ohio Board of Nursing (OBN) and defines its structure and function.

Ohio Board of Nursing (OBN)

The Nurse Practice Act (ORC 4723) authorizes the OBN to make and enforce rules and regulations for registered nurses, licensed practical nurses, advanced practice nurses (certified nurse-midwives, certified nurse practitioners, certified nurse specialists, and certified registered nurse anesthetists), dialysis technicians, and community health workers. The board regulates over 300,000 licenses and certificates. Its top priorities are to efficiently license the nursing workforce and remove dangerous practitioners from practice in a timely manner to protect Ohio patients (OH BON, 2021).

MEMBERSHIP

Board members are public officials and meetings are open to the public. The board is made up of thirteen members: eight registered nurses, four licensed practical nurses, and one consumer appointed by the governor. At least two of the registered nurses shall hold a current, valid license issued under the ORC that authorizes the practice of nursing as an advanced practice registered nurse. The board has the legal authority to administer and enforce all provisions of the NPA. It must review each rule within the Ohio Administrative Code (OAC) at least once every five years. The board is funded and supported by mandatory licensure fees paid by nurses wishing to practice legally in the state of Ohio. The board does not have authority over employers (ORC 4723.02).

SCOPE OF PRACTICE

Because nursing is a dynamic practice, questions may arise about whether certain tasks are within the nurse's scope of practice. All nursing care should be consistent with the nurse's preparation, education, experience, knowledge, and demonstrated competency.

The Ohio Board of Nursing has developed a Scope of Practice Decision-Making Model to help nurses determine whether a task is within their scope of practice. The model uses a decision tree with references and is based on legality, competency, safety, and accountability.

OBN SCOPE OF PRACTICE DECISION-MAKING MODEL

The Scope of Practice Decision-Making Model includes the following steps:

1. Define/describe the activity or task: Is the activity or task within the scope of practice and **not** prohibited or precluded by any other law or rule?

2. Can the nurse perform the activity or task and meet the standards of safe nursing practice as defined in OAC, chapter 4723-4? Can the nurse demonstrate and document current knowledge, skills, and abilities?

3. Is this activity or task safe and appropriate to perform with this patient at this time?

4. The nurse may perform the activity/task according to acceptable and prevailing standards of safe nursing care and prepare to accept accountability for the nursing actions.

Each of these steps must be answered with a "yes" before proceeding to the next step. If at any point an answer is "no," the nurse must not perform the action (OBN, 2019).

Ohio Administrative Code

The rules of the Board of Nursing regulate nursing practice in Ohio and are contained in Section 4723 of the Ohio Administrative Code (OAC). This course reviews those chapters in Section 4723 that set forth the standards of competency, safe nursing practice, delegation, application of the nursing process, and discipline for registered nurses and licensed practical nurses in the state of Ohio.

CONTINUING EDUCATION FOR RENEWAL FOR RNs and LPNs

For the period immediately following Ohio licensure by NCLEX examination, the nurse is not required to complete any contact hours of CE for the first license renewal. Other than the first renewal immediately following licensure by exam, nurses must complete at least 24 contact hours of CE that includes at least one contact hour of Category A CE for each renewal. A nurse who has been licensed in Ohio by reciprocity for less than or equal to one year prior to the first Ohio license renewal must complete at least 12 contact hours, rather than 24 (OBN, 2020).

STANDARDS OF COMPETENCY FOR RNs

[This section covers subsections (A) thru (K) of the OAC 4723-4-03, Standards relating to competent practice as a registered nurse.]

Registered nurses (A) provide nursing care within the **scope of practice** described in the Ohio Revised Code and the rules of the Ohio Board of Nursing and (B) maintain **current knowledge** of the duties, responsibilities, and accountabilities of safe nursing practice.

RNs must (C) be **competent and accountable** in all areas of practice, including consistent performance of all aspects of nursing care and appropriate recognition, referral or consultation, and intervention when complications arise.

RNs may (D) provide nursing **care beyond basic nursing preparation** for an RN provided they:

- Obtain additional education
- Demonstrate appropriate knowledge, skills, and abilities
- Maintain documentation of their additional education and training
- Have a specific current order from an authorized individual acting within their professional practice
- Do not carry out a function or procedure prohibited by any law or rule

RNs must (E) **implement** any order in a timely manner unless they believe or have reason to believe the order is:

- Inaccurate
- Not properly authorized
- Not current or valid
- Harmful or potentially harmful to a patient
- Contraindicated by other documented information

RNs must (E) **clarify** an order that meets any of the above criteria by consulting with an appropriate licensed practitioner.
When RNs (F) **decide not to follow an order** or prescribed medication or treatment after consulting with an appropriate licensed practitioner, the RN must:

- Notify the ordering practitioner of the decision not to follow the order
- Document that the practitioner was notified and state the reason for not following the direction
- Take any other action to ensure the safety of the patient

RNs (G) **report to and consult with** other nurses or members of the healthcare team and make referrals as necessary in a timely manner.

RNs must (H) **maintain the confidentiality** of patient information, communicating patient information with other members of the healthcare team for healthcare purposes only and accessing patient information only for patient care purposes or for fulfilling nursing responsibilities. This includes not disseminating patient information through social media, texting, emailing, or any other form of communication for purposes other than patient care.

To the maximum extent feasible, RNs must (I) **not disclose** identifiable patient healthcare information unless the patient has consented to such disclosure and must report individually identifiable patient information without written consent in limited circumstances only and in accordance with authorized laws and rules.

RNs must (J) **use acceptable standards** of safe nursing care as a basis for any observation, advice, instruction, teaching, or evaluation and communicate information that is consistent with acceptable standards of safe nursing care.

When RNs (K) give **direction to LPNs**, they must first assess:

- Condition and stability of the patient who needs nursing care
- The type of nursing care required
- The complexity and frequency of the care required
- The training, skill, and ability of the LPN who is to perform the specific function or procedure
- The availability and accessibility of resources needed to safely perform the function or procedure

The tasks assigned to LPNs must also be within the licensed practical nurse's legal scope of practice.

STANDARDS OF COMPETENCY FOR LPNs

[This section covers subsections (A) thru (J) of the OAC 4723-4-04, Standards relating to competent practice as a licensed practical nurse.]

A licensed practical nurse (LPN) must (A) function within the **scope of practice** of an LPN as set forth in division (F) of Section 4723.01 of the Ohio Revised Code and the rules of the Ohio Board of Nursing.

An LPN must (B) maintain **current knowledge** of the duties, responsibilities, and accountabilities for safe nursing practice.

An LPN must (C) demonstrate **competency and accountability** in all areas of practice, including consistent performance of all aspects of nursing care and appropriate recognition, referral or consultation, and intervention when complications arise.

An LPN may (D) provide nursing **care beyond basic preparation** for an LPN provided the LPN obtains appropriate education; demonstrates knowledge, skills, and abilities; and maintains satisfactory records of meeting these requirements. The LPN must have a valid order or direction from an authorized individual acting within their professional practice, and the nursing care cannot involve a function or procedure prohibited by any law or rule.

LPNs must (E) **implement or clarify** an order in a timely manner unless or whenever they believe or have reason to believe the order is:

- Inaccurate
- Not properly authorized
- Not current or valid
- Harmful or potentially harmful to a patient
- Contraindicated by other documented information

When (F) clarifying an order or direction, the LPN must consult with an authorized practitioner or directing RN. If the LPN **decides not to follow** the direction, the LPN, in a timely manner, must:

- Notify the ordering practitioner or directing RN of the decision not to follow the order
- Document that the ordering practitioner or directing RN was notified and state the reason for not following the direction
- Take any other action to ensure the safety of the patient

An LPN must (G) **report to and consult with** other nurses or other members of the healthcare team and make referrals as necessary.

An LPN must (H) **maintain the confidentiality** of patient information, communicating patient information with other members of the healthcare team for healthcare purposes only and accessing patient information only for patient care purposes or for fulfilling assigned job responsibilities. This includes not disseminating patient information through social media, texting, emailing, or any other form of communication for purposes other than patient care.

An LPN (I) **does not disclose** identifiable patient healthcare information unless the patient gives written consent by a properly executed release of information. Only in limited circumstances in accord with authorized legal authority does an LPN release individually identifiable patient healthcare information without a written consent of the patient.

When directed to observe, advise, instruct, or evaluate the performance of a nursing task, the LPN (J) **uses acceptable standards** of safe nursing care as a basis for that observation, advice, instruction, teaching, or evaluation and communicates information consistent with acceptable standards of safe nursing care with respect to the nursing task.

STANDARDS OF COMPETENCY FOR ADVANCED PRACTICE NURSES

[This section covers subsections (A) thru (D) of the OAC 4723-4-05, Standards relating to competent practice as a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist.]

A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, and clinical nurse specialist must (A):

- Function within the **scope of practice** of nursing for a registered nurse as set forth in division (B) of Section 4723.01 of the Ohio Revised Code and the rules of the Ohio Board of Nursing.
- Function within the nurse's applicable scope of practice as set forth in section 4723.43 of the Ohio Revised Code and the rules of the Ohio Board of Nursing.
- If authorized by Ohio law to prescribe, practice according to Section 4723.481 of the Ohio Revised Code and Section 4723-9 of the Ohio Administrative Code.

When the practice of a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist is evaluated, the (B) **evaluation** must be done by a collaborating licensed physician or podiatrist, or an advanced practice registered nurse holding a current, valid license with the same designation as the individual being evaluated.

When the practice of a certified registered nurse anesthetist is evaluated, the (C) **evaluation** must be done by a supervising licensed physician, podiatrist, dentist, or certified registered anesthetist whose license is current and valid.

A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist may provide care within their specialty, provided the nurse (D):

- Obtains appropriate education from a recognized body of knowledge
- Demonstrates knowledge, skills, and abilities
- Maintains documented evidence of these skills and abilities

STANDARDS THAT PROMOTE PATIENT SAFETY

[This section covers subsections (A) thru (Q) of the OAC 4723-4-06, Standards of nursing practice promoting patient safety.]

(A–C) When providing direct nursing care to patients or engaging in nursing practice in person or by telecommunication, licensed nurses, certified nurse-midwives, certified nurse practitioners, certified registered nurse anesthetists, or clinical nurse specialists must **display and identify their applicable title** or initials (degree) or identify to each patient or healthcare provider the nurse's title or initials (degree) as a registered nurse or licensed practical nurse.

Licensed nurses must (D) **delegate nursing tasks, including medication administration**, only in accordance with chapters 4723-13, 4723-23, 4723-26, or 4723-27 of the OAC. (See also "Delegation Guidelines" below.)

Licensed nurses must (E) **report and document** their nursing assessments and observations, care provided, and the patient's response to that care in a complete, timely, and accurate manner. Licensed nurses must document any (F) **errors in or deviations** from a prescribed regimen to the appropriate practitioner in a timely and accurate manner.

Licensed nurses must (G) **not falsify, or conceal by any method, patient records** or any other document prepared or used in the course of nursing practice. This includes case management documents or reports, time records, reports, and other documents related to billing for nursing services.

Licensed nurses must (H) implement measures to **promote a safe environment** for patients and (I) delineate, establish, and maintain a **professional boundary** between themselves and patients. They must (J) **provide privacy** during examination and care and treat each patient with courtesy, respect, and full recognition of dignity and individuality.

Licensed nurses must (K) not engage in behavior that causes or may cause physical, verbal, mental, or emotional **abuse** to a patient or engage in behavior that a reasonable person would interpret as physical, verbal, mental, or emotional abuse.

A licensed nurse must not (L) **misappropriate the property of patients** or:

- Engage in behavior to seek or obtain personal gain at the patient's expense, or that may reasonably be interpreted as such
- Engage in behavior that constitutes inappropriate involvement in the patient's personal relationships or financial matters, or that may reasonably be interpreted as such

A licensed nurse must not (M):

- Engage in **sexual conduct** with a patient, or conduct that may be interpreted as sexual

- Engage in **verbal behavior that is seductive or sexually demeaning** to a patient, or that may be interpreted as such

The patient is always presumed incapable of giving free, full, or informed consent to the behaviors by the nurse set forth in (L) and (M) above.

When licensed nurses (N) function in **administrative roles**, they must make sure that there are procedures in place and implemented to verify that every nurse, dialysis technician, or

medication aide working under their administration has a current valid license or valid certificate in Ohio to practice in the role to which they are assigned.

Only RNs may (O) **supervise or evaluate** the nursing practice of RNs and LPNs; however, non-nursing supervisors may evaluate nurse employees in matters other than the practice of nursing.

A licensed nurse must not (P) make, submit, or cause to be submitted any **false, misleading, or deceptive statements** to the OBN, current or prospective employers, facilities or organizations for whom the nurse is working, members of the healthcare team, or law enforcement personnel.

A nurse must (Q) not use **social media, texting, emailing**, or other forms of communication with or about a patient for nonhealthcare purposes or for purposes other than fulfilling the nurse's assigned job responsibilities.

DELEGATION GUIDELINES

When all conditions for delegation set forth in Chapter 4723-13-05 of the OAC are met, a registered nurse may delegate a nursing task to an unlicensed person and a licensed practical nurse may delegate a nursing task to an unlicensed person at the direction of the registered nurse. These conditions are summarized below.

Except as otherwise authorized by law or this chapter, a licensed nurse may delegate to an unlicensed person the **administration of only the following medications**:

- Over-the-counter topical medications to be applied to intact skin for the purpose of improving a skin condition or providing a barrier
- Over-the-counter eye drop, ear drop, and suppository medications, foot soak treatments, and enemas

Prior to delegating a nursing task to an unlicensed person, the delegating nurse must make certain determinations regarding the **nature of the task and the qualifications of the unlicensed person** who will carry it out.

- The nursing task is within the scope of practice of the delegating nurse

- The nursing task is within the knowledge, skill, and ability of the nurse delegating the nursing task
- The nursing task is within the training, ability, and skill of the unlicensed person who will be performing the delegated nursing task
- Appropriate resources and support are available for the performance of the task and management of the outcome
- Adequate and appropriate supervision by a licensed nurse of the performance of the nursing task is available
- That:
    - The nursing task requires no judgment based on nursing knowledge and expertise on the part of the unlicensed person performing the task
    - The results of the nursing task are reasonably predictable
    - The nursing task can be safely performed according to exact, unchanging directions, with no need to alter the standard procedures for performing the task
    - The performance of the nursing task does not require that complex observations or critical decisions be made with respect to the nursing task
    - The nursing task does not require repeated performance of nursing assessments
    - The consequences of performing the nursing task improperly are minimal and not life-threatening

Prior to delegating a nursing task, the delegating nurse must also make certain determinations regarding the **patient and the conditions**:

- Identify the individual on whom the nursing task may be performed and a specific time frame during which it may be performed.
- Complete an evaluation of the conditions that relate to task to be performed, including:
    - An evaluation of the individual who needs nursing care
    - The types of nursing care the individual requires
    - The complexity and frequency of the nursing care needed
    - The stability of the individual who needs nursing care
    - A review of the evaluations performed by other licensed healthcare professionals

The delegating nurse shall **be accountable** for the decision to delegate nursing tasks to an unlicensed person.

If a licensed nurse determines that an unlicensed person is not correctly performing a delegated nursing task, the licensed nurse shall **immediately intervene**.

STANDARDS FOR APPLYING THE NURSING PROCESS FOR RNs

[This section covers subsections (A) and (B) of the OAC 4723-4-07, Standards for applying the nursing process as a registered nurse.]

A registered nurse must apply the nursing process in the practice of nursing as set forth in division (B) of section 4723.01 of the ORC and in the rules of the board. Nurses give care to patients using a cyclic series of steps called the *nursing process*. With critical thinking and clinical judgment, RNs **assess**, **analyze/report**, **plan**, **implement**, and **evaluate** the changing status of patients. They apply the nursing process in various practice settings and collaborate with patients, family, significant others, and members of the healthcare team according to the following standards.

The standards for implementing the nursing process also apply to a certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist.

Assessment

Assessment involves the accurate and timely collection of both subjective and objective data about a patient's condition from the patient, family members, significant others, and members of the healthcare team. The RN may direct or delegate the gathering of data but must document and report it, as appropriate, to other members of the healthcare team.

Analysis and Reporting

In an accurate and timely manner, RNs identify, organize, assimilate, and interpret relevant data. They establish, accept, or modify a nursing diagnosis, which is used as a basis for nursing interventions, and report the patient's health status and nursing diagnosis as needed to other members of the healthcare team.

Planning

In an accurate and timely way, RNs develop, establish, maintain, or modify the nursing care plan with current nursing science, including the nursing diagnosis, desired patient outcomes or goals, and nursing interventions. They communicate the plan of care and all modifications to members of the healthcare team.

Implementation

In an accurate and timely way, RNs implement the nursing care plan. They execute the nursing regimen; implement current valid orders or directions by authorized practitioners; and provide

nursing care commensurate with their education, knowledge, skills, and abilities. They assist and collaborate with other healthcare providers in the care of the patient and delegate nursing tasks, including medication administration, only in accordance with applicable rules and laws (see also "Delegation Guidelines" earlier in this course).

Evaluation

In an accurate and timely way, RNs evaluate, document, and report patient responses to nursing interventions and progress toward expected outcomes to appropriate members of the healthcare team. They then reassess the patient's health status, establishing or modifying any aspect of the nursing plan.

STANDARDS FOR APPLYING THE NURSING PROCESS FOR LPNs

[This section covers the OAC 4723-4-08, Standards for applying the nursing process as a licensed practical nurse.]

Licensed practical nurses contribute to the nursing process as set forth in division (F) of section 4723.01 of the ORC and rules of the board. The steps of the nursing process are cyclic in nature, so that the patient's changing status affects the action of nurses as they **assess**, **plan**, **implement**, and **evaluate** the patient's status. The LPN collaborates, as appropriate, with the patient, family, significant others, and members of the healthcare team. The licensed practical nurse shall use the following standards for applying the nursing process.

Assessment

The LPN contributes to the nursing assessment of a patient. In an accurate and timely manner, LPNs collect and document objective and subjective data related to the patient's health status and report the data to the directing registered nurse or healthcare provider and other members of the healthcare team. The subsequent analysis and reporting of this data, however, is not part of the LPN's role.

Planning

In an accurate and timely manner, LPNs contribute to the development, maintenance, or modification of the nursing component of the care plan and communicate the nursing care plan and all modifications of the plan to appropriate members of the healthcare team.

Implementation

Licensed practical nurses implement the nursing care plan in an accurate and timely manner as follows:

- Provide nursing interventions

- Collect and report patient data as directed
- Administer medications and treatments prescribed by an authorized individual
- Provide basic nursing care at the direction of an RN, advanced practice registered nurse, or licensed physician, dentist, optometrist, chiropractor, or podiatrist
- Collaborate with other nurses and members of the healthcare team
- Delegate tasks as directed, including medication administration, only in accordance with the OAC (see also "Delegation Guidelines" earlier in this course)

Evaluation

In an accurate and timely manner, LPNs contribute to the evaluation of patient responses to nursing interventions, document and communicate patient responses to nursing interventions to appropriate members of the healthcare team, and contribute to the reassessment of the patient's health status and to modifications of any aspect of the nursing plan of care.

CONCLUSION

The Ohio Nurse Practice Act defined the scope of practice for nurses in Chapter 4723 of the Ohio Revised Code and established the Ohio Board of Nursing. The Board of Nursing is responsible for the administration and enforcement of the Nurse Practice Act. This responsibility is accomplished through Section 4723 of the Ohio Administrative Code (OAC). The OAC are the rules written by the Ohio Board of Nursing in accordance with the Ohio Nurse Practice Act.

Chapters 1 through 27 of the OAC contain the rules and regulations for all aspects of nursing practice in the state of Ohio. It sets forth the standards of competent nursing practice and standards for promoting patient safety. By so doing, OAC 4723 fulfills the mission of the Board of Nursing to actively safeguard the health of the public through the effective regulation of nursing care. It is the responsibility of all nurses in the state of Ohio to be familiar with and to abide by these laws and rules.

RESOURCES

Ohio Administrative Code (OAC), Section 4723, Board of Nursing
http://codes.ohio.gov/oac/4723

Ohio Board of Nursing
http://www.nursing.ohio.gov

Ohio Revised Code (ORC), Chapter 4723, Nurses
http://codes.ohio.gov/orc/4723

REFERENCES

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1. Ohio's Scope of Practice Decision-Making Model helps a nurse determine whether to take an action based on legality, competency, safety, and:

a. Efficiency.

b. Integrity.

c. Cost-effectiveness.

d. Accountability.

2. When an RN has reason to believe an ordered drug may be harmful to a patient, the nurse consults with the appropriate licensed practitioner and then makes a decision not to administer the drug. Which further action must the nurse take?

a. Notify the patient of the risk of taking the drug

b. Notify the licensed practitioner of the decision not to administer the drug

c. Advise the facility administrator of the decision not to administer the drug

d. Document withholding the drug but do not document the reason for doing so

3. The LPN discloses identifiable patient information only:

a. When the patient has given written consent.

b. To close friends who phone in asking about the patient.

c. If the patient's physician authorizes the nurse to do so.

d. To staff members from another hospital department who wonder how the patient is doing.

4. Which is **not** a true statement regarding delegating a nursing task to an unlicensed person?

a. The delegating nurse must identify a specific time frame during which the delegated nursing task may be performed.

b. A licensed practical nurse may delegate a nursing task to an unlicensed person without the direction of the registered nurse.

c. The delegated nursing task must be able to be safely performed according to exact, unchanging directions, with no need to alter the standard procedures for performing the task.

d. A licensed nurse may delegate the administration of over-the-counter topical medications to be applied to intact skin.

5. According to the rules of the Ohio Administrative Code, the "analysis/reporting" step of the nursing process involves:

a. Delegating the gathering of data to others.

b. Implementing various nursing interventions for the good of the patient.

c. Identifying, organizing, and interpreting assessment data.

d. Evaluating the availability of staff and resources to care for the patient.

6. According to the OAC standards for applying the nursing process, LPNs do **not** perform which action?

a. Evaluating a patient's responses to nursing interventions

b. Planning and modifying the care plan to reflect new medical and nursing diagnoses

c. Implementing the nursing care plan by administering patient care

d. Analyzing collected data from the patient assessment