It is within the Scope of Practice for a Registered Nurse (RN*) to: (1) assess patients, recognize the potential for, or existence of any condition or active labor; (2) initiate appropriate nursing intervention and care; (3) report findings to an appropriately licensed individual; and (4) pursuant to orders, when such orders are required, implement care, treatments, medication administration, and either discharge the patient or perform ongoing assessment for either stabilization and/or transfer of the patient if the following requirements are met*:

I. GENERAL REQUIREMENTS

A. Written policy, procedures and protocols regarding the RN’s responsibilities in assessing patient conditions including the potential for or existence of an immediate life threatening condition and instituting appropriate nursing actions are developed and maintained by the agency/employer.

B. The Registered Nurse is responsible for maintaining competencies and practice currency (Clinical experience required in a given time period prior to initial or annual registration) that allow him/her to be current with standards of care/practice (R4-19-402). These competencies include but are not limited to:

- Knowledge of anatomy and physiology pertinent to the area of practice in the clinical setting,
- Knowledge of indications of clinical conditions specific to the area of clinical expertise that have potential for or presence of actual life threatening condition,
- Knowledge of parameters for assessing patient conditions and the presence of potential or existent life threatening conditions,
- Knowledge of nursing interventions pertinent to clinical conditions of the area of clinical practice,
- And knowledge of parameters for reporting the findings of assessments and findings of life threatening conditions.

C. Documentation of supervised clinical practice and competency is on file with the agency/employer.

*While this Advisory Opinion is not limited to any particular nursing service, setting or specialty, examples of the types of assessments that RN’s may perform include:
• Assessment of the presence or absence of labor including fetal heart tones, the regularity and duration of uterine contractions, cervical dilation and effacement, fetal station, and status of uterine membranes, i.e. ruptured, or intact.
• Assessment of risk of suicide or homicide, disorientation, and risk of assault behavior to self or others

II. RATIONALE

To ensure consistency and competency by Registered Nurses in the performance of patient/client assessment.

III. REFERENCES

