REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Board of Nursing

RULE CITATION: All Rules

DEADLINE FOR RECEIPT: Monday, November 4, 2024

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

In your Submission for Permanent Rule Form, box 9A, you've checked "Petition for rulemaking" as the prompt for this action. Additionally, in box 9B you've explicitly stated that these rules are filed pursuant to a petition filed with the Board on April 23, 2024. However, under G.S. 150B-20(a), the Board was required to file that petition with OAH within three business days of receipt. OAH is then required to post it on its website within three business days of receipt from the agency.

According to the "Rules Division Official Notices and Postings" website, OAH has not posted a petition received from the Board of Nursing. Further, communication with OAH publications staff indicated that no petition was received from the Board of Nursing. Can you provide proof that the Board transmitted the petition to OAH in a timely manner?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Brian Liebman
Commission Counsel
Date submitted to agency: October 21, 2024

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Board of Nursing

RULE CITATION: 21 NCAC 36 .0229

DEADLINE FOR RECEIPT: Monday, November 4, 2024

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

I am not sure you have statutory authority to allow RNs or LPNs to pronounce death, for the reasons stated in my requests for changes for Rule .0810, which are incorporated herein.

Specifically to this rule, can you address whether LPNs are nurse practitioners under G.S. 90-8.2, 90-18(c)(14), 90-171(b)(14), and 90-18.2 which explicitly refers to "registered nurses" and not "licensed practical nurses"? Further, address whether the distinction between "the practice of nursing by a registered nurse" and "the practice of nursing by a licensed practical nurse" in 90-171.20 is relevant here.

Additionally, to the extent that the Medical Board does not have a rule explicitly allowing physicians to delegate the task of pronouncing someone dead to an LPN, does this comply with G.S. 90-8.2, which requires both the Medical Board and the Board of Nursing to adopt the same rules in order for them to become effective?

In (1), line 6, what are the "requisite qualifications and experience" necessary to assess, interpret, and formulate the determination to pronounce someone dead? Without specifically identifying these, I believe this is not only ambiguous, but potentially in excess of statutory authority, as the Rule fails to identify the standards that "govern" the proposed medical act, as required by G.S. 90-8.2 and 90-18(c)(14).

In (2), line 8, the reference to "site-specific policies and procedures" essentially delegates the two boards' responsibility to develop rules governing the performance of these acts to the "site". This does not appear permissible under either G.S. 90-171(b)(14) or any of the statutes elsewhere in Ch. 90 that refer to the process of delegating medical acts from a physician to a nurse.

Moreover, this appears to be an incorporation by reference of another body's policies and procedures—the Board is saying a violation of a practice site's policies and procedures constitutes a violation of the Board's rule—without specifying what it is incorporating. G.S. 150B-21.6 governs incorporation by reference, and requires not

only that the material being incorporated be a "rule" adopted by an agency, or a "code, standard, or regulation adopted by another agency, the federal government, or a generally recognized organization or association." It does not appear to me that the policies of any particular clinic, office, or hospital cross this threshold, and in any event, you haven't complied with any of the other procedural requirements of G.S. 150B-21.6 (i.e. stating whether the incorporation applies to subsequent editions or amendments).

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

21 NCAC 36 .0229 is proposed to be adopted as published in NCR 39:01, page 39, as follows:

21 NCAC 36 .0229 DETERMINATION AND PRONOUNCEMENT OF DEATH

Determination and pronouncement of death is an act that can be delegated to a registered nurse or a licensed practical nurse, provided that:

(1) The registered nurse or licensed practical nurse has the requisite qualifications and experience to assess, interpret, and formulate this determination and pronouncement; and

(2) This delegation is consistent with the registered nurse's or licensed practical nurse's site-specific policies and procedures.

History Note: Authority 90-171.20(7) and (8); 90-171.23(b)

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Board of Nursing

RULE CITATION: 21 NCAC 36 .0810

DEADLINE FOR RECEIPT: Monday, November 4, 2024

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

I am not sure you have statutory authority to allow nurse practitioners to issue DNRs or determine or pronounce death. First, I think specific statutes within Ch. 90 require that both tasks be completed by physicians. Second, to the extent that the Board can allow nurse practitioners to issue DNRs or declare a person dead, I do not think that this rule complies with the requirements of G.S. 90-8.2.

First, with respect to Do Not Resuscitate orders, G.S. 90-21.17(b) states that a "physician" may order a portable DNR or MOST for a patient. G.S. 90-21.17(c) goes on to describe the forms for a DNR and a MOST, and explicitly draws a distinction when contemplating who can sign each form. According to 90-21.17(c), the "official DNR form shall include fields for . . . the name, address, and telephone number of the ***physician****; the signature of the* ***physician****. . . ." Meanwhile, the "official MOST form shall include fields for . . . the name, telephone number, and signature of the* ***physician, physician assistant, or nurse practitioner*** *authorizing the order. . . ." Thus, it appears that the GA acknowledged the possibility of nurse practitioners issuing such orders, and explicitly decided to limit them to signing the MOST form rather than the DNR form.*

Second, with respect to the ability to determine and pronounce death, G.S. 90-323 explicitly states that "the determination that a person is dead shall be made by a ***physician*** *licensed to practice medicine applying ordinary and accepted standards of medical practice."*

While G.S. 90-8.2(a), 90-18(c)(14) and 90-18.2 speak to the performance of "medical acts" by a nurse practitioner, that term is undefined in either your statutes or rules. However, G.S. 90-18.2 defines the "limitations on nurse practitioners," and appears to restrict a nurse practitioner to writing prescriptions (paragraph (b)), compounding and dispensing drugs (paragraph (c)), and ordering medications, tests, and treatments (paragraph (d)). Thus, it appears the specific statutes governing DNRs/MOSTs and

the pronouncement of death control over the general statute permitting the practice of nurse practitioners.

Second, as discussed above, G.S. 90-8.2 requires both the Medical Board and the Board of Nursing to adopt rules that "govern the performance of medical acts" by the nurse practitioner. G.S. 90-18(c)(14) states that it is not the unlicensed practice of medicine for a nurse to perform "acts otherwise constituting medical practice . . . when performed in accordance with rules and regulations . . . ." Finally, G.S. 90-18.2(b), (c), and (d) all speak to the development of specific rules and regulations for each task.

Here, the Board is permitting a nurse practitioner to issue a DNR or pronounce death "so long as all applicable requirements are met and doing so is permitted by and consistent with practice-site-specific policies and procedures". Setting aside issues of ambiguity (see below), this language essentially delegates the two boards' responsibility to develop rules governing the performance of these acts to the "practice site". This does not appear permissible under any of the statutes cited by the Board in the History Note for this Rule.

Moreover, this appears to be an incorporation by reference of another body's policies and procedures—the Board is saying a violation of a practice site's policies and procedures constitutes a violation of the Board's rule—without specifying what it is incorporating. G.S. 150B-21.6 governs incorporation by reference, and requires not only that the material being incorporated be a "rule" adopted by an agency, or a "code, standard, or regulation adopted by another agency, the federal government, or a generally recognized organization or association." It does not appear to me that the policies of any particular clinic, office, or hospital cross this threshold, and in any event, you haven't complied with any of the other procedural requirements of G.S. 150B-21.6 (i.e. stating whether the incorporation applies to subsequent editions or amendments).

In (2)(c), line 20, what are the "applicable requirements"? Failing to state what "applicable requirements" govern the performance of these duties is impermissibly ambiguous under G.S. 150B-21.9(a)(2).

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

21 NCAC 36 .0810 is proposed to be amended as published in NCR 39:01, pages 39-40, as follows:

21 NCAC 36 .0810 QUALITY ASSURANCE STANDARDS FOR A COLLABORATIVE PRACTICE AGREEMENT

The following are the quality assurance standards for a collaborative practice agreement:

(1) Availability: The primary or back-up supervising physician(s) and the nurse practitioner shall be continuously available to each other for consultation by direct communication or telecommunication.

(2) Collaborative Practice Agreement:

(a) shall be agreed upon, signed, and dated by both the primary supervising physician and the nurse practitioner, and maintained in each practice site;

(b) shall be reviewed at least yearly. This review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the nurse practitioner, appended to the collaborative practice agreement, and available for inspection by either Board;

(c) shall include the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the nurse practitioner consistent with Rule .0809 of this ~~Section; and~~ Section and may include issuing do not resuscitate orders as outlined in G.S. 90-21.17(b) and determining and pronouncing death pursuant to G.S. 90-323 so long as all other applicable requirements are met and doing so is permitted by and consistent with practice-site-specific policies and procedures; and

(d) shall include a pre-determined plan for emergency services.

(3) The nurse practitioner shall demonstrate the ability to perform medical acts as outlined in the collaborative practice agreement upon request by members or agents of either Board.

(4) Quality Improvement Process:

(a) The primary supervising physician and the nurse practitioner shall develop a process for the ongoing review of the care provided in each practice site, including a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.

(b) This plan shall include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified time frame.

(c) The quality improvement process shall include scheduled meetings between the primary supervising physician and the nurse practitioner for a minimum of every six months. Documentation for each meeting shall:

(i) identify clinical problems discussed, including progress toward improving outcomes as stated in Sub-item (4)(b) of this Rule, and recommendations, if any, for changes in treatment plan(s);

(ii) be signed and dated by those who attended; and

(iii) be available for review by either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

(5) Nurse Practitioner-Physician Consultation. The following requirements establish the minimum standards for consultation between the nurse practitioner and primary supervising physician(s):

(a) During the first six months of a collaborative practice agreement between a nurse practitioner and the primary supervising physician, there shall be monthly meetings to discuss practice-relevant clinical issues and quality improvement measures.

(b) Documentation of the meetings shall:

(i) identify clinical issues discussed and actions taken;

(ii) be signed and dated by those who attended; and

(iii) be available for review by either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

History Note: *Authority G.S. 90-8.2; 90-18(c)(14); 90-18.2; 90-171.23(b)(14);*
Recodified from 21 NCAC 36 .0227(i) Eff. August 1, 2004;
Amended Eff. December 1, 2009; August 1, 2004;
Readopted Eff. January 1, 2019;
Amended Eff. June 1, 2021.