



RN SCOPE OF PRACTICE - CLARIFICATION

POSITION STATEMENT for RN Practice

A Position Statement is not a regulation of the NC Board of Nursing and does not carry the force and effect of law and rules. A Position Statement is not an interpretation, clarification, or other delineation of the scope of practice of the Board. A Position Statement is adopted by the Board as a means of providing direction to licensees who seek to engage in safe nursing practice. Board Position Statements address issues of concern to the Board relevant to protection of the public and are reviewed regularly for relevance and accuracy to current practice, the Nursing Practice Act, and Board Administrative Code Rules.

INTRODUCTION

The Nursing Practice Act, G.S. 90-171.20(7) and North Carolina Administrative Code, 21 NCAC 36.0224 (RN rules) govern Registered Nurse (RN) practice in North Carolina. Reading this Position Statement and the RN rules together serves to clarify the RN Scope of Practice/Components of Practice for RNs, LPNs, employers, consumers, and others. Comparison with 21 NCAC 36.0225 provides distinction from LPN scope of practice.

RN Practice encompasses the full scope of nursing and includes caring for all clients in all settings. The RN scope of practice in all steps of the nursing process is independent and comprehensive. RN practice does not require assignment or supervision by a higher level health care provider.

Note: The practice of nursing is constantly evolving as new and changing technology and therapies are introduced. The North Carolina Board of Nursing defines and interprets scopes of practice for all levels of providers of nursing care. Each agency/employer is responsible for developing policies/procedures/standards of practice and ensuring competency of the nursing staff. An agency/employer, including authorized licensed health care providers, may restrict the nurse's practice but never expand the practice beyond the legal scope as defined. RN practice is not defined by specific activities or tasks but rather as a process consisting of a legally defined set of Components of Practice using the steps of the nursing process as outlined in the RN rules, 21 NCAC 36.0224.

For specific questions, the NCBON Scope of Practice Decision Tree for the RN and LPN is available at www.ncbon.com – select Nursing Practice on the top banner – select Position Statements and Decision Trees – select Scope of Practice Decision Tree. NCBON Practice Consultants can also be reached for clarification at 919-782-3211.

Critical Thinking: Critical thinking is used throughout all components of the nursing process. Critical thinking is purposeful and reflective judgment in response to events, observations, experiences, and verbal or written expressions. It involves determining the meaning and significance of what is observed or expressed to determine need for action. Nurses (RNs and LPNs) use critical thinking in clinical problem-solving and decision-making processes relative to scope of practice, knowledge, competency, and experience.

ACCEPTING AN ASSIGNMENT

The first decision required by the RN is whether or not to accept the responsibilities of their position and/or assignment. The responsibilities which any registered nurse can safely accept are determined by the variables in each nursing practice setting. Paragraph (a) of the RN rules lists the variables in each practice setting which the RN must consider in making this decision. Please see Position Statement, Accepting Assignment, for additional guidance on this important topic at www.ncbon.com – select Nursing Practice on the top banner – select Position Statements and Decision Trees – select Accepting Assignment.

COMPONENTS OF RN PRACTICE

ASSESSMENT, the first step of the nursing process and an essential component of nursing practice, is an ongoing process. Beginning with the initial encounter and continuing throughout the episode(s) of care, assessment is the basis for nursing judgments, decisions, and interventions. Nursing assessment is the gathering of information about a patient's physiological/biological, psychological, sociological, and spiritual status.

Both registered nurses and licensed practical nurses assess clients. Some elements of assessment are identical for both the RN and LPN. These include:

- The collection of data for a nursing history, psychological, spiritual, and social history, and physical examination (including vital signs, head to toe and/or targeted physical assessment, and other physiological/biological data).
- Comparison of the data collected to normal values and findings.
- Ongoing determination of client status for changes in condition, positive and negative.

The RN develops impressions or inferences about the meaning of the data beyond normal vs. abnormal. The RN:

- Distinguishes between relevant and irrelevant data,
- Determines whether and where there are gaps in the data, and
- Identifies patterns of cause and effect.

The RN nursing assessment is comprehensive. The RN is responsible for extensive data collection (initial and ongoing) for individuals, families, groups, and communities that addresses anticipated changes in client conditions as well as emergent changes in a client's health status while recognizing alterations to previous client conditions. The RN is responsible for 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 in planning nursing interventions. The RN is responsible for evaluating the need for different interventions and the need to communicate and consult with other health team members. The RN determines the need for, extent of, and frequency of assessment based on client needs, interventions, responses, and condition. (National Council of State Boards of Nursing, Model Law and Rules, 2008)

The **registered nurse (RN)**, while considering the input of the LPN, maintains overall responsibility for both initial and ongoing nursing assessments to identify actual and potential problems and to determine nursing care needs (Nursing Practice Act G.S. 90-171.20(7) and RN rules 21 NCAC 36.0224(b).

PLANNING is the second step of the nursing process and includes identifying the client's needs and selecting or modifying nursing interventions related to the findings of the nursing assessment. See Paragraph (c) of the RN rules for the elements of the planning component. It is important to note that while the LPN may provide input in the planning process, the final responsibility for prioritizing nursing diagnoses and needs and developing the nursing plan of care rests with the RN.

IMPLEMENTATION is the third step of the nursing process. In the implementation component, the RN initiates and delivers nursing care according to an established plan. This component also includes analyzing responses to nursing interventions and assigning, delegating and supervising nursing activities of other licensed and unlicensed assistive personnel (UAP). See Paragraph (d) of the RN rules for additional elements of the implementation component.

The appropriate and effective RN delegation of nursing activities to UAP is an essential element in assuring safe client care. The NCBON Decision Tree for Delegation to UAP and the Position Statement on Delegation and Assignment of Nursing Activities (both available at www.ncbon.com) provide guidance for RN practice.

EVALUATION is the fourth step of the nursing process and consists of determining the extent to which desired outcomes of nursing care are met and planning for subsequent care. Elements of evaluation include: collecting evaluative data from relevant sources, analyzing the effectiveness of nursing interventions, and modifying the plan of care based upon ongoing data collection and problem identification related to changes in the client's condition and expected outcomes. The LPN may provide information based on their experience in the client's care, but the RN maintains final responsibility for the evaluation component.

REPORTING and RECORDING by the registered nurse are those communications required in relation to all aspects of nursing care. Reporting is the verbal communication of information to other persons responsible for or involved in the care of the client. Recording is the written or electronic documentation of information on the appropriate client record, nursing care plan or other documents. See RN rules, Paragraph (f), for more information on the required elements of reporting and recording.

COLLABORATING involves communicating and working cooperatively with individuals whose services may have a direct or indirect effect upon the client's health care. The RN may initiate, coordinate, plan and implement nursing or multidisciplinary approaches for the client's care. More detailed information on collaborating is included in Paragraph (g) of the RN rules.

TEACHING and COUNSELING clients is the responsibility of the registered nurse and includes having the responsibility for assessing the client's needs, developing the teaching plan, evaluating the effectiveness of teaching and counseling and making referrals to appropriate sources. This component is addressed in Paragraph (h) of the RN rules.

PLEASE NOTE:

SUPERVISING, TEACHING AND EVALUATING those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services are unique to the practice of the RN as stated in the Nursing Practice Act [G.S. 90-171.20(4)] and Paragraphs (i) and (j) of the RN rules.

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 nursing referenced above in the Nursing Practice Act and includes:

- Continuous availability for direct participation in nursing care, onsite when necessary, as indicated by the client's status and by variables cited in Paragraph (a) of the RN rules;
- Assessing capabilities of personnel in relation to client status and plan of nursing care;
- Delegating responsibility or assigning nursing care functions to personnel qualified to assume such responsibility and to perform such functions;
- Direct observation of clients and evaluation of nursing care given.

Only the RN may validate the competency of licensed and unlicensed staff providing nursing care.

ADMINISTERING NURSING SERVICES is the responsibility of the registered nurse as specified in the legal definition of nursing referenced above in the Nursing Practice Act. Administering nursing services includes, but is not limited to the following:

- Identification, development and updating of standards, policies and procedures related to the delivery of nursing care;
- Implementation of the identified standards, policies and procedures to promote safe and effective nursing care for clients;
- Planning for and evaluation of the nursing care delivery system;

- Management of licensed and unlicensed personnel who provide nursing care consistent with Paragraphs (a) through (i) of the RN rules and which includes
 - Staffing to promote safe and effective nursing care;
 - Defined levels of accountability and responsibility within the nursing organization;
 - A mechanism to validate qualifications, knowledge and skills of nursing personnel;
 - Provision of educational opportunities related to expected nursing performance;
 - Ensuring the implementation of a system for periodic performance evaluation.

ACCEPTING RESPONSIBILITY for self for individual nursing action, competence and behavior is a component of practice shared by LPNs and RNs. The elements within this component of practice are listed in the RN rules in Paragraph (j).

Please see the [RN Rules](#) and the [RN and LPN Scope of Practice Comparison Chart](#)

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