
A Position Statement does not carry the force and effect of law and rules but 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 North Carolina Administrative Codes, [21 NCAC 32M .0101-.0117](#), [21 NCAC Chapter 33](#), [21 NCAC 36 .0226](#), [21 NCAC 36. 0228](#), regulate the practice of Nurse Practitioners (NP), Certified Nurse-Midwives (CNM), Clinical Nurse Specialists (CNS), and Certified Registered Nurse Anesthetists (CRNA). This Position Statement and applicable rules serve to clarify the scope of practice of Advanced Practice Registered Nurses (APRNs) for nurses, employers, consumers, and others.

APRNs include CRNAs, CNMs, CNSs and NPs. APRNs are educated in one of the four roles and in at least one of the six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. The 2008 Consensus Model for APRN Regulation*: Licensure, Accreditation, Certification & Education was developed by the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee to provide guidance to states in developing uniformity in the regulation of APRNs. The model defines APRN practice and describes the APRN regulatory model.

*NC law prevents full adoption of the Consensus Model. The Consensus Model has been adopted by accreditation, certification and education bodies. This position statement refers to components of the Consensus Model that are applicable to interpretation of current NC laws and rules and should guide the APRN in decisions about scope of practice.

NORTH CAROLINA SCOPE OF PRACTICE FOR APRNS

Nurse Practitioners [[21 NCAC 36 .0802](#)] defined by the NP's academic educational preparation, national certification and maintained competence.

Certified Nurse Midwives [[NC GS 90-178.2](#)] the act of providing prenatal, intrapartum, postpartum, newborn and interconceptional care.

Certified Registered Nurse Anesthetists [[21 NCAC 36 .0226](#)] activities and responsibilities include: pre-anesthesia preparation and evaluation; anesthesia induction, maintenance, and emergence; post-anesthesia care; inserting central vascular access catheters and epidural catheters; identifying, responding to, and

managing emergency situations, including initiating and participating in cardiopulmonary resuscitation; providing consultation related to respiratory and ventilatory care and implementing such care according to established policies within the practice setting; and initiating and managing pain relief therapy using pharmaceutical agents, regional anesthetic techniques, and other accepted pain relief modalities according to established policies and protocols within the practice setting.

Clinical Nurse Specialists [[21 NCAC 36. 0228](#)] incorporate understanding and application of nursing principles at an advanced practice registered nurse level in the area of clinical nursing specialization in which the clinical nurse specialist is educationally prepared and for which competency is maintained.

HOW DO I APPLY NC LAWS AND RULES TO MY APRN PRACTICE?

The NC Board Of Nursing is frequently asked questions about specific roles, tasks, or procedures for an APRN such as: “can I accept a position doing ‘abc’, or can I accept a position in ‘xyz’ facility?” or “is this procedure or task something a CRNA, PMHNP, or CNM can do?” To answer these questions the APRN needs to consider in sequential order the questions below. If at any point the answer is **no** – the APRN knows it is outside their current scope of practice. The Consensus Model states specialty training cannot replace educational preparation in the role of one of the six population foci. The APRN would need to return to school to obtain the additional academic education and national certification that would allow for certification in another population foci.

1. Did didactic content cover this role, task or procedure, practice scenario, population, etc. in my formal academic education?
2. Is this included in the standards of practice for my role?
3. Is this within my national certification?
4. Does evidenced based literature support my role performing this activity?
5. Do I have the knowledge and skills to perform this activity?
6. Do I have the documented competency (from school, training, employer) for doing this activity?
7. Would a reasonable and prudent nurse with my same education and national certification provide similar care?
8. Does my employer allow this activity? (Remember your employer may be more restrictive than the laws and rules but shall not be less restrictive.)

Again, if at any point the answer is **no**, it is outside the scope of the APRN.

From the Consensus Model:

“All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is **not defined or limited by setting but rather by patient care needs.**” *page 8*

“The Certified Nurse Practitioner

For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. ... **Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.**” *page 9*

“APRN Specialties

Preparation in a specialty area of practice is optional, but if included must build on the APRN role/population-focused competencies. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialty practice may focus on specific patient populations beyond those identified or health care needs such as oncology, palliative care, substance abuse, or nephrology. The criteria for defining an APRN specialty is built upon the ANA (2004) Criteria for Recognition as a Nursing Specialty (see Appendix B). APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an Adult-Gerontology

CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model. Professional certification in the specialty area of practice is strongly recommended.” *page 12*

What about obtaining additional training to add to my scope of practice? Specialty training cannot replace formal educational preparation in the role or one of the six population foci; preparation in a specialty cannot expand the APRN’s scope of practice beyond the role or population focus and only addresses a subset of the population-focus of the APRN. Continuing education and activities to maintain competence or develop additional skills/knowledge are requirements of all nursing professionals. These activities do not replace the formal educational preparation required for adding a new role or additional population foci.

References:

[Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, July 7, 2008](#)

[21 NCAC 32M .0101-.0117](#)

[21 NCAC Chapter 33](#)

[21 NCAC 36 .0226](#)

[21 NCAC 36. 0228](#)