MEMORANDUM

TO: Advisory Committee on Advanced Practice Registered Nursing (APRN Advisory Committee)
FROM: Lisa Emrich, Program Manager
DATE: September 19, 2019
RE: Revised Draft CNP Interpretive Guideline

Attached, please find the Revised Interpretive Guideline (IG) with Attachments A and B.
The changes to this draft are summarized as follows:

- The CME definition of critical care was replaced with a summary of “acute care” taken from the WHO Bulletin article (see the IG footnote).
- As a result of the change to the critical care language, the term “acute care” is used to describe the higher or “red” level of care identified in Attachment A.
- Paragraph A 3.b. was made more specific by adding the word psychiatry to precede pediatrics, and by referencing that the certification of the psychiatric-mental health nurse practitioner is by the American Nurses Credentialing Center.
- In paragraph B the word “national” was inserted before “certification.”
- In the second paragraph below the Accountability and Responsibility of APRN-CNPs bolded header, the words “and setting” were removed.
- Additional statutory citations that apply to APRNs were added at the end of the document: Sections 4723.50; 4723.51, and 4723.53, ORC.

The prior “chart” is now titled Attachment A and contains individual graphs for each type of national certification. The verbiage in the vertical line was changed to “Illness/Condition/Severity/Stability” with color ranges of green to red maintained. Waved lines without a lined border were also used as reflected on the applicable graphs.

Attachment B of the IG is the Reference list with links to the certifying organizations. This attachment remains largely unchanged. The links to the national certifying body information and test plans are live links, so that any person may access the publicly available test plans and information directly from the certifying organization’s website. It was not possible to link the NONPF competencies as membership was required to access that information link directly from that website.

As discussed at previous meetings, separate from the IG, staff are looking into a Frequently Asked Questions document. If that document is completed prior to the October 28, 2019 meeting date, it will be forwarded to the committee members and interested parties at that time.

This draft IG is being distributed and posted in advance of the October 28, 2019 meeting of the Board’s APRN Advisory Committee for review, consideration and comment. Any comments regarding the draft IG should be sent to PracticeAPRN@nursing.ohio.gov with the phrase “Draft IG” included in the subject line of the e-mail. Comments may also be postal mailed to the Board at the address listed in the header to this document and sent to the attention of the “Practice Unit.” The Board requests that comments be received no later than 8:00 a.m. Friday October 18,
2019, to allow time for staff to compile and forward those comments to committee members in advance of the October 28th meeting.
Interpretive Guideline (DRAFT 9 6 2019)

Title: APRN-CNP Licensure, National Certification and Management of Patient Conditions

This Interpretive Guideline is provided as guidance to APRN-CNPs seeking to meet their scope and standards of practice in the State of Ohio relative to patients’ stage of growth and development, gender and managed conditions as established in Sections 4723.41, 4723.43(C) and 4723.431 of the Ohio Revised Code (ORC) and administrative rules adopted thereunder.

For purposes of this Interpretive Guideline, the higher (red) level of the care required by the patient’s condition as used within Attachment A will have the same meaning as the term “acute care” explained by Hirshon, Risko, Calvello, de Ramirez, Narayan, Theodosis & O’Neil ¹ as:

[...the most time-sensitive, individually-oriented diagnostic and curative actions whose primary purpose is to improve health. A proposed definition of acute care includes the health system components, or care delivery platforms, used to treat sudden, often unexpected urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention. The term acute care encompasses a range of clinical health-care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization. (pg. 386)]

A. APRN-CNP authorized practice is dependent on the following:
   1. A current, valid Ohio APRN-CNP license issued by the Ohio Board of Nursing (Board);
   2. Maintenance of national certification by a national certifying organization approved by the Board;
   3. Entry into a standard care arrangement with a collaborating physician or podiatrist who is:
      a. Authorized to practice in Ohio
      b. Practicing in a specialty that is the same as or similar to the APRN-CNP’s nursing specialty; or whose practice is psychiatry, pediatrics, primary care or family practice if the APRN-CNP is certified as a psychiatric-mental health nurse practitioner by the American Nurses Credentialing Center.

B. APRN-CNP defined practice includes provision of the following within the APRN-CNP’s specialty and consistent with the APRN-CNP’s education and national certification:
   1. Preventive and primary care services;
   2. Services for acute illnesses;
   3. Evaluation and promotion of patient wellness.

C. APRN-CNP practice is consistent with the master’s or doctoral degree program that qualified the APRN to take their national certification exam, and in accordance with their national certification as provided in Section 4723.41, ORC. 

D. National certification for APRN-CNPs may be in one or more of the following patient populations pertaining to physiologic age, gender, and presenting state of health as indicated on Attachment A:
1. Family Across the Lifespan (Primary Care) (ANCC and AANPCB)
2. Adult-Gerontology Acute Care (ANCC)
3. Adult-Gerontology Primary Care (ANCC and AANPCB)
4. Pediatric Acute Care (PNCB)
5. Pediatric Primary Care (PNCB) (ANCC: retiring)
6. Neonatal (NCC)
7. Women’s Health Care (NCC)
8. Psychiatric/Mental Health Across the Lifespan (ANCC)

Accountability and Responsibility of APRN-CNPs

Section 4723.43(C), ORC, defines the scope of practice for the certified nurse practitioner. Chapters 4723-4, 4723-8, and 4723-9, Ohio Administrative Code (OAC), hold advanced practice registered nurses responsible for practicing in accordance with their education and clinical experience, national certification, the Nurse Practice Act (Chapter 4723., ORC) and rules adopted under the Nurse Practice Act.

The APRN-CNP must apply the Nurse Practice Act and rules regulating the practice of nursing (Chapters 4723-1 to 4723-27, OAC) to their specific practice. Further, the APRN-CNP must utilize good professional judgment in determining whether or not to engage in a given patient care and management activity, consistent with the law and rules.

In this Interpretive Guideline, the Board does not announce a new policy but instead gives APRN-CNPs specific instructions regarding their obligations under existing law and rules.

APRN-CNPs should also review the following:

ORC Sections 4723.01; 4723.151(B) and (C), 4723.41; 4723.43; 4723.431, 4723.44, 4723.48, 4723.481, 4723.4810, 4723.481, 4723.488, 4723.489, 4723.492, 4723.50; 4723.51; 4723.52; 4723.99.

OAC Chapters: 4723-4; 4723-8; 4723-9, 4723-13

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2 Section 4723.46(A)(4), ORC, requires that Board approved national certifying organizations have testing requirements that are developed in accordance with accepted standards of validity and reliability, and are open to registered nurses who have successfully completed the education program required by the organization.
Attachment B: References and Links to Organizations


Pediatric Nursing Certification Board; Certified Pediatric Nurse Practitioner-Primary Care Exam Detailed Content Outline. Effective September 15, 2018. Retrieved February 19, 2019 from https://www.pncb.org/sites/default/files/resources/2018_CPNP-PC_Exam_Content_Outline_FINAL.pdf


Family Nurse Practitioner Scope of Practice Issues When Treating Patients With Mental Health Issues

Melanie L. Balestra, JD, NP

Abstract

In primary care settings, family nurse practitioners (FNPs) are often the first to see patients with mental illnesses. FNPs can diagnose and treat patients with uncomplicated mental illness, such as depression and anxiety, within their scope of practice (SOP). However, FNPs should be aware of areas that fall outside of their SOP, such as diagnosing and treating patients with complicated or severe mental illnesses or exceeding prescribing authority for psychiatric medications. Any breach of their SOP could lead to civil liability and disciplinary actions. FNPs should adopt best practices to ensure patient safety and protect their licenses.

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American Association of Nurse Practitioners (AANP) members may receive 1.0 continuing education contact hours, including 0.25 pharmacology credit, approved by AANP, by reading this article and completing the online posttest and evaluation at aanp.inreachce.com.

Introduction

Scope of practice (SOP) is a cornerstone for professional regulation used by nurse practitioner (NP) licensing boards across the country, usually a state's Board of Nursing (BON). This concept defines the procedures, actions, and processes that NPs can perform as part of their professional licensure. Regulations are handled by each state and can vary from state to state.

By definition, the SOP for family NPs (FNPs) is broad, with FNPs caring for a wide spectrum of patients (from pediatrics to geriatrics) and domains (private practices to hospital clinics and other outpatient settings, both urban and rural). In some rural or remote settings, FNPs may be the only health care provider available to patients.

The SOP for FNPs could include providing mental health care services, and FNPs in primary care settings often are the first to see patients with common mental illnesses, such as depression and anxiety. In fact, FNPs are increasingly providing mental health care as demand from patients has increased. According to the National Institute of Mental Health, nearly 1 in 5 adults in the United States suffers from a mental illness (44.7 million in 2016). Among adolescents, an estimated 49.5% of young people aged 13 to 18 have had a mental disorder.

Among mental illnesses, major depression is common, with approximately 16.2 million adults (6.7% of all US adults) having had at least 1 major depressive episode. Anxiety disorders also greatly affect US adults, with more than 31% having had an anxiety disorder sometime in their lives. Furthermore, this increase in patient demand has been exacerbated in recent years by a growing shortage of mental health care practitioners, including psychiatrists, whose numbers declined by 10% from 2003 to 2013.

Although a legal or regulatory concept, the importance of SOP cannot be overstated. FNPs need to be familiar with their state's SOP to ensure patient safety as well as to protect their professional license, because acting outside of their recognized SOP in any patient care setting could expose them to civil liability and disciplinary actions brought by their BON, with the potential of having their professional licenses revoked. This is especially true when treating patients with mental illness or working with behavioral health issues, where an FNP may be trained and have the skills to diagnosis and initially treat mental illness but may be restricted by his or her SOP on the breadth and depth of care permitted.

With that in mind, this article will outline several important SOP issues for FNPs working with patients with mental health issues and provide recommendations to help them ensure best practices and patient safety. The recommendations also will help them avoid blurring the boundaries delineated by their SOPs and protect their professional licenses.

FNP SOP Issues With Behavioral Health Care

Patients with mental illnesses, such as depression, anxiety, and attention-deficit/hyperactivity disorder, are often initially treated...
by primary care providers such as FNPs. FNPs are well positioned to provide mental health care, going beyond mental health screening to initial intervention, which dovetails with the FNP philosophy of patient-centered care. However, FNP education covers only some aspects of mental health care and does not sufficiently prepare FNPs to treat patients with complex mental illnesses compared with psychiatric mental health NPs or other behavioral health specialists. FNPs should be aware of potential scenarios where the care they provide could breach their SOP. Below are some key examples of possible violations:

- Failure to monitor patient outcomes and refer patients to a psychiatric mental health NP, psychologist, or psychiatrist if symptoms have not improved, the patient is getting worse (acute decompensation) or is noncompliant, or the FNP disregards family members who have raised concerns about a patient.
- Failure to refer patients with common mental illness, such as depression, when specifically required by a state’s SOP.
- Failure to refer patients with complicated or severe (complex) mental illnesses, such as personality disorders, or if a specialist is needed based on the level of care or emergent conditions that prompt a referral/psychiatric consultation.
- Exceeding prescribing authority for psychopharmacotherapy (in states where FNPs are authorized to prescribe/furnish such medications) or psychotherapy.
- Failure to focus only on direct medical problems, such as blood pressure or diabetes, when treating patients with substance misuse diagnoses.

Any of these scenarios could lead to an allegation of a breach in SOP and a complaint to a state BON, which in turn would trigger an investigation and potential disciplinary action. A BON investigation has serious implications for any FNP, who would require legal assistance (and the associated costs of hiring an attorney) and could face the possibility of losing his or her professional license.

A look at closed/paid claims in connection with legal assistance provided to protect NPs licenses provides FNPs with valuable information about high-risk areas, including breaches in SOP. According to a 2017 closed claims data analysis compiled by Nurses Service Organization (available on its website), SOP claims have increased significantly, with total claims more than doubling from 9% in 2012 to 22.1% in 2017, with an average payment in 2017 of $6,687. Within SOP allegations, allegations of “practice violates SOP and standards of care” were the most frequent (60.3%), with defense costs averaging $7,030.

Considerations When Integrating Mental Health Care Into Practice

FNPs should consider the following recommendations to help them determine whether they are practicing within their SOP when treating patients with mental health illness and to protect themselves from civil liability and BON disciplinary/license issues. FNPs should:

- Thoroughly know their state’s SOP for FNPs and conduct an annual review of their SOP to stay current of any changes. FNPs also should consider using tools such as a decision tree to determine whether they are practicing within the legal SOP. One example is the Scope of Practice Decision Making Guidelines for All Licensed Nurses from the State of Oregon. Another example is the Kentucky Board of Nursing Scope of Practice Decision-Making Model for advanced practice registered nurses. FNPs also are encouraged to study national organization standards of practice and stay abreast of FNP literature and research, especially about integrating behavioral health care into primary care.
- Be rigorous and very specific in their assessment of patients with mental health complaints. They also should document all details such as the patient’s assessment, treatment plan, and compliance with follow-up appointments.
- Use psychopharmacology tools/questions, such as the Beck Depression Inventory—II, a widely used indicator of the severity of depression in adults, and mental health guide handouts available from the National Association of Pediatric Nurse Practitioners that are tailored by age and provide information on prevention, screening, intervention, and management of common mental health disorders.
- Be aware of their prescribing authority in connection with psychopharmacotherapy.
- Collaborate/refer with psychiatric health care professionals to expand care (ie, psychotherapy or psychopharmacologic therapy) when needed. Appropriate psychiatric consultations are a key part of helping FNPs stay within their SOP when treating patients with mental health issues. It is important to note that after the initial point of contact and diagnosis of the patient, followed by referral or psychiatric consultation, patient management and overseeing coordinated patient care may remain under the control of the FNP as the primary care provider.
- Be aware that charges of patient abandonment may be more likely to occur when treating a patient with depression. If a patient fails to make follow-up appointments, calls in for medication refills, etc, and the FNP feels that the patient would benefit from obtaining care from another primary care provider, the FNP must provide adequate notice so that the patient can locate another health care provider to avoid claims of patient abandonment. Alternately, if the patient is getting worse, the FNP should initiate a referral for a psychiatric consultation.
- Follow the FNP SOP when treating patients with substance misuse disorder, such as treating for blood pressure, diabetes, etc, but be aware that treatment of the addiction would be beyond the FNP SOP. Federal statute prevents NPs from prescribing some drugs for the treatment of opioid addiction and also limits the role of FNPs in serving as addiction treatment providers.
- Use caution when prescribing alternative care. FNPs must ensure that they have a thorough understanding about the alternative care they are prescribing and monitor the patient when this care is added.
- Take additional coursework. Core mental health is covered in FNP curricula and certification requirements, but additional course work is invaluable. FNPs can benefit greatly from in-depth workshops or continuing education courses on depression and anxiety so that they can determine when these diagnoses may be progressing or becoming so severe that patient care is no longer within their SOP and requires a referral (ie, common depression to severe depression or anxiety to panic attacks).
- FNPs should not treat any kind of severe or complex mental illness, such as schizophrenia, bipolar disorder, or personality disorder. These patients should be referred to a psychiatric consultation (physician or psychiatric mental health NP).
- Complete the studies and obtain the appropriate certification as a psychiatric mental health NP if they want their professional focus to be in mental health care.

BON and Disciplinary Actions in Connection With SOP Violations With Patients with Mental Health Issues

FNPs who perform patient care outside of their SOP put their licenses at risk. Any task performed outside of the FNP’s SOP,
including mental health care, is grounds for disciplinary action by his or her state BON. Complaints could come from patients and family members of patients if they are unhappy with the way the patient is being treated, and the BON could charge that the FNP was practicing psychiatry.

The result of these actions could range from probation and suspension (with or without fines) to license revocation. In addition, SOP breaches could lead to more serious civil issues, such as claims of malpractice, because these types of actions usually occur after a patient undergoes some sort of severity (ie, suicide, admission to a psychiatric hospital).

The following case scenarios describe litigation or disciplinary actions, or both, taken by BON for charges of practicing beyond the SOP in connection with patients with mental health issues, the defense presented, and final outcome/sanctions ordered by the BON. Importantly, risk control recommendations also are included and could be used by FNPs seeking to improve and enhance their everyday practice strategies and risk management procedures when treating patients with mental health issues.

**CASE SCENARIO: Pediatric Patient With Psychiatric Comorbidities**

An FNP began seeing a female patient as an infant. The patient was easily upset, would cry, and was difficult to comfort. The patient continued to be upset and was emotionally withdrawn as she got older. She could be a very loving child but would scream when her mother left the room. In her early teens, the patient became increasingly sullen and angry. She would indulge in impulsive behaviors, such as having sex with a young man she barely knew. The patient had only a few friends and found it difficult to make new friends. At times, the patient seemed terrified without her mother. The patient started cutting behavior and experiencing panic attacks. The FNP treated the patient with antidepressants and quetiapine fumarate at age 16. The patient committed suicide at age 18 by overdosing herself on quetiapine fumarate.

A malpractice lawsuit was filed, alleging that the FNP had been practicing outside her SOP and should have referred the patient to a psychiatrist or psychiatric mental health NP early in the patient's life. An expert witness supported the plaintiff's claim. The lawsuit was settled on behalf of the plaintiff and was then reported to the BON. After an investigation, the BON placed the FNP on probation for practicing outside of her SOP. Risk control recommendations:

* Have parents keep a diary of a child's behavior when monitoring for mental illness.
* Continue to assess the child with psychological testing.
* Counsel parents if it is determined that the child's behavior is not normal.
* Refer the patient to a psychiatrist or psychologist for evaluation and treatment.
* Check with parents to ensure that referral recommendation has been followed.

**CASE SCENARIO: Adult Patient in an Addiction Facility**

An adult man was admitted to a treatment facility with a diagnosis of an addiction to heroin. The patient had been in and out of several addiction facilities without success. An FNP was assigned to treat the patient medically for diagnoses of alcoholism and bulimia. The FNP ordered laboratory tests, and the results supported the bulimia diagnosis. A meeting was held at the facility to discuss transferring the patient to a higher level of care. Before the transfer occurred, the patient "collapsed with a seizure" and cardiopulmonary resuscitation was performed, but the patient died. The emergency department admission record stated that the patient was being treated by a physician (naming the FNP) and that the FNP attempted pain and psychiatric management. The FNP's license was revoked. The BON found that the FNP should have referred the patient to a psychiatrist, psychologist, or pain management specialist when the FNP realized that treatment was not adequately helping the patient. Risk control recommendations:

* Use a validated and reliable assessment tool that could help improve the diagnosis and management/treatment assessment of depression in the primary care setting. One example is the Patient Health Questionnaire-9, which is available for adults and adolescents and also is available in Spanish.
* Use methods other than medication for pain control.
* Refer the patient to a mental health specialist or pain management specialist, or both, when treatment modalities are not working.

**CASE SCENARIO: Adult Patient With Pain and Depression**

An adult mother of 3 children visited an FNP complaining that she had no energy and was having trouble getting out of bed in the morning. The patient also stated that she suffered from migraines and joint pain. After a physical examination of the patient, followed by much discussion, the FNP diagnosed the patient with depression and prescribed alprazolam for depression and hydrocodone bitartrate and acetaminophen (Norco; Allergan, Dublin, Ireland) for pain. The patient continued to call in for refills but did not show up for appointments. When she did return, she stated that her pain had increased and she needed more hydrocodone bitartrate and acetaminophen. The FNP increased the dosage of hydrocodone bitartrate and acetaminophen. This pattern went on for several years. The patient eventually attempted suicide, and her husband reported the FNP to the BON, complaining that the FNP's inappropriate treatment of his wife caused her suicide attempt. After an investigation, the BON found that the FNP attempted pain and psychiatric management of a patient that was outside of her SOP. The BON also found that she failed to explore other treatment modalities and continued to prescribe a drug with an addictive nature. The BON placed the FNP on probation for practicing outside of her SOP. The BON determined that the FNP should have referred the patient to a psychiatrist, psychologist, or pain management specialist when the FNP realized that treatment was not adequately helping the patient. Risk control recommendations:

* When caring for patients with a substance misuse disorder, treat only direct medical problems within the FNP SOP, such as high blood pressure, infection, or diabetes; do not treat the addiction.
* Take a thorough history upon initial patient assessment to determine whether there are any signs or symptoms of an eating disorder, such as predisposition for perfectionism or compulsivity or mood intolerance and impulsivity along with addiction behavior.
* Order appropriate laboratory tests and report any abnormalities to a psychiatrist.
* Refer the patient for in-hospital treatment immediately if test results are extremely abnormal.
Medical Malpractice and Disciplinary Insurance

The importance of buying individual professional liability insurance cannot be overemphasized. This topic has been previously covered in the professional literature and at conferences and remains relevant today; in fact, it is essential. Any FNP providing patient care needs to ensure that he or she carries his or her own professional liability coverage that goes beyond employer-provided coverage. This insurance should provide for malpractice coverage as well as for legal defense of licensing and disciplinary actions. It also is important that this insurance allows the FNP to select his or her own attorney—someone who is familiar with FNPs, SOP issues, and licensing boards. The ability to select his or her own attorney is critical if the action could negatively affect the FNP’s professional license and prevent him or her from seeing patients.

Conclusion

The prevalence of mental illness is increasing in the US, while at the same time there is a decrease in psychiatric providers. The result is that FNPs are going to see a variety of patients with mental health care needs. As such, FNPs need to be familiar with their state’s SOP when providing behavioral health services, including prescribing limits and when referrals to specialists are needed. They also should use best practices to help protect their licenses and avoid any disciplinary action by their BON. Finally, if an FNP finds that he or she has a passion for this care area, he or she should consider getting a psychiatric mental health NP certification—an excellent combination for an FNP committed to providing mental health services in a primary care setting.

References


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In compliance with national ethical guidelines, the author reports no relationships with business or industry that would pose a conflict of interest.
**Setting or Patient Care Needs: Which Defines Advanced Practice Registered Nurse Scope of Practice?**

Kenneth Miller, PhD, C-FNP

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**Abstract**

The purpose of this article is to provide insight into the roles and population focus of both the family nurse practitioner and the adult gerontology/acute care nurse practitioner. The article looks at problems that seem to be increasing in prevalence in terms of who should be taking care of primary care patients and who should be taking care of acute care patients. Solutions are offered that could keep both types of practitioners out of the sphere of litigation.

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Scope of practice (SOP) is the key element in defining the limitations of the clinical role of advanced practice registered nurses (APRNs). The Pew Health Professions Commission defines SOP as the “definition of the rules, the regulations, the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge and experience may practice.”[1] This definition serves as a safety line to protect the public from misguided providers. As an adjunct to this definition and a further delineation of the regulations of the SOP, the Consensus Model for APRN Regulation identified 4 regulatory elements: licensure to practice in a given state (or states depending on participation in the compact state program); accreditation of the APRN program by a national organization; certification by a national body that confirms the applicant's knowledge, skills, and experience; and education at the graduate or postgraduate certificate level.[2] Yet, despite these potential safeguards, there is still confusion by both employers and new APRN graduates as to their SOP. An example of this phenomenon exists when one confuses the adult-gerontology primary care nurse practitioner (AGPCNP) and the adult-gerontology acute care nurse practitioner (AG/ACNP) in terms of the roles. The latter (AG/ACNP) could take on the role of the AGPCNP in the primary care setting, but the AGPCNP could not take on the role of the AG/ACNP in the hospital setting. The scope determines the role. The purposes of this article are to look at 2 of the 4 APRN roles, namely the family nurse practitioner (FNP) and the AG/ACNP, and to explore the problems that are arising and offer some solutions to rectify these variances.

Each APRN student is educated with a specific population focus. For example, FNPs focus on family/individuals across the life span, whereas AG/ACNPs focus on adults and gerontology patients.[3,4] At the completion of their program, students will sit for a certification examination as an assessment of their competence that is congruent with their population focus and academic education. In short, FNs have been educated to provide primary care, and AG/ACNPs have been educated to provide acute care for their patients. This educational difference is what defines each of the nurse practitioner (NP) roles.

The SOP for APRNs is based on state statutes. There is no consistency across all states. The American Association of Nurse Practitioners notes that 22 states and the District of Columbia have full practice authority and can practice autonomously, 16 states require a collaborative agreement with a physician, and 12 states require physician supervision.[5] Each state statute then controls the boundaries in which the APRN may practice.

According to the Consensus Model, the primary care NP (the FNP) is prepared to provide “... comprehensive, chronic continuous care characterized by a long term relationship between the patient and the primary care NP.”[2,3] The National Organization of Nurse Practitioner Faculties White Paper further notes that “... primary care is not limited to preventive maintenance care of the well person but includes continuous care for patients with stable acute/or chronic conditions.” On the other hand, the acute care NP (ie, AG/ACNP) “... provides care for patients with unstable, chronic, complex acute, and critical conditions.”[6] However, it is important to note that the role of the primary care and the acute care provider will sometimes overlap. For example, if a patient shows up at a clinic in a hypertensive crisis, the FNP has a legal duty to immediately stabilize the patient and then arrange immediate transport to a hospital where an AG/ACNP (or other acute care provider) could then treat the unstable hypertensive patient until he or she was stabilized and ready for discharge. The AG/ACNP could then refer the patient back to the FNP for care of his or her chronic hypertension. Both providers would then be working within their respective SOPs. The key point in this scenario is something that is emphasized in the Consensus Model, namely...
“Scope of practice of the primary care or acute care Certified Nurse Practitioner (CNP) is not setting specific but is based on patient care needs.”

Patient care needs define who is the most appropriate provider clinically, educationally, and legally to care for primary or acute care patients. The problem arises when neither the graduate APRN nor the employer fully understands the role of the APRN. The issue is bimodal. Some newly graduated NPs may believe that if they have been working as a registered nurse (RN) in a specific specialty that when they finish their NP program they can return to that specialty. For example, M.B. has spent the past 7 years working as an intensive care nurse in an intensive care unit (ICU). During her FNP master’s program, she continued to work in the ICU part-time. Upon graduation, she said she is planning on returning to the same ICU as an NP. It is this type of scenario that has profound legal implications for both the NP as well as the hospital. If the hospital credentials the NP, they leave themselves open to malpractice litigation.

Upon graduation, she said she is planning on returning to the same ICU as an NP. It is this type of scenario that has profound legal implications for both the NP as well as the hospital. If the hospital credentials the NP, they leave themselves open to malpractice litigation for approving a nonqualified NP to work outside her SOP should an untoward event occur to an unstable, complex acute, and critically ill patient. The FNP in this same situation could not only become the primary defendant in a malpractice lawsuit but could also be disciplined by the Board of Nursing and potentially lose her certification as well as her RN license for practicing outside her SOP. In short, RN experience is not equivalent to the graduate education and certification that APRNs must achieve to be considered legally competent providers.

The second part of this bimodal problem rests with the employing entity. Hospital credentialing committees rarely have an APRN as a member. The members of such committees are typically physicians who do not understand the limitations imposed by the different APRN SOPs. The differences are in the educational roles. FNPs should not be asked to care for critical, unstable, complex patients in an ICU unless they are dual certified as AG/ACNP. Yet, there has been an uptick in malpractice suits related to this very scenario as noted in the Nursing Services Organization’s Nurse Practitioner Claim Report (4th edition). This lack of understanding has the potential to subject the hospital, the credentialing committee, the collaborating or supervisory physician, and the APRN to legal liability if an untoward outcome adversely affects the patient, as noted previously in the case of M.B. Additionally, any malpractice carrier that issued a policy to the APRN would probably not provide a defense for such a situation. So, what is the solution?

The solution to this problem of misunderstanding one’s SOP is multifaceted and is going to require change at all levels of APRN education and practice. First, nursing school admission committees should ascertain whether their applicants are clear on the role and population they wish to work with before they are admitted to the program. Knowing this will better help the student to make a reasoned career choice. Second, graduate APRN programs should incorporate state statutes and the APRN regulations into their curriculum so students understand what this APRN role requires. Third, faculty and experienced APRNs should educate hospitals and other health care providers about the SOP for the various APRN roles. Fourth, APRNs in hospital settings need to advocate for inclusion on credentialing committees so they can help correct any misunderstandings or misconceptions that physicians have about placing APRNs in inappropriate roles. Fifth, graduate APRN programs need to include lectures on the legal aspects of practice as well as how to avoid litigation in their curriculum that address malpractice suits and how to avoid the same. Finally, didactic courses should incorporate decision-making frameworks, such as the scope of nursing practice decision-making framework developed by the Tri-Council (American Association of Colleges of Nursing, American Nurses Association, American Organization of Nurse Executives, and National League for Nursing), for all nurses to determine whether the skill was within their role and SOP.

It is projected that by 2020 the NP workforce will grow by 20%. In order to ensure that APRNs are practicing within their SOP as dictated by their state statutes and nursing practice act implementation of the previously mentioned recommendations should provide a safer environment for all primary and acute care patients. It is also incumbent on APRNs to review their state SOP on an annual basis and to continue to lobby for inclusion on credentialing committees as equal partners. As partners in this journey, academicians need to verify that newly admitted graduate students are clear on which role and which population they wish to serve. Following these few simple changes should not only ensure patient safety but also will help other health care providers to understand the role of the APRN. Finally, litigation cases related to APRNs working outside their SOP should be minimized.

References


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In compliance with national ethical guidelines, the author reports no relationships with business or industry that would pose a conflict of interest.