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RN RULES

21-36.0221. LICENSE REQUIRED

21-36.0224. COMPONENTS OF NURSING PRACTICE FOR THE REGISTERED NURSE

21-36.0221. LICENSE REQUIRED

(a) No cap, pin, uniform, insignia or title shall be used to represent to the public, that an unlicensed person is a registered nurse or a licensed practical nurse as defined in G.S. 90-171.43.

(b) The repetitive performance of a common task or procedure which does not require the professional judgment of a registered nurse or licensed practical nurse shall not be considered the practice of nursing for which a license is required. Tasks that may be delegated to the Nurse Aide I and Nurse Aide II shall be established by the Board of Nursing pursuant to 21 NCAC 36 .0403. Tasks may be delegated to an unlicensed person which:

- (1) frequently recur in the daily care of a client or group of clients;
- (2) are performed according to an established sequence of steps;
- (3) involve little or no modification from one client-care situation to another;
- (4) may be performed with a predictable outcome;
- and
- (5) do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself.

Client-care services which do not meet all of these criteria shall be performed by a licensed nurse.

(c) The registered nurse or licensed practical nurse shall not delegate the professional judgment required to implement any treatment or pharmaceutical regimen which is likely to produce side effects, toxic effects, allergic reactions, or other unusual effects; or which may rapidly endanger a client's life or well-being and which is prescribed by a person authorized by state



law to prescribe such a regimen. The nurse who assumes responsibility for implementing a treatment or pharmaceutical regimen shall be accountable for:

- (1) recognizing side effects;
- (2) recognizing toxic effects;
- (3) recognizing allergic reactions;
- (4) recognizing immediate desired effects;
- (5) recognizing unusual and unexpected effects;
- (6) recognizing changes in client's condition that contraindicates continued administration of the medication;
- (7) anticipating those effects which may rapidly endanger a client's life or well-being; and
- (8) making judgments and decisions concerning actions to take in the event such untoward effects occur.

(d) When health care needs of an individual are incidental to the personal care needs of the individual, nurses shall not be accountable for care performed by clients themselves, their families or significant others, or by caretakers who provide personal care to the individual.

(e) Pharmacists may administer drugs in accordance with 21 NCAC 46 .2507.

*History Note: Authority G.S. 90-85.3; 90-171.23(b); 90-171.43; 90-171.83;
Eff. May 1, 1982;
Amended Eff. July 1, 2004; April 1, 2002; December 1, 2000;
July 1, 2000; January 1, 1996; February 1, 1994; April 1, 1989; January 1, 1984;
Emergency Amendment Eff. September 10, 2004;
Amended Eff. December 1, 2004.*

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RULES DEFINING COMPONENTS OF PRACTICE FOR THE REGISTERED NURSE

Rules which further define the Nursing Practice Act have been established by the Board of Nursing. These rules are considered law and provide the parameters for the legal scope of practice for the licensed nurse; therefore, every nurse should have working knowledge of these rules in order to provide the public with safe nursing care.

21-36.0224. COMPONENTS OF NURSING PRACTICE FOR THE REGISTERED NURSE

(a) The responsibilities which any registered nurse can safely accept are determined by the variables in each nursing practice

setting. These variables include:

- (1) the nurse's own qualifications including:
 - (A) basic educational preparation; and
 - (B) knowledge and skills subsequently acquired through continuing education and practice;
 - (2) the complexity and frequency of nursing care needed by a given client population;
 - (3) the proximity of clients to personnel;
 - (4) the qualifications and number of staff;
 - (5) the accessible resources; and
 - (6) established policies, procedures, practices, and channels of communication which lend support to the types of nursing services offered.
- (b) Assessment is an on-going process and consists of the determination of nursing care needs based upon collection and interpretation of data relevant to the health status of a client, group or community.

(1) Collection of data includes:

(A) obtaining data from relevant sources regarding the biophysical, psychological, social and cultural factors of the client's life and the influence these factors have on health status, including:

- (i) subjective reporting;
- (ii) observations of appearance and behavior;
- (iii) measurements of physical structure and physiological functions;
- (iv) information regarding available resources; and

(B) verifying data collected.

(2) Interpretation of data includes:

(A) analyzing the nature and inter-relationships of collected data; and

(B) determining the significance of data to client's health status, ability to care for self, and treatment regimen.

(3) Formulation of a nursing diagnosis includes:

(A) describing actual or potential responses to health conditions. Such responses are those for which nursing care is indicated, or for which referral to medical or community resources is appropriate; and

(B) developing a statement of a client problem identified through interpretation of collected data.

(c) Planning nursing care activities includes identifying the client's needs and selecting or modifying nursing interventions related to the findings of the nursing assessment. Components of planning include:

(1) prioritizing nursing diagnoses and needs;

(2) setting realistic, measurable goals and outcome criteria;

(3) initiating or participating in multidisciplinary planning;

(4) developing a plan of care which includes determining and prioritizing nursing interventions; and

(5) identifying resources based on necessity and availability.

(d) Implementation of nursing activities is the initiating and delivering of nursing care according to an established plan, which includes, but is not limited to:

(1) procuring resources;

(2) implementing nursing interventions and medical orders consistent with 21 NCAC 36 .0221(c) and within an environment conducive to client safety;

(3) prioritizing and performing nursing interventions;

- (4) analyzing responses to nursing interventions;
 - (5) modifying nursing interventions; and
 - (6) assigning, delegating and supervising nursing activities of other licensed and unlicensed personnel consistent with Paragraphs (a) and (i) of this Rule, G.S. 90-171.20(7)d and (7)i, and 21 NCAC 36 .0401.
- (e) Evaluation consists of determining the extent to which desired outcomes of nursing care are met and planning for subsequent care. Components of evaluation include:
- (1) collecting evaluative data from relevant sources;
 - (2) analyzing the effectiveness of nursing interventions; and
 - (3) modifying the plan of care based upon newly collected data, new problem identification, change in the client's status and expected outcomes.
- (f) Reporting and Recording by the registered nurse are those communications required in relation to all aspects of nursing care.
- (1) Reporting means the communication of information to other persons responsible for, or involved in, the care of the client. The registered nurse is accountable for:
 - (A) directing the communication to the appropriate person(s) and consistent with established policies, procedures, practices and channels of communication which lend support to types of nursing services offered;
 - (B) communicating within a time period which is consistent with the client's need for care;
 - (C) evaluating the responses to information reported; and
 - (D) determining whether further communication is indicated.
 - (2) Recording means the documentation of information on the appropriate client record, nursing care plan or other documents. This

documentation must:

(A) be pertinent to the client's health care;

(B) accurately describe all aspects of nursing care including assessment, planning, implementation and evaluation;

(C) be completed within a time period consistent with the client's need for care;

(D) reflect the communication of information to other persons; and

(E) verify the proper administration and disposal of controlled substances.

(g) Collaborating involves communicating and working cooperatively with individuals whose services may have a direct or indirect effect upon the client's health care and includes:

(1) initiating, coordinating, planning and implementing nursing or multidisciplinary approaches for the client's care;

(2) participating in decision-making and in cooperative goal-directed efforts;

(3) seeking and utilizing appropriate resources in the referral process; and

(4) safeguarding confidentiality.

(h) Teaching and Counseling clients is the responsibility of the registered nurse, consistent with G.S. 90-171.20(7)g.

(1) Teaching and counseling consist of providing accurate and consistent information, demonstrations and guidance to clients, their families or significant others regarding the client's health status and health care for the purpose of:

(A) increasing knowledge;

(B) assisting the client to reach an optimum level of health functioning and participation in self care; and

(C) promoting the client's ability to make informed decisions.

(2) Teaching and counseling include, but are not limited to:

(A) assessing the client's needs, abilities and knowledge level;

(B) adapting teaching content and methods to the identified needs, abilities of the client(s) and knowledge level;

(C) evaluating effectiveness of teaching and counseling; and

(D) making referrals to appropriate resources.

(i) Managing the delivery of nursing care through the on-going supervision, teaching and evaluation of nursing personnel is the responsibility of the registered nurse as specified in the legal definition of the practice of nursing and includes, but is not limited to:

(1) continuous availability for direct participation in nursing care, onsite when necessary, as indicated by client's status and by the variables cited in Paragraph (a) of this Rule;

(2) assessing capabilities of personnel in relation to client status and plan of nursing care;

(3) delegating responsibility or assigning nursing care functions to personnel qualified to assume such responsibility and to perform such functions;

(4) accountability for nursing care given by all personnel to whom that care is assigned and delegated; and

(5) direct observation of clients and evaluation of nursing care given.

(j) Administering nursing services is the responsibility of the registered nurse as specified in the legal definition of the practice of nursing in G.S. 90-171.20 (7)i, and includes, but is not limited to:

(1) identification, development and updating of standards, policies and procedures related to the delivery of nursing care;

(2) implementation of the identified standards, policies and procedures to promote safe and effective nursing care for clients;

(3) planning for and evaluation of the nursing care

delivery system; and

(4) management of licensed and unlicensed personnel who provide nursing care consistent with Paragraphs (a) and (i) of this Rule and which includes:

(A) appropriate allocation of human resources to promote safe and effective nursing care;

(B) defined levels of accountability and responsibility within the nursing organization;

(C) a mechanism to validate qualifications, knowledge and skills of nursing personnel;

(D) provision of educational opportunities related to expected nursing performance; and

(E) validation of the implementation of a system for periodic performance evaluation.

(k) Accepting responsibility for self for individual nursing actions, competence and behavior is the responsibility of the registered nurse, which includes:

(1) having knowledge and understanding of the statutes and rules governing nursing;

(2) functioning within the legal boundaries of registered nurse practice; and

(3) respecting client rights and property, and the rights and property of others.

History Authority G.S. 90-171.20(7); 90-171.23(b); 90-
Note: 171.43(4);;
Eff. January 1, 1991;
Temporary Amendment Eff. October 24, 2001;
Amended Eff. August 1, 2002.