Maximising the RVN role under current legislation

For veterinary professionals

1. Introduction and background

The British Veterinary Nursing Association (BVNA) has developed this document to clarify how veterinary practices can maximise their utilisation of the registered and student veterinary nurse (RVN/SVN) to the benefit of the client, their pet and the veterinary practice. Whilst BVNA is calling for overall reform of the outdated Veterinary Surgeons Act 1966 (VSA), we recognise that there are still missed opportunities to utilise RVNs and SVNs more fully under the existing legislation.

The BVNA considers that, following the 'under care' review in 2022/3, there is insufficient guidance from the Royal College of Veterinary Surgeons (RCVS) regarding how their interpretation of 'under care' relates to RVNs. This review identified how the scope of the RVN role has grown; mainly that the veterinary surgeon does not need to perform a physical examination of an animal to make a clinical diagnosis and prescribe certain medications, and that this physical examination can instead be delegated to RVNs.

There are four main pieces of legislation/guidance that have a direct impact on the role of the veterinary nurse:

1. The VSA (1966)[1] identifies that only a veterinary surgeon registered with the RCVS can carry out acts of veterinary surgery in the UK. This includes diagnosis, medical and surgical treatments, and the performance of surgical operations.
2. The Schedule 3 Amendment (2002)[2] allows the veterinary surgeon to delegate to an RVN in their employ, any medical treatment or minor surgery (not entering a body cavity) to a companion animal under specified circumstances.
3. The Royal Charter (2015)[3] recognised veterinary nursing as a profession; making RVNs associates of the College. The Veterinary Nurses Council sets standards of education, training and conduct of RVNs.
4. The RCVS 'under care' guidance (2023)[4] states that a veterinary surgeon does not need to physically examine an animal under their care to make a clinical assessment leading to a diagnosis and treatment plan. This interpretation of the existing legislation is an important factor in enhancing the RVN/SVN role, as they can carry out the physical examination and diagnostic tests of a patient to inform the clinical decision-making process. The exceptions to this, and where a veterinary surgeon must physically examine an animal, are:
    - When a notifiable disease is suspected
    - When prescribing antimicrobials, antiparasitics or controlled drugs.

For the purposes of this document, the term 'RVN' will be used relating to Schedule 3; SVNs are able to carry out medical tasks under supervision and minor surgery under direct, continuous and personal

[1] https://www.legislation.gov.uk/ukpga/1966/36
[2] https://www.legislation.gov.uk/ukdsi/2002/0110395271
[3] https://www.rcvs.org.uk/document-library/supplemental-royal-charter-2015/
[4] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/under-care-new-guidance/

supervision[5]. There is also the caveat that the RVN is experienced, competent, and confident to carry out the task. It is essential that a RVN feels able to say if they are not comfortable completing the task and is not put under pressure to work outside their competency or comfort zone.

2. What does 'under care' mean for veterinary nurses?

Given the caveat of an animal being under the care of the veterinary surgeon, the veterinary surgeon does not need to complete a physical examination of an animal themselves. For example, as part of their clinical assessment, a competent RVN can perform a physical examination and gather information to apprise the veterinary surgeon.

A clinical assessment is where a veterinary surgeon is given enough information to diagnose and prescribe for an animal under their care, safely and effectively. BVNA recognises that a physical examination is often the preferred method for gathering information about a patient, and that a competent RVN can carry out the examination and perform diagnostic tests to allow the veterinary surgeon to make an informed decision.

Essentially, the RVN can effectively support the veterinary surgeon in their clinical decision-making process, as long as they are **not:**

- Prescribing
- Diagnosing
- Performing major surgery
- Entering a body cavity

3. What does this mean for clinical practice?

When reviewing roles and responsibilities within the veterinary profession, it is essential to consider the relationship between the veterinary team, the client and the patient, often referred to as the 'vet-client-patient relationship' (VCPR). Without a bond between these parties, it is more challenging to safeguard the patient's health and welfare and provide contextualised care. It is the trust between the client and the veterinary team that ensures a patient/client centred approach to veterinary care and improves animal health and welfare. It is widely acknowledged that RVNs have a positive impact on the relationship between the client, patient and practice.

There is a real opportunity for RVNs to take on more clinical responsibility within the veterinary practice, enabling the team to work more efficiently by allowing the veterinary surgeon to spend more time on tasks only they can do. While considering what these changes mean for RVNs and SVNs, it is important to include delegation. Under Schedule 3 of the VSA, RVNs and SVNs are allowed to carry out certain procedures in veterinary practice, as delegated to them by a veterinary surgeon employed in the same practice[6]. It is often felt that there is ambiguity around what tasks can be delegated, amongst both veterinary surgeons and RVNs alike. The main point to consider is that an RVN does not carry out Schedule 3 tasks without being delegated to by a veterinary surgeon.

The RCVS avoids providing a definitive list of tasks that can be completed under Schedule 3, in case it is considered to be an exhaustive list and therefore stifles any future progression under the current legislation framework. The wording of the legislation means there are a number of grey areas; the

[5] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/advice-on-schedule-3/
[6] https://www.legislation.gov.uk/ukdsi/2002/0110395271

RCVS have stated that if there is any doubt about what can be done under Schedule 3, that the veterinary surgeon or RVN should contact them and they will be able to clarify on a case-by-case basis. BVNA does not consider that this is an effective approach to identifying tasks that can be performed by individual RVNs.

It is the view of the BVNA that offering guidance on what tasks can be completed under Schedule 3 of the VSA will empower RVNs to contribute fully to the veterinary team. Supporting a veterinary surgeon to free up their time to diagnose and prescribe to patients under their care will enable the RVN to fully utilise their training, and allow ownership of specific areas of practice to progress in their clinical roles. Whilst BVNA agrees that solely providing a list of tasks is not the most effective way of enhancing the RVN role, it does provide some clarity for veterinary surgeons and RVNs/SVNs around what can be delegated. This may provide a platform to encourage the veterinary team to properly utilise the RVN.

Rather than restrict the veterinary nursing role by following a list of Schedule 3 tasks, the BVNA encourages the veterinary team to first think in terms of what **cannot** be done by a competent RVN i.e. prescribing, diagnosing, performing major surgery or entering a body cavity.

3.1 Direction, supervision and delegation

The RCVS provides guidance[7] around the phrases of:

> '**Under direction**' - the delegator does not need to be present or on the premises for the RVN to complete the task;
>
> '**Under supervision**' - the delegator needs to be on the premises and contactable if they are needed.
>
> '**Under direct, continuous and personal supervision**' (which often refers to new SVNs) – the delegator is present and giving the SVN their undivided attention.

The RCVS has tried to clarify what tasks can be carried out legally and safely under Schedule 3 of the VSA using the 'SUPERB' poster and case studies[8], but there is still concern around who is responsible should inappropriate delegation occur and what tasks can be delegated[9]. The SUPERB checklist poster identifies six questions the veterinary surgeon needs to ask themselves before delegating and only if the answer is 'yes' to all six, is it appropriate.

The veterinary surgeon can choose to delegate a task when they are confident in the RVN's competence. The RCVS states that it is a veterinary surgeon's judgement of whether they 'should' delegate a task, and it (RCVS) welcomes queries from the veterinary team as to whether it is appropriate for specific cases.

Whilst BVNA agrees that there should not be a definitive list of Schedule 3 tasks, clarification of the points below would enable the veterinary team to feel confident in the roles and responsibilities when managing a patient under the practice's care.

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[7] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/delegation-to-veterinary-nurses/

[8] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/advice-on-schedule-3/

[9] https://www.bva.co.uk/media/3832/enhancing-the-vn-role-minutes-12-november-2020.pdf

3.2 Accountability

The delegation of tasks should be viewed alongside the Code of Professional Conduct (CoPC) for veterinary surgeons[10] and veterinary nurses[11]; particularly section 18 of the supporting guidance[12]. Within the five Principles of Practice[13]; RVNs must work within their professional competence and take professional accountability.

If the RVN does not feel comfortable completing a task, they should let the veterinary surgeon know[14]. The most effective approach is to acknowledge a desire to undertake the task while indicating a lack of confidence at that moment and requesting further training. The veterinary surgeon is likely to appreciate the RVN's honesty and integrity, thereby fostering a comfortable environment for future delegation. This also ensures that appropriate training is provided, facilitating the completion of the task in the future.

There is concern with some veterinary surgeons about who is accountable for an RVN's actions when they deem themselves to be competent, but are not. RVNs are accountable for their own actions, however, if a veterinary surgeon has delegated a task to an RVN who is not competent, do they hold some responsibility for the RVN's act?

The CoPC for both professions clearly states that they must work within their professional competency, and that a veterinary surgeon should only delegate tasks to an RVN who is competent[10,11]. Therefore, in the instance of an RVN carrying out a delegated task that they are not proficient at, both parties have a responsibility; the veterinary surgeon for delegating the task, and the RVN for completing the task. However, it is the RVN who is accountable and therefore liable for any disciplinary action. This scenario highlights the importance of effective interprofessional working and communication, to reduce the risk that a veterinary surgeon may delegate a task to an RVN who is not competent. If there is any concern by the veterinary team surrounding delegation, they should contact the RCVS for clarification.

It would be useful to have further clarity from the RCVS around accountability for the tasks delegated to RVNs, to help both RVNs and veterinary surgeons feel confident in this area of Schedule 3.

3.3 Which tasks may be delegated to RVNs?

It is difficult to create a definitive list of the tasks that can be completed by a competent RVN under Schedule 3 as it depends on the individual i.e. previous training, competency, experience and confidence. Ideally, the BVNA believes that enhancing the veterinary nursing role should be principle-based rather than task-based, as it will differ between practitioners.

[10] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/
[11] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-nurses/
[12] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/delegation-to-veterinary-nurses/
[13] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-nurses/#principles
[14] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-nurses/#team

To simplify the question, “what can an RVN do?”, ask:

a) Has this skill been included in the RCVS Day One Competences, Skills and Professional Behaviours for Veterinary Nurses[15]? If the task is included, it is acceptable to be delegated to an RVN.

b) What is the purpose of the task that has been delegated? For example, if it is to diagnose or prescribe, then the task should not be delegated.

Examples of the purpose of delegated Schedule 3 tasks:

1. An RVN can place an endoscope into the stomach
   Acceptable purpose – to remove a foreign body
   Not an acceptable purpose – to visualise the stomach lining to identify the cause of the patient’s clinical signs (therefore diagnosing), **however** images taken can be used to relay to the veterinary surgeon for diagnosis instead.

2. An RVN can perform a nerve block in a distal limb
   Acceptable purpose – to provide analgesia in a lame horse
   Not an acceptable purpose – to identify the cause of the lameness (therefore diagnosing)

Based on the guidance from the RCVS, whilst not an exhaustive list, Schedule 3 tasks may include:

i. Taking blood samples
ii. Placing an IV catheter
iii. Administering intravenous, intramuscular, subcutaneous, oral, rectal and topical medications
iv. Wound assessment, dressing and bandaging (not including prescribing treatment)
v. Suturing superficial, uncomplicated wounds
vi. Performing local anaesthesia nerve blocks (the BVNA advises contacting the RCVS before performing nerve blocks to ensure they do not fall into the major surgery category)
vii. Euthanasia
viii. Inserting urinary catheters into the bladder
ix. Placing naso-gastric feeding tubes into the stomach
x. Placing endoscopy tube into the stomach (with the caveat that it is not for diagnostic purposes i.e. the RVN can take images from the endoscopy to relay to the veterinary surgeon who will make the diagnosis)
xi. Performing intrauterine ultrasonography in large animals
xii. Managing/reducing aural haematoma

[15] https://www.rcvs.org.uk/setting-standards/accrediting-primary-qualifications/accrediting-veterinary-nursing-qualifications/rcvs-day-one-competences-skills-and-professional-behaviours-for/

xiii. Inducing general anaesthesia via incremental doses providing a patient specific protocol has been created by the veterinary surgeon and RVN (see notes below on general anaesthesia).

3.4 Terminology

Despite Schedule 3 excluding RVNs from carrying out any tasks which enter body cavities, there is currently ambiguity over the meaning of 'body cavity'. The RCVS does not currently provide a clear definition, as this can mean different areas for different species. The British Veterinary Association (BVA) has also identified that it is difficult to define the term clearly and added to the ambiguity around what tasks can be completed by a competent RVN[16]. Additional clarity would also be beneficial surrounding the definition of 'minor surgery' and 'major surgery', which are again only loosely defined.

The advice from the RCVS is for veterinary surgeons or RVNs to contact them about specific tasks to confirm whether it is appropriate for it to be delegated. Each task may be considered in terms of whether there is more risk for an RVN to carry out a task than if it were to be completed by the veterinary surgeon. This is not a judgement on the ability of RVNs but is seen as a limitation of the VSA.

4. Enhancing the RVN role within current legislation

4.1 General anaesthesia (GA)

Anaesthesia is covered in the Day One Competences and Day One Skills during veterinary nursing training[17]. In order to enhance the RVN role, it was recommended by the RCVS Legislation Working Party (LWP)[18] that an RVN could have a more involved role within anaesthesia; the principle of a team protocol-driven approach to anaesthesia was subsequently supported jointly by BVNA and BVA[19]. It is hoped that this can be made clearer with legislative reform.

However, BVNA considers that further clarity from the RCVS would be beneficial regarding the RVN's role within anaesthesia within the current VSA. There are opportunities for greater RVN utilisation under current legislation, but also the potential for ambiguity in the guidance to undermine the confidence in delegation to RVNs. For example, according to the RCVS CoPC for both professions, 'Administering medicine incrementally or to effect, to induce and maintain anaesthesia may be carried out only by a veterinary surgeon'[20,21]. However, it is acknowledged that a patient-specific, protocol-driven standard operating procedure (SOP) can enable RVNs to have greater involvement within anaesthesia; enabling them to make changes within predefined parameters. RVNs are not required to prescribe a dose, but instead work within a dose range which has been prescribed by the veterinary surgeon[22]. Consequently, this approach does enable RVNs to carry out incremental dosing, with the caveat that they are working within this predetermined range as agreed by the veterinary surgeon.

[16] https://www.bva.co.uk/media/3832/enhancing-the-vn-role-minutes-12-november-2020.pdf
[17] https://www.rcvs.org.uk/setting-standards/accrediting-primary-qualifications/accrediting-veterinary-nursing-qualifications/rcvs-day-one-competences-skills-and-professional-behaviours-for/
[18] https://www.rcvs.org.uk/news-and-views/publications/rcvs-recommendations-for-future-veterinary-legislation/
[19] https://www.bva.co.uk/media/4038/response-to-rcvs-legislative-reform-consultation-final-11-march-2021.pdf
[20] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/
[21] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-nurses/supporting-guidance/delegation-to-veterinary-nurses/
[22] https://www.beva.org.uk/career-support/nurses/schedule-three

How is a patient-specific, protocol-driven approach developed? This must be a practice team approach to anaesthesia which includes a pre-operative discussion between the veterinary surgeon and RVN where an anaesthetic protocol is developed with all eventualities identified and prepared for, with each individual patient. With the veterinary surgeon's authorisation, the RVN can make informed choices if the anaesthetic varies from the norm based on the protocol developed for that specific patient, utilising their training and experience. RVNs are empowered to make changes within predefined parameters, allowing them to respond to an anaesthetised patient becoming unstable without delay; a concern given their current lack of prescribing powers[23]. Crucially, this process enables the RVN to manage the patient without the need for a prescribing decision, which ultimately remains with the veterinary surgeon. The protocol must also identify clear 'red flags' where the veterinary surgeon must be notified, such as the potential need to deviate from the agreed dose range.

An SOP for general anaesthesia induction can be developed, grounded in evidence-based veterinary medicine, and be used as the foundation for the individual patient following the discussion between the veterinary surgeon and RVN. The protocol should identify when the RVN should consult the veterinary surgeon if there is any deviation from the plan, and there should be written evidence of the discussion.

4.2 Local anaesthesia

Another area of anaesthesia to consider is the application of local nerve blocks, including intravenous regional anaesthesia. With the increase in the use of local anaesthesia within the surgical procedure, it is advantageous to utilise the RVN's skills in this area. However, the RCVS has stated that some nerve blocks are considered more than minor surgery and therefore fall outside of the scope of Schedule 3. This demonstrates the ambiguity around Schedule 3, and any RVN wanting to perform nerve blocks should contact the RCVS to check whether it is within the bounds of delegation.

4.3 Vaccination

Another topic that has raised concern amongst veterinary surgeons is the issue of administering vaccinations[24]. Under the RCVS' guidance, if they deem it appropriate, a veterinary surgeon can remotely prescribe a vaccination course and direct an RVN to administer it, without the veterinary surgeon carrying out a physical examination of the animal[25].

It is currently BVNA and BVA's joint position[26] that the veterinary surgeon should carry out the initial clinical examination at the point of first vaccination, for early identification of any clinical conditions and to discuss the risks of allergic reactions and side effects with the client. However, the first vaccination does provide a valuable opportunity for the RVN to have greater involvement with the client and patient. Following the veterinary surgeon's examination and prescription of first vaccination, this could then be administered by the RVN; also enabling them to speak to owners about preventative health care, nutrition and reproductive health.

[23] https://www.bva.co.uk/media/4038/response-to-rcvs-legislative-reform-consultation-final-11-march-2021.pdf
[24] https://www.bva.co.uk/media/3119/veterinary-nurse-prescribers-march-2019.pdf
[25] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/delegation-to-veterinary-nurses/

Again, the booster consultation can be a team-based approach opportunity. The veterinary surgeon only needs to perform a physical examination if antiparasitics are to be prescribed, otherwise, the RVN can complete all aspects of a booster vaccination that has been prescribed by the veterinary surgeon. It is an opportunity to discuss preventative healthcare, and enable both team members to participate in generating income for the practice. There is an opportunity to train RVNs to a level where they can competently physically examine a dog, cat, rabbit or ferret prior to administering a booster vaccination. However, in older patients the veterinary surgeon may deem it necessary to carry out the physical examination at the time of the booster, in order to identify any emerging conditions[23].

This tag-team, protocol-driven approach also ensures the client feels satisfied with the information and time given to them, thus improving client-practice relations.

Please note that if vaccination certification is required, the veterinary surgeon must perform the physical examination and administer the vaccination.

4.4 Chronic illness management

There is an opportunity for RVNs to lead in the management of chronic cases, following a discussion between the veterinary surgeon and RVN outlining the treatment protocol and consideration of any deviation from expectations. The veterinary surgeon can write a clinical assessment, repeat prescriptions and give permission for the RVN to assess the patient at given intervals. Although this has always been the case, the BVNA is aware that these opportunities have not been fully utilised. Now, as a result of the 'under care' review, it has been clarified that in certain circumstances a veterinary surgeon does not need to carry out a physical examination, and therefore an RVN can play a more active role with these cases. This approach would be on the understanding that the RVN completes the clinical notes on the patient's record and informs the veterinary surgeon of any outcomes. This would reduce the number of times that the veterinary surgeon needs to physically examine the animal.

4.5 Palliative care

The RVN could also lead on end-of-life care, ensuring the client and patient are the centre of any palliative care given. Again, parameters would be set with patient-specific protocols in place to ensure the welfare status of the patient is maintained. The RVN would be the first port of call for the client should they have any questions or need additional support. Discussions such as quality of life (QoL), mobility issues, home adaptations such as rugs on hard floors and thick bedding will add value to the owner's experience and improve relations between the practice and the client.

If there is any change in circumstances for the owner or animal, the RVN must report to the veterinary surgeon who will make a clinical assessment on whether they need to examine the animal to review any medications. It is still the case that an RVN cannot prescribe medications. The RVN can discuss euthanasia with the client, and can carry this out if the client prefers this.

5. Case examples

Case 1. Jasper is a cocker spaniel with recurring ear problems and has been shaking his head for four days. He has started to whimper when Mrs Walker strokes his head. This type of case is appropriate to book in with a RVN where they can gather evidence to enable the veterinary surgeon to make a clinical assessment to diagnose and prescribe treatment.

The RVN sees Jasper and following the protocol makes an assessment of whether it is possible to examine his ears. Following a pain assessment, the RVN dispenses analgesia and arranges a recheck appointment 3 days later.

When Jasper returns, the RVN is able to examine his ears and visualise the tympanic membrane, which is intact. If the RVN could not visualise the tympanic membrane or could see that it was ruptured, they would refer the client to the veterinary surgeon.

The RVN takes a swab for cytology and cleans the ear, dispenses cleaning lotion and arrange to speak to the client once the results of the swab have been received. It is essential that clear clinical records are completed that allow the veterinary surgeon to make a clinical assessment on the patient.

The RVN performs the cytology and reports to the veterinary surgeon.

The veterinary surgeon and RVN discuss the results and prescribe steroid drops for treatment.

The RVN makes another appointment with Mrs Walker to explain the results, demonstrates how to apply the ear drops and dispenses the treatment to the client.

Case 2. Toby is a 12-year-old, anxious, neutered male cat. He has once again lost a fight with his neighbour. Mr Thomas has noticed that the fur on his neck is wet and there is a horrid smell. Toby has not been eating as much food as normal. He has been booked in with the RVN.

During the consultation, the RVN gives Toby a full physical examination following the protocol and identifies a burst cat bite abscess on the left side of his neck. He is otherwise fit and healthy, although tender around the wound.

The RVN clips the area as Toby is comfortable with the process, they flush the site and clean the area. The RVN explains how to monitor the wound to the owner.

The RVN completes the clinical notes and the veterinary surgeon makes a clinical assessment, prescribing analgesics.

The RVN dispenses the analgesics to the owner, explaining how to administer them and books a review appointment.

RVNs can lead in the management of chronic cases based on protocols being developed that consider all scenarios for the patient. It is essential that the veterinary surgeon and RVN take a team-based approach to the development of the protocols, and identify when it is necessary for the veterinary surgeon to be involved or re-examine the patient.

Case 3. Willow is a 15-year-old cat with chronic renal disease. She is due a review of her medication and therefore booked in with the RVN. The RVN checks the understanding of the client regarding kidney function and the impact of renal failure, how they are managing the medication and completes a physical examination. The RVN takes a history, takes a blood sample, weight, body condition score and blood pressure measurement. The owner has brought in a urine sample. The RVN explains why each of the parameters are monitored.

The RVN runs the blood tests according to the protocol and checks the urine sample. The results are put on to the clinical history and the RVN informs the veterinary surgeon of the results of the diagnostic tests and the results of the physical examination.

The veterinary surgeon makes a clinical assessment and prescribes a repeat prescription. The RVN dispenses the medication and discusses the benefits of feeding clinical renal diets to support the kidney function and schedules a recheck appointment.

The RVN adds value to the consultation by taking time to discuss Willow's disease process and how it relates to the tests performed and medication given.

Case 4. The veterinary surgeon has seen a healthy 2-year-old Labrador, Lily, with right hind limb lameness. She is booked in to have a series of x-rays.

The veterinary surgeon and RVN have a pre-induction meeting to discuss Lily's procedure and devise a plan for her sedation, GA and recovery. The plan lists all predicted outcomes and complications with actions to be taken at each point including when to alert the veterinary surgeon of a deviation from the norm. As GA and radiographic positioning is taught during veterinary nursing training, the RVN will take the lead in the procedure.

According to the surgical safety checklist, they check that Lily has been starved for at least six hours and her water removed for a minimum of two hours. Her last toileting is noted and the results of her physical examination by the veterinary surgeon has been checked, and an ASA level is assigned.

An IV catheter has been placed and secured by the RVN.

The veterinary surgeon calculates the premedicant, induction agent and any other medications that may be required during the procedure.

The RVN draws up medications including the induction agent and administers the premedicant. The RVN induces anaesthesia according to Lily's protocol, places the endotracheal tube and attaches her to the GA machine for anaesthesia to be maintained. Lily is monitored whilst being x-rayed by a second RVN and throughout the procedure.

The veterinary surgeon checks the x-ray images and confirms a diagnosis. Lily's anaesthetic is unremarkable and she recovers well in her kennel.

6. Summary of what the 'under care' review means for veterinary nurses

When viewing the 'under care' review and Schedule 3 together, it is evident that there are opportunities to enhance the RVN role. Further training or qualifications may be required to ensure the RVN is competent and confident in performing the desired tasks.

It is also essential to note that the veterinary practice must harbour a safe environment where the RVN can decline to complete a task, and be offered further training to improve competency. RVNs are accountable for their own actions and must adhere to the CoPC with regards to working within their area of competence. It is important that RVNs do not feel pressured into carrying out tasks where they do not feel competent or confident to do so.

Physical examinations can be completed by RVNs, and their clinical notes on the patient's record can inform the veterinary surgeon's clinical assessment. This can potentially free up the veterinary surgeon's time to focus on the diagnosis and treatment of the patient. The caveat to this is that should the patient require antimicrobials, antiparasitics, controlled drugs or have a suspected notifiable disease, then the veterinary surgeon must perform the physical examination themselves prior to diagnosis and prescribing.

Taking this a step further, the veterinary team can develop protocols to be followed, including red flags of when a veterinary surgeon should be involved. For example, protocols can be developed to identify cases that the RVN can see before, or instead of, the veterinary surgeon.

7. Future proofing the VN profession

The BVNA advocates that legislative change is required to enable the veterinary nursing profession to take a more proactive role in a team-based approach to patient care. However, there are already adjustments that can be made now that will enhance the RVN role before these changes come into place.

Whilst this may initially be uncomfortable for some members of the team, it will be outweighed by the improvement in patient care, job satisfaction and enhanced client relations with the practice. The added value RVNs and SVNs can bring to caring for patients is not just about treatment options; it includes aspects of QoL, preventative care, and client education.

Using examples from our colleagues in human-centred nursing, we can identify areas where the enhanced RVN role will improve animal health and welfare.

7.1 Prescriber role

The RCVS is exploring the option of creating a prescriber nurse role. The BVNA and BVA share the view that veterinary nursing training should include SQP status in the future, which would enhance the RVN role by allowing the prescribing of Prescription Only Medications – Veterinarian, Pharmacist, Suitably Qualified Person (POM-VPS)[27] wormer and flea treatments. Some training centres and awarding organisations are already incorporating the qualification within their courses. However, it is arguably a more valuable qualification for RVNs working in large animal and equine practice rather than small animal. Future consideration could therefore also be given to creating a more advanced prescriber qualification that is specific to RVNs, to allow them to prescribe certain medications.

[27] https://www.bva.co.uk/media/3119/veterinary-nurse-prescribers-march-2019.pdf

A more holistic approach to this role may be to allow RVNs to specialise in specific areas such as wound management or palliative care and be able to prescribe within that remit. This would enable RVNs to lead in the management of specific cases, plus improve efficiency within the veterinary team.

7.2 Community nursing

With the proposed legislative changes to reduce the restrictions for RVNs to only work under the direction of the veterinary surgeon they are employed by, the community veterinary nursing role becomes more viable. It would be valuable for RVNs to work autonomously to the benefit of the client and patient, improving the health and welfare of animals under their care. Areas of practice that may benefit from this approach include; breeders for pre-mating checks, vaccinating puppies and kittens, chronic illness management, and palliative care. Patients who are stressed by visits to the practice can be examined by the RVN who will be gathering evidence for the veterinary surgeon to make a clinical assessment, rather than travelling to the practice.

If based on the human-centred nursing model, medical nurses have emphasised that there must be safeguarding policies in place and a support network, as working away from the veterinary practice environment can be isolating[28].

Whilst this area of veterinary nursing needs legislative reform, the BVNA fully supports the idea of autonomous RVNs working in the community, whilst recognising there needs to be appropriate qualifications completed and safeguarding policies in place to protect both the client and the RVN.

7.3 General practitioner RVN

The BVNA recognises that many RVNs wish to work in primary care practice, as a valuable member of the veterinary team and an integral part of patient care. Whilst some RVNs wish to specialise in specific areas, it is essential that general practitioners are acknowledged for the work they do.

7.4 Referral RVN

Working in a referral practice can enable RVNs to focus on specific areas of practice such as orthopaedics, neurology, surgery, anaesthesia or medical cases. This can lead to a defined career pathway and progression on to speaking at conferences or webinars.

7.5 Leadership

RVNs can now own their own practice as long as they have a veterinary surgeon supervisor; or become directors of veterinary practices, taking an active part in the running of the practice.

There are opportunities to become clinical nurse directors, taking responsibility for the nursing care of the practice and championing evidence-based nursing care.

[28] https://vnfutures.org.uk/research-and-development-of-the-community-veterinary-nurse-role/

8. Challenges to enhancing the RVN role

Investing in the veterinary nursing profession has limited value if the role itself does not change, and this change needs to come from RVNs and veterinary surgeons. Whilst the 'under care' review has highlighted many opportunities that are currently being missed in practice, there are still limitations placed on the role under current legislation.

The cost of additional qualifications to enable the RVN to progress their career within veterinary practice may be prohibitive for many. Consideration of this should be given if the role of enhanced and advanced RVN practitioners is to be progressed, and practices need to invest in their veterinary nursing staff.

Currently, veterinary nursing training can differ depending on whether the SVN is training under the diploma or degree path. Whilst all courses will embed the Day One Competences and Day One Skills, learners will be taught at different levels which impacts on the depth of knowledge gained. Veterinary nurses trained via the diploma route should not be disadvantaged when applying for further qualifications and their practice experience should be taken into account.

The creation of post-registration qualifications is beneficial to enhancing the RVN role, but the cost of the course can be a barrier for many RVNs. Veterinary practices should be encouraged to invest in the RVN profession by paying for accredited courses, enabling growth of the role, and giving appropriate renumeration for qualifications gained.

It is important to identify what level of competency and skills are required for Day One of an RVN's career. Rather than increasing the knowledge and skills required during training, a review should take place in context to requirements by the industry and post-registration progression.

9. Final considerations

The BVNA considers that protecting the title 'veterinary nurse' will help to future proof the veterinary nursing profession, and is leading the campaign in lobbying policymakers to achieve this as part of urgently needed legislative reform of the VSA. It is essential that only trained, registered veterinary nurses are completing Schedule 3 tasks, and leading in the nursing care of animals under their care.

Raising awareness amongst animal owners of the RVN role, along with their knowledge and skills, is essential to empower RVNs and will enhance the veterinary team and animal welfare. Ensuring transparency of roles and responsibilities within the veterinary practice will improve the VCPR which in turn will improve animal health and welfare. With the ongoing investigation of the Competition and Markets Authority (CMA) into veterinary businesses, it is important that practices are transparent about who is involved in the care of patients as well as the costs of treatment. This will include charging appropriate fees for an RVN's time in accordance to the knowledge and skills gained during qualification.

The BVNA feels strongly that diversification of the RVN profession will ensure a sustainable workforce. As part of the joint RCVS and BVNA VN Futures project, there has been a focus on widening participation by showcasing role models[29] from different ethnicities and social backgrounds. Career case studies[30] also show the variety of roles an RVN can hold and demonstrates the progression pathways available. Clear career pathways may improve the retention of RVNs in clinical practice, with

[29] https://bvna.org.uk/blog/category/diversity-inclusivity-and-widening-participation-working-group/
[30] https://vnfutures.org.uk/our-activities/careers-in-veterinary-nursing/career-case-studies/

veterinary practices supporting the veterinary nursing profession by providing appropriate CPD budgets.

There were a number of recommendations as a result of the LWP regarding the RVN role[31] and it is hoped that these will improve the working conditions for RVNs and allow a clear pathway for career progression. The BVNA considers that this enhancement of the RVN role should be managed around a principle-based framework rather than task-based i.e. a list of tasks the RVN can carry out. However, the BVNA recognises that for some, a list of tasks can help when talking to the veterinary team. Remember, if the task is not diagnosing, prescribing, major surgery or entering a body cavity, a competent RVN **can** carry out the task.

It should be recognised that there are ways to enhance the role before legislation comes into place, such as team-based, protocol-driven policies that allow RVNs to run consultations of commonly seen disorders and have a greater role within general anaesthesia. Patient-based protocols created by the attending veterinary surgeon and RVN will allow greater autonomy for veterinary nurses who can make informed choices on patient care based on their training.

[31] https://www.rcvs.org.uk/news-and-views/publications/rcvs-recommendations-for-future-veterinary-legislation/