



RN Scope of Practice - Clarification Position Statement for RN Practice

INTRODUCTION

The Nursing Practice Act, G.S. 90-171.20(7) and North Carolina Administrative Code, 21 NCAC 36.0224 (see attached RN rules) govern Registered Nurse (RN) practice in North Carolina. Reading this Position Statement and the attached 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.

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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 attached 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.

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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.

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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 attached RN rules in Paragraph (j).

For a brief outline of the differences between the RN and LPN components of practice, please see the RN and LPN Scope of Practice Comparison Chart attached to this statement, following the RN rules.

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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 NCAC 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

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- (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

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J:\PRACT\Handouts\Position Statements\2014 revisions for Linda Burhans review\RN Position Statement Revision 1-2014.doc

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

RN and LPN Scope of Practice Components of Nursing Comparison Chart

By law, the scopes of practice for the registered nurse (RN) and the license practical nurse (LPN) differ. The RN functions at an independent level while the LPN functions at a dependent level. This chart provides a snapshot comparison. For more information, please refer to the NCBON's RN Scope of Practice Position Statement and the LPN Scope of Practice Position Statement available on the North Carolina Board of Nursing's website (www.ncbon.com) under Practice – Position Statements.

Components of Nursing Practice	RN Scope of Practice <i>Independent role</i>	LPN Scope of Practice <i>Dependent role</i>
Accepting an Assignment	Accepts assignments based on variables in nursing practice setting	Accepts assignment dependent on availability of RN supervision and practice setting variables
Assessment	<ul style="list-style-type: none"> • Determines assessment • Collects, verifies, and interprets data in relation to health • Formulates nursing diagnoses 	Participates in: <ul style="list-style-type: none"> • Collecting data • Recognizing relationship to diagnosis • Determining immediate need for intervention
Planning	<ul style="list-style-type: none"> • Identifies client's needs • Determines priorities of nursing diagnoses, nursing care goals, and interventions appropriate to client • Develops a plan of care 	Participates in identifying client's needs through suggestion of goals and interventions for review by RN
Implementation	<ul style="list-style-type: none"> • Implements plan of care including procuring resources • Assignment, delegation, and supervision of licensed and unlicensed personnel 	Implements established plan of care with following limitations: <ul style="list-style-type: none"> • RN supervision required • Assignment to other LPNs and delegation to UAPs • Supervision by LPN limited to assuring that tasks have been completed according to agency policies and procedures
Evaluation	<ul style="list-style-type: none"> • Evaluates both effectiveness of nursing interventions and achievement of expected outcomes • Modifies plan of care 	Participates in evaluation by identifying client's response to nursing intervention and suggesting to the RN revision to plan of care
Reporting and Recording	Reports and Records	Reports and Records
Collaborating	<ul style="list-style-type: none"> • Communicates and works cooperatively with individuals whose services may affect client's health care • Initiates, coordinates, plans, and implements nursing care of client within the multidisciplinary team 	Participates in collaboration as assigned by the RN
Teaching and Counseling	<ul style="list-style-type: none"> • Responsible to teach and counsel clients, families and groups • Identifies learning needs • Develops and evaluates teaching plans • Makes referrals to appropriate resources 	Participates in teaching and counseling of clients and families as assigned by the RN through the implementation of an established teaching plan or protocol
Managing Nursing Care	<ul style="list-style-type: none"> • Manages nursing care • Supervises, teaches, and evaluates nursing personnel 	Not within the LPN scope of practice NOTE: See limited supervisory role for LPN in the Implementation Section above.
Administering Nursing Services	Administers nursing services	Not within the LPN scope of practice
Accepting Responsibility for Self	Accepts responsibility for self	Accepts responsibility for self

NOTE: Color version of chart is available on the NCBON website at www.ncbon.com under Practice – Position Statements - COLOR - RN and LPN Scope of Practice Components of Nursing Comparison Chart.

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