



**Certified Nurse Practitioners (CNPs)
Primary Care and Acute Care Practice**

July 2017

This report addresses national certification for certified nurse practitioners (CNPs) practicing primary or acute care in Ohio. Section 4723.43, Ohio Revised Code (ORC), requires a CNP to practice consistent with the nurse's education and certification. To practice acute care, the CNP's education and certification must be in acute care. Certain stakeholders agree with this position and other stakeholders maintain that a CNP who is not nationally certified in acute care may engage in acute care practice, based on clinical experience obtained post-graduate through the course of employment/workplace training. Further these stakeholders contend that the Board is not following the national Consensus Model for APRN Regulations (Consensus Model)¹ and differs from other state boards of nursing enforcing the law in this manner.

Background

In response to correspondence to the Board expressing concern that CNPs were practicing acute care without the CNP holding national certification in acute care, in the fall of 2016, the Board published an article in its quarterly newsletter *Momentum* entitled "Certified Nurse Practitioners (CNPs) in Primary and Acute Care." (Attachment 1)

Over the past several years, individuals and health care facilities have periodically asked the Board about the national certification required for CNPs practicing primary or acute care in Ohio. The Board's responses have been based on the statutory provisions of the Nurse Practice Act (NPA), and consistent through the years with the interpretation of law reiterated in the 2016 *Momentum* article. The NPA provisions were enacted dating back to 1996. Attached are examples of Board responses to individuals and facilities. (Attachment 2) Another attachment is a memorandum from a health care facility entitled "Specialty Specific Credentials" that instructs APRNs about the requirements. (Attachment 3)

In addition, the Ohio Association of Advanced Practice Nurses (OAAPN) requested information in 2009 for their "Tip of the Month" stating that when OAAPN representatives were attending national conferences, they identified this as an emerging issue impacting APRNs in many states. See Attachment 4 for the OAAPN correspondence and their Tip of the Month in its entirety.

In summary, with the recent proliferation of acute care pediatric and adult acute care NP programs, if you choose to care for patients with complex acute, critical and chronic health

¹ *The Consensus Model for APRN Regulations: Licensure, Accreditation, Certification & Education*, July 7, 2008, (Consensus Model) was completed through the work of the national APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee.

conditions, then choose an educational program that prepares you for certification as an acute care nurse practitioner. If however, you wish to work in a primary care setting, then choose an educational program that prepares you for certification as an adult, pediatric, women's health, geriatric or family nurse practitioner.

Following publication of the 2016 *Momentum* article, the Board received correspondence from OAAPN asserting that the statute should now be construed to permit CNPs to engage in acute care practice based on clinical experience obtained post-graduate through the course of employment/workplace training and that the national certification in acute care was not required. (Attachment 5)

Because of heightened concerns expressed by multiple stakeholders, on March 8, 2017, the Board requested a formal Opinion from the Ohio Attorney General Office asking "whether under Section 4723.43, Ohio Revised Code, a Certified Nurse Practitioner (CNP) not nationally certified in acute care may engage in acute care practice, based on clinical experience obtained post-graduate through the course of employment/workplace training. (Attachment 6)

The Opinion request itself resulted in strong concerns expressed by certain stakeholders who questioned the need for the request and asked about the possibility of withdrawing the request. The Board explained that the request is consistent with the Board's past actions when there have been strong opinions and disagreement about the interpretation of statutory language. The Board believes an Opinion request is necessary in this matter to resolve conflicting opinions regarding statutory language, especially in light of substantial and consistent history reflecting the Board's reading of Ohio law and national consensus on the topic. The Opinion request provides a means to reach a legal conclusion recognized by law in order to clarify the interpretation of statute whose meaning is in dispute or doubt. The Opinion will serve as a basis for future decisions and actions. The letters from interested parties regarding the AGO are provided in Attachment 7.

Consensus Model for APRN Regulations

The Consensus Model was the result of collaborative work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee, with extensive input from a larger APRN stakeholder community, including national certification entities, national accreditation organizations, and national associations representing APRN education and practice. It was adopted based on a nationally recognized educational model to establish a firm foundation and greater standardization for APRN practice across the country, based on the health care environment of the 21st century. A listing of the organizations is on pages 29-39 of the document.

The Consensus Model defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation. The information below summarizes pertinent parts of the Consensus Model. The Consensus Model in its entirety is included in Attachment 6, as part of the Opinion request.

- APRN education programs must be accredited and include education in three graduate-level courses in advanced physiology/pathophysiology, health assessment, and pharmacology, as well as appropriate clinical experience, known as the APRN core.
- The Consensus Model recommends four APRN roles: CRNA, CNM, CNS, and CNP. APRNs are educated in one of the four roles. (Page 6)

- In addition to the roles, the APRN must be educated in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, or psych/mental health. (Page 6)
- Individuals who have the appropriate education must take a national certification examination to assess national competencies of the APRN core, role, and at least one population focus area of practice for regulatory purposes. (Page 6)
- Individuals are licensed to practice at the level of one of the four roles within at least one of the six population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. (Page 6)
- Beyond role and population focus, APRNs may specialize but they are not licensed by specialty area. Specialties provide depth in one's practice within the established population foci. Preparation in a specialty area of practice is optional and focuses on specific patient populations or health care needs. APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. (Page 12)
- APRN specialty preparation cannot expand one's scope of practice beyond the role or population focus and addresses a subset of the population-focus. (Page 12)
- State licensing boards do not regulate APRN specialties because the specialty evolves from the APRN role/population focus and indicates that an APRN has additional knowledge and expertise in a more discrete area of a specialty. Specialty practice is acquired either by educational preparation or experience and may be recognized through professional nursing credentialing centers. (Page 12)
- For licensure purposes, one exam must assess the APRN core, role, and population focused competencies. For example, a primary care family nurse practitioner would take one national certification examination, which tests the APRN core, CNP role, and "family" population-focused competencies. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty *if used for entry into advanced practice registered nursing and for regulatory purposes*, must also prepare individuals in one of the nationally recognized APRN roles and in one of the six population foci. (Page 12)
- The CNP provides care along the wellness-illness continuum by providing direct primary and acute care across settings. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care. *"CNPs 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)
- "Scope of practice of the primary care or acute care CNP is not setting specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain [national] certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles." (Page 10)

The “APRN Consensus Model Frequently-Asked Questions,” published by NCSBN/LACE², includes the following question and answer: Attachment 8

6. How does an acute care NP fit into the APRN Consensus Model?

The certified nurse practitioner (CNP) is educationally prepared to meet core competencies for all NPs and competencies for a population focus. The competencies at the population focus may be primary care or acute care. Currently the acute care NP preparation is available with an adult-gerontology or pediatric focus. The graduate of an adult-gerontology acute care NP program is eligible to sit for an acute care adult-gerontology certification exam. Similarly, the graduate of a pediatric acute care NP program is eligible to sit for an acute care pediatric NP certification exam. Graduates of acute care population focused NP programs are not eligible to sit for primary care population focused NP certification exams and vice versa. The certified NP would identify himself/herself as an APRN-CNP with either an adult-gerontology or pediatric acute care population focus. (Page 2)

13. If I want to specialize as an APRN in an area such as oncology, palliative care, or nephrology, how would I do so after the APRN Consensus Model is implemented?

Areas such as oncology, palliative care, and nephrology are among the many specialty areas of APRN practice and are not one of the population foci in the APRN Consensus Model. To be eligible for APRN licensure and certification, the APRN must complete his/her educational program in a role and population focus (or foci) as defined in the Consensus Model but can also specialize in a more specific area of practice. Preparation in a specialty area of practice is optional, but if included in the educational program, it must build on the APRN role/population focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus. Educational programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN educational programs, including preparation in the APRN core, role and population core competencies. A specialty area of practice is developed by the professional organization and is not regulated by boards of nursing. Professional organizations determine the expected competencies for the specialty and establish certification or assessment requirements. It is not required but recommended that the APRN practicing in a specialty area of practice seek specialty certification if available. (Page 3)

National Organizations, Statements, and Publications

Below is information from various national organizations and publications gathered for review and further consideration. It is not intended to be an extensive review of all organizations or publications, but rather is meant to reflect the basis for the Board’s past and current interpretation of Ohio law in this matter.

➤ The National Council of State Boards of Nursing (NCSBN)

² LACE is a communication network to include organizations that represent the Licensure, Accreditation, Certification, and Education components of APRN regulation. LACE is intended to be a transparent process for communicating about APRN regulatory issues, facilitating implementation of the APRN Consensus Model, and involving all stakeholders in advancing APRN regulation.

At the time the Board published the 2016 *Momentum* article, NCSBN staff reviewed the article and confirmed it was congruent with the Consensus Model. NCSBN recognized this as a pertinent topic and informed Board staff the issue was being addressed in many states.

Subsequently, NCSBN requested that Lisa Emrich, RN, MSN, FRE, Board Program Manager, present this topic at the NCSBN April 2017 APRN Roundtable. Ms. Emrich's presentation was well received at the APRN Roundtable.

The Board requested further clarification from NCSBN about the position of the Consensus Model regarding the education and national certification requirements for CNPs providing primary and acute care. On July 6, 2017 NCSBN responded in a letter (Attachment 9), concluding "**...it is the position of NCSBN that the Consensus Model specifies CNPs who are engaged in acute care practice are to hold national certification in acute care. NCSBN agrees with your Board's position.**"

➤ National Organization of Nurse Practitioner Faculties

The National Organization of Nurse Practitioner Faculties issued a "Statement on Acute Care and Primary Care Nurse Practitioner Practice," September 2011 (Statement). The article's "Key Elements" are summarized below. The Statement also provides exemplars that illustrate practice distinctions for the Acute Care Nurse Practitioner (ACNP) and Primary Care Nurse Practitioner (PCNP). The Statement is included in Attachment 6, as part of the AGO Opinion Request, in its entirety.

The PCNP and the ACNP are prepared to deliver different types of care. The main emphasis of PCNP educational preparation is on comprehensive, chronic, continuous care characterized by a long-term relationship between the patient and PCNP. In contrast, the ACNP educational preparation focuses on restorative care that is characterized by rapidly changing clinical conditions. The ACNP provides care for unstable chronic conditions, complex acute illnesses, and critical illnesses.

Key Messages

- Scope of practice must be tied to formal APRN education and not pre-APRN experience or on-the-job training.
- NP educational programs are either primary care or acute care focused – it is not the full range. Certification as both an ACNP and PCNP requires completion of both formal educational programs or a dual-track adult-gerontology or pediatric program that meet all of the corresponding ACNP and PCNP competencies. (This would be adult-gerontology or pediatric ACNP competencies, and adult-gerontology, family/lifespan, pediatric, or women's health/gender PCNP competencies).
- Certification must match educational preparation. Certification eligibility should be linked to the educational preparation, and similarly a NP graduate should sit only for certification that corresponds with the population focus of his/her educational preparation.
- Both the PCNP and the ACNP can serve as the point of entry to health care and they also collaborate with each other when managing patients.

- Both the PCNP and ACNP may engage in specialty practice, but this specialization occurs as supplemental to the formal NP education and national certification.
- Both the PCNP and ACNP might evaluate an acutely ill patient, but the severity of the symptoms would determine which provider is most appropriate and best matched to the patient's acuity level. The PCNP does not have the educational preparation to care for the complex acute or critical patient but does have preparation to manage the simple acute patient. Likewise, the ACNP does not have the educational preparation to provide comprehensive, continuous care but does have the preparation to provide preventive services within the context of restorative care.
- Patient safety is jeopardized when clinicians practice outside their scope of practice. Regardless of the willingness of some employers to credential the NP to practice beyond his/her educational preparation and certification, the NP is obligated to adhere to his/her scope of practice, as determined by the state in which they practice.
- NPs should be regulated according to the services they perform and population served and not where they provide services.

➤ Journal of the American Academy of Nurse Practitioners

"Defining NP scope of practice and associated regulations: Focus on acute care," was published in the *Journal of the American Academy of Nurse Practitioners* 24 (2012). The following summarizes the section, "Contemporary NP and ACNP issues." The article is included in Attachment 6, as part of the AGO Opinion Request, in its entirety.

Any NP can work in a hospital if they meet the job qualifications and pass the credentialing and privileging process. For example, the NP prepared as an adult NP working for a cardiology practice seeing patients both in the clinic and during hospitalization for heart failure; managing diuretic therapy on a medical unit is within the NP SOP [scope of practice] in these patients. However, if a patient does not stabilize or deteriorates to the point where more advance therapy is required, such as inotropic support, the patient's care needs clearly move into the SOP of the ACNP.

What NPs do clinically and where they function within the hospital tends to pose more issues that could be interpreted as practicing beyond their approved SOP. One example is the NP who is not ACNP educated but seeks to provide care to patients who have acute and critical care conditions based on having prior work experience as an RN in an acute/critical care intensive care unit. This RN experience is often erroneously perceived as providing an NP who does not hold ACNP certification with the qualifications to manage these patients when it does not, as NP SOP is based on NP licensure, accreditation, certification and education.

The majority of primary care programs prepare NP graduates with primary care didactic and clinical practice in clinic settings and to a lesser extent, hospital settings. Although primary care NP education is not focused on the management of high acuity patients in a hospital setting, primary care NPs can manage hospitalized patients within their NP SOP. Family and adult NPs often function in hospitals in roles that do not extend to the ICU and caring for the complexly ill patient. Such roles include services in pre-admission screening and testing, palliative care, pain management fast track emergency care, and disease-specific care.

➤ Carolyn Buppert, MSN, JD, Healthcare Attorney

Ms. Buppert responds to legal/professional nursing questions for *Medscape*, "Ask the Expert." Ms. Buppert presented at the NCSBN 2017 APRN Roundtable and spoke with Ms. Emrich, who also presented at the Roundtable, about the congruency of their presentations. Attachment 10 provides the "Ask the Expert" *Medscape* articles.

➤ Credentialing and Privileging

According to the 2008 *Medscape* article, "Developing an Advanced Practice Nursing Credentialing Model for Acute Care Facilities" (Attachment 11):

In the acute care hospital setting, it becomes especially important that nursing administrators have a clear understanding of the scope of practice of the APRNs seeking credentialing and privileging. APRNs requesting credentialing and privileging for acute care skills require proper educational preparation and training and the requisite skills to be practicing within their scope of practice....APRNs who might have been educationally prepared as an adult nurse practitioner or family nurse practitioner who are hired to work in an acute care setting may need post-master's acute care nurse practitioner education to ensure they are practicing within their scope of practice. For APRNs practicing in the acute care setting who are not trained for acute care practice, seeking credentials and privileging must be in compliance with their education and training as an APRN. Prior nursing experience in a specialty area, such as critical care or acute care, does not entitle APRNs to seek credentials and privileges for acute care practice if their APRN education and training is not acute care focused. However, obtaining a post-masters' acute care certification training enables APRNs to see credentialing and privileging for acute practice. (Page 281)

➤ Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution

According to the 2007 *Medscape* article, "Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution" (Attachment 12), the 2003 Institute of Medicine (IOM) report, "Health Professions Education: A Bridge to Quality" called for competency-based education and interdisciplinary practice models for the future. Physician assistant education has developed under a single accrediting body, core curriculum, and board certification mechanisms in the 1970s. The NP role, however evolved in a more fragmented fashion, and curriculum standardization and accreditation standards followed, rather than directed, education. The development in 2002-2004 of the National Organization of Nurse Practitioner Faculties offered a framework for education core competencies. Experience and environment can and will stretch the NP's knowledge and competency beyond that of the basic education level. The article provides the following question and answer:

Should the NP who is educationally prepared as an acute care NP work in an adult primary care setting? The answer is no. The acute care NP program prepares graduates for a specialty focus in acute, episodic, and critical conditions that are primarily managed in a hospital-based setting. The program of study does not contain adequate clinical and didactic content to support the ACNP for a broader role in outpatient primary care diagnosis, treatment, and follow-up. Diagnosis and outpatient management of stable and unstable chronic illness, as well as directing health maintenance of a wide range of conditions, is a required competency for practice in the primary care role. (Page 6)

➤ Decision Making Models

Decision making models published by boards of nursing are intended to assist nurses *determine if procedures, activities, or tasks are within their scope of practice* and if they have the knowledge, skills, and abilities to perform the procedure or task. Decision making models are not designed to define population focus or specialty for APRNs.

Nurses frequently find themselves in the position of needing to learn new procedures, equipment, technology, or an unfamiliar patient care situation. Decision making models are designed for use in these situations. By going through the steps of a decision making model, the nurse determines if the procedure or task is within their scope of practice and/or if they need to obtain orientation, continuing education, demonstrations, training, etc. in order to be competent to perform the procedure/activity. Boards hold all nurses, including APRNs, accountable for their continuing competence in practice.

The Board "APRN Decision Making Model," (Attachment 13) states:

The Decision Making Model is a guide for APRNs to use when determining whether a specific procedure, task or activity is within the APRN scope of practice and, if so, whether the specific procedure, task or activity is consistent with standards of practice, appropriate to perform based on the individual APRN's knowledge and skills, and is appropriate based on the clinical setting.

Other State Boards of Nursing

Below is information from state boards of nursing, but it is not intended to be an extensive review of all the states.

➤ Arizona State Board of Nursing

The Arizona State Board of Nursing adopted a white paper, "Registered Nurse Practitioner (RNP) Practicing in an Acute Care Setting on November 19, 2009. (Attachment 14)

Registered nurse practitioner education has evolved into a system consisting of advanced core and focused specialty courses. This educational model prepares graduates for advanced nursing practice as direct care providers **within a focused population of care** (also known as specialty area). RNP does not follow the medical model therefore RNPs do not readily fit into the process used by facilities to credential physicians and medical residents....The primary component of the RNP ability to practice is their licensure and recognition through national certification in an established population area of practice.....Population is not only defined by diagnosis, gender, and age, but also by acuity and type of care needed. (Page 1)

There are 2 broad categories of RNP preparation: primary care with didactic and clinical education focused on health promotion, disease prevention and treatment of patients primarily in ambulatory and community settings; and acute care with didactic and clinical education focused on the manage of patients with complex acute, critical and chronic health conditions primarily in acute care (hospital) settings. (Page 2)

Therefore, it is the position of the Board that an RNP who provides acute care services cannot exceed the limits of the advanced practice specialty area. Sole and independent

management of the care of complex unstable patients in an acute care setting, including but not limited to an intensive care unit, is in the exclusive domain of the nurse practitioner who has completed an approved acute care nurse practitioner program. A primary care nurse practitioner may have a role in assisting or directing management of the acute care patients as long as the aspect of care is within the limits of their specialty [focused population] and role of nurse practitioner certification. (Page 3)

The RNP is expected to utilize appropriate judgment to determine if a specific role or procedure within a patient care situation is within the scope of practice that he or she is educationally prepared to provide....Experience as an RN, on-the-job training, having a physician sign off order, and the personal comfort of the RNP is not a sound basis for accepting an assignment or role beyond the RNP's scope of practice. (Page 3)

➤ Kentucky Board of Nursing

The Kentucky Board of Nursing published an article in the spring 2017 issue of *KBN Connection* entitled, "Certified Nurse Practitioner: Acute Care or Primary Care is my Practice Setting Specific to my Role?" (Attachment 15)

In summary, regardless of the setting, the CNP may legally only manage the care of those patients and conditions for which the CNP is formally educated and for which the CNP is nationally certified. Many of the nurse practitioner certification test plans are available online for review through the specific national certifying agency website. Additionally, the Kentucky Board of Nursing has published the "APRN Scope of Practice Determination Guidelines" and the "APRN Scope of Practice Decision-Making Model" which contain a decision chart providing guidance to APRNs in determining whether a selected act is within an individual APRN's scope of practice. (Page 2)

➤ Nebraska Board of Nursing

The Nebraska Board of Nursing published an article in the spring 2017 issue of the *Nebraska Board of Nursing News* entitled, "The Practice Lane, The Many Lanes of APRN Roles and Populations." (Attachment 16)

In summary, APRNs commit early in the course of education and training to a particular role and population focus. Practice lanes are affirmed with professional certification and subsequent licensure. Lane changes are best preceded with attention and planning for the acquisition of new competencies and other means for defensible practice. Advance practice nurses must assume responsibility for recognizing practice opportunities that may be misaligned with education and certification, and ultimately present risks patient safety and outcomes. (Page 13)

➤ Texas Board of Nursing

On their website the Texas Board of Nursing provides FAQs for APRN Practice. (Attachment 17) In response to a question about two APRNs approved in different population foci, the Board states:

It is important to understand that scope of practice for the advanced practice registered nurse is founded first and foremost upon his/her advanced education preparation. The patient population, individual advanced education program content and competencies attained in the advanced practice registered nursing education program always serve as the foundation for advanced practice registered nursing practice. Rule 221.13(b), relating

to the core standards for advanced practice, further states that advanced practice registered nurses must practice within the role and population focus appropriate to their educational preparation.... Each advanced practice registered nurse is responsible for practicing within the role and population focus licensed by the board and appropriate to his/her education preparation. Additionally, each advanced practice registered nurse is responsible for recognizing when he/she is in danger of exceeding his/her personal and professional scope of practice. (Pages 7-8)

➤ Wyoming Board of Nursing

The Wyoming Board of Nursing published, "What Wyoming APRNs Need to Know about Scope of Practice" in the Summer 2017 issue of the *Wyoming Nurse Reporter*. (Attachment 18)

For CNPs, which represent the largest group of the four APRN roles, the APRN Regulatory Model also provides clarification regarding acute care versus primary care practice. Specifically, the footnote on p. 10 directly under the model states: The CMP is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is **not setting specific** but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

Thus according to the APRN Regulatory Model, CNPs prepared for the family/across the lifespan role (e.g., FNPs) are prepared for primary care. There is not the acute care role for FNPs, and FNPs who desire to engage in acute care must be prepared at either the adult-gerontology or pediatric population level as an adult-gerontology acute care nurse practitioner (AGACNP) and/or a pediatric acute care nurse practitioner (PACNP). It is also important to note that model does not distinguish primary care from acute care by practice setting and allows for primary care occurring in traditional acute care settings (e.g., urgent care clinic in a hospital) and acute care occurring in ambulatory settings. (Pages 10-11)

Summary and Framework for Further Discussions

The intent in researching and presenting this document is to provide a range of evidence-based information for informed discussions. For discussion purposes, a comprehensive review of the Consensus Model is encouraged in order to reach agreement on the Consensus Model recommendations and direction. **The fundamental question is whether Ohio will follow the Consensus Model, which will determine the future direction of APRN practice in Ohio. The following options are posed for consideration.**

Option One: Ohio Continues to Follow the Consensus Model

If Ohio continues to follow the Consensus Model, the CNP must be educated in core competencies for a specified population focus (or foci) and based on that education, be nationally certified to practice acute care or primary care.

The first option is for Ohio to continue to follow the Consensus Model, and assure the statute and administrative rules are clear regarding the requirements.

Option Two: Ohio Decides to No Longer Follow the Consensus Model

If Ohio decides to no longer follow the Consensus Model, the Board may adopt rules specifying that national certification in acute care would not be required in order for CNPs who were educated in primary care to practice acute care if the CNP received sufficient documented post-graduate clinical training by a health care employer.

Under this option Board staff would need to review each individual APRN's post-graduate clinical experience and training provided by the workplace to determine if it meets the requirements.

CERTIFIED NURSE PRACTITIONER (CNPs) in Primary Care or Acute Care



The Board receives questions routinely about laws and rules governing nursing practice, including issues involving Certified Nurse Practitioners (CNPs) practicing primary or acute care and about what settings are appropriate. A recent question asked was what is the appropriate national certification for CNPs to practice in a hospital emergency department or a critical care unit?

To answer the question, the CNP and their employer must first consider the level of care required by the patient and the patient's condition and then determine if the CNP's formal nursing graduate education and national certification

align with the level of patient care required, regardless of the practice setting. CNPs are only authorized to provide the care and treatment of patients/conditions for which they are prepared based on their formal graduate education and national certification. Section 4723.43, Ohio Revised Code (ORC).

An example of formal graduate education that qualifies as meeting this requirement is validated by passing the examination in Adult-Gerontology Acute Care that is administered by the American Nurses Credentialing Center. That examination is designed to certify that the practitioner has the requisite

knowledge to diagnose and manage complex acute and critically ill patient conditions, regardless of setting. However, the national certifications for Adult-Gerontology Primary Care, Pediatric Primary Care, or Family, are not certifications that are designed for the management and treatment of critically ill, and/or unstable patients. CNPs with these national certifications should not be routinely managing and treating critically ill or unstable patients in their daily practices. It is not legally permissible for a CNP with national certification in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family to engage in Acute Care practice

as discussed above without obtaining formal graduate education and subsequent national certification in Acute Care.

Questions also arise when CNPs are practicing in an emergency department or urgent care setting. In these settings, CNPs who are nationally certified in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family, are educated and nationally certified to address "urgent" types of patient conditions, similar to patient conditions treated by primary care health providers in non-hospital settings. These CNPs are not prepared to manage individuals who present in critical and/or unstable conditions commonly associated with acute care. Examples of critical and/or unstable conditions include patients experiencing acute myocardial infarction, pulmonary edema, acute respiratory failure, severe traumas, amputations or near amputations. These conditions are provided as examples and do not constitute an exhaustive list.

National certifications in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family validate knowledge regarding "primary care" practice for a generalized primary practice, or specialization in a specific area of wellness or primary disease/chronic or disease/systems management within the certification population foci, such as urology, dermatology, cardiology, rheumatology, etc. Practice settings may be varied, such as an urgent care clinic, a hospital clinic/department, or an office/clinic as long as the conditions or level of acuity managed by the CNP remain consistent with the CNP's specific national certification.

Another important consideration for CNP practice is the type of physician collaboration established. CNPs nationally certified in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family must collaborate and enter into a standard care arrangement with

a physician whose practice is the same or similar to that of the nursing specialty. Section 4723.431, ORC. CNPs nationally certified in Adult-Gerontology Acute Care and practicing in a hospital setting are required to collaborate with a physician whose practice is the same as or similar to the CNP's specialty and could include an intensivist. However, a collaborative agreement with an intensivist would not be appropriate for CNPs nationally certified in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family.

Section 4723.43, ORC, states that a "certified nurse practitioner may provide to individuals and groups nursing care that requires *knowledge and skill obtained from advanced formal education and clinical experience*. In this capacity as an advanced practice registered nurse ... a certified nurse practitioner is subject to division (C) of this section...." Section 4723.43(C), ORC states that a "nurse authorized to practice as a certified nurse practitioner, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness *within the nurse's nursing specialty, consistent with the nurse's education and certification*, and in accordance with rules adopted by the board...." In addition, Section 4723.431(A), ORC, states in part: "Each collaborating physician or podiatrist must be actively engaged in direct clinical practice in this state and practicing in a specialty that is *the same as or similar to the nurse's nursing specialty*." In addition, Section 4723.44(C) (4), ORC, the section regarding unauthorized practice, prohibits a CNP from entering into a standard care arrangement with a physician or podiatrist whose practice is not the same or similar to the nurse's nursing specialty, the

violation of which has significant criminal penalties established in Section 4723.99, ORC.

Standards of practice are in Rule 4723-8-02, Ohio Administrative Code :

(A) An advanced practice registered nurse shall provide to patients nursing care that requires knowledge and skill obtained from advanced formal education, which includes a clinical practicum, and clinical experience specified in sections 4723.41 and 4723.43 of the Revised Code and this chapter.

(B) Except as otherwise precluded by law or rule, each advanced practice registered nurse shall practice in accordance with the following: (1) The advanced practice registered nurse's education and clinical experience; (2) The advanced practice registered nurse's national certification as provided in section 4723.41 of the Revised Code; and (3) Chapter 4723. of the Revised Code and rules adopted under that chapter.

In summary, regardless of the setting, the CNP may only manage the care of those patients and conditions for which the CNP's formal education has prepared the CNP, as evidenced by the CNP's national certification examination.

For reference, many of the CNP certification examination/test plans are available online for review. The "APRN Consensus Model" is available on the Board website at www.nursing.ohio.gov under on the "Practice APRN" link. Another resource available on the Board website is the "Decision Making Model for Determining APRN Scope of Practice" to assist in determining whether a specific procedure, task, or activity is within the APRN scope of practice. For questions, email practice@nursing.ohio.gov. *



Tip of the month

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Dr. Scordo is Professor and Director of the Acute Care Nurse Practitioner Program at Wright State University, Dayton, Ohio, a member of the expert content panel at the American Nurses Credentialing Center (ANCC), the OAAPN legislative committee, OAAPN schedule II committee and has been in practice in cardiology as an APRN for over 25 years.

N.B. The information below does NOT pertain to clinical nurse specialists (CNS)—this pertains only to acute care, pediatric, geriatric, women's health and family nurse practitioners. The intent is to provide information to nurses who are currently considering graduate education as a nurse practitioner (NP). For those who wish further information, there are references listed at the end.

QUESTION: *I would like to pursue a career as a nurse practitioner and work with acutely ill patients such as those in a critical care area (intensive care, coronary intensive care, cardiothoracic surgery, step-down units, etc.) What type of education and certification would I need to work with this population? If, however I choose, to work in a Health Care Clinic, then what type of an educational focus and certification should I pursue?*

ANSWER: To understand the answer requires an understanding of scope of practice which will determine the limits and privileges of your licensure and certification as an advanced practice nurse. The Ohio Board of Nursing (Board) authorizes and regulates the practice of advanced practice nurses, including certified nurse practitioners (CNP). The Board does not regulate the facility in which a CNP practices, rather the Board regulates the practice in which a CNP engages. Section 4723.43(C) Ohio Revised Code, sets forth the statutory scope of practice for the CNP. The CNP scope of practice includes the CNP's provision of preventive and primary care services and evaluation and promotion of patient wellness within the nurse's nursing specialty, **consistent with the nurse's education and certification**, and in accordance with the Board's rules. However, just as medical specialists have evolved, so have nursing specialties. The acute care examinations are relatively new, thus there are many outstanding certified nurse practitioners with many years of critical care experience who currently work with complex acute, critical ill patients. "From a workforce standpoint, to require that NPs without acute care certification stop practicing and go back to get their acute care certification would mean huge disruptions in hospital systems."¹

According to the competencies set forth by the National Organization of Nurse Practitioner Faculties (NONPF),² the Scope and Standards of Practice for the ACNP (acute care nurse practitioner),³ and NAPNAP,⁴ acute care nurse practitioners are educationally prepared to provide advanced nursing care to patients with complex acute, critical and chronic health conditions, including the delivery of acute care services, such as those patients found in the critical care areas throughout the hospital. These programs of study do not contain adequate

clinical and didactic content to support the ACNP for a broader role in outpatient primary care diagnosis, treatment, and follow-up. In contrast, adult, women, geriatric, family and some pediatric nurse practitioners educational focus is on primary care. For instance, the family nurse practitioner is a specialist in family nursing, in the context of community, with broad knowledge and experience with people of all ages.⁵ NPs prepared with a primary care focus primarily practice in ambulatory care settings, including family medical practices and women health centers. This environment of primary care is not congruent with the acute care secondary or tertiary care training focus. A lack of congruence between the practice environment and level of expertise results in a decreased level of safety for the patient and increased risk of liability for the CNP.^{6,7} (See the OBN Decision-Making Guide for Determining Individual APN Scope of Practice at the end of this document.)

This is further supported by the Consensus Model for APRN Regulation put forth by the American Association of Colleges of Nurses which states:

The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. Scope of practice of the primary care or acute care CNP is not setting specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.⁸

Furthermore, the scope of practice as a CNP is more specifically defined by the practice of the associated collaborating physician and the standard care arrangement between the CNP and collaborating physician. In the state of Ohio, the requirement by law is that the supervising or collaborating physician's practice is the same or similar to the nurse's practice (OAC 4723-8-04.). The collaborating physician's practice and the standard care arrangement however, **do not serve to expand the education and certification** as an acute care, or adult, geriatric, pediatric or women's health CNP. In order for a primary care NP to manage and treat acute, clinically unstable clients, or the acute care NP to manage patients in a primary care setting, both would need appropriate education and certification in that prepares the primary care NP to manage acutely ill clinically unstable clients, and the acute care NP to manage primary care patients. scope of practice is dependent on the NP education and training - not on prior nursing experience. If you plan to be certified as both a primary care and acute care NP, you will have to complete the required hours for certification in both specialties—clinical hours used for one certification *cannot* be applied towards an additional certification. Nurses with a masters degree in one field, have the option of returning for a second masters or post-masters certification in another specialty.

In summary, with the recent proliferation of acute care pediatric and adult acute care NP programs, if you choose to care for patients with complex acute, critical and chronic health conditions, then choose an educational program that prepares you for certification as an acute care nurse practitioner. If however, you wish to work in a primary care setting, then choose an educational program that prepares you for certification as an adult, pediatric, women's health, geriatric or family nurse practitioner.

References

¹ Buppert, C. Match your area of practice to your certification. *Journal of Nurse Practitioners*. May 2006, p.296.

²National Organization of Nurse Practitioner Faculties. Acute Care Nurse Practitioner Competencies. Available at: <http://www.nonpf.org/ACNPcompsfinal20041.pdf>

³Scope and Standards of Practice for The Acute Care Nurse Practitioner. American Association of Critical-Care Nurses. (2006)

⁴NAPNAP Position Statement on The Acute Care Nurse Practitioner (2005). Available at: <http://www.napnap.org/userfiles/File/AC - Position Statement.pdf>

⁵National Organization of Nurse Practitioner Faculties. Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health. Available at: <http://www.nonpf.org/finalauq2002.pdf>

⁶Nurses Service Organization. NP practice continues to evolve. NSO Risk Advisor. 2004;12:1-2.

⁷ Klein, R. Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution. 2005. Available at: http://www.medscape.com/viewarticle/506277_1

⁸ Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education July 7, 2008 Available at: <http://www.aacn.nche.edu/Education/pdf/APRNReport.pdf>

Special thanks to, Ohio Board of Nursing staff for their expert review.

For further information, please see the OBN's Decision-Making Guide for Determining Individual APN Scope of Practice
<http://www.nursing.ohio.gov/PDFS/AdvPractice/APNModelandIntro072406.pdf>

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From: "Houchen, Betsy" <BHouchen@nursing.ohio.gov>
Subject: Fwd: OBON Momentum SOP Article Creates Questions for FNPs
Date: May 26, 2017 8:31:30 AM EDT
To: "Houchen, Betsy" <BHouchen@nursing.ohio.gov>

■ OAAPN NEWS

OBON Momentum SOP Article Creates Questions for FNPs



OAAPN

In the Fall of 2016, the Ohio Board of Nursing (OBON) released an article in their e-zine, *Momentum*, on the scope of practice (SOP) between acute care nurse practitioners (ACNP) and primary care (ANP, AGNP, FNP, WHNP) nurse practitioners. The article provided the OBON's interpretation on the difference between these two population-focused specialties. The crux of the discussion was the word "unstable." The OBON interpreted that if a patient was unstable, regardless of setting, only an ACNP could manage this patient. Then, if there was a "possibility" of a patient becoming "unstable," as in an acute care hospital, only an ACNP could care for hospital patients. Further, if the FNP who has been managing primary care, urgent and emergent patients in an Emergency Department for years and has certifications in ACLS, TCLS and competency based education in ED procedures and emergency patient management, then these facts had no bearing on the subject matter as only ACNP's can manage "unstable" patients. In fact, the American Academy of Nurse Practitioners states in their requirements to sit for the new Emergency NP examination you must be nationally certified as a Family Nurse Practitioner (FNP). You must also have a minimum of 2,000 direct, emergency practice hours as an FNP. How is one supposed to obtain these hours, if not permitted in the ED?

OAAPN has learned that at least 12 non-ACNPs have been reported to the Ohio Board of Nursing by ANCPs for practicing outside of their scope. These complaints were lodged before the publication of the OBON's fall 2016 *Momentum*. These non-

ACNPs are fully credentialed and privileged at the hospital systems where they work. There is no documentation of unsafe practice.

Unfortunately, there are unintended consequences of these actions which are not going unnoticed by the rest of the health care community. Hospital administrators, physicians and non-APRNs are shaking their heads over the actions of some ACNPs. Additionally, our physician assistant colleagues are strengthening the perspective that PAs can work anywhere as long as they have a supervising physician.

OAAPN will be meeting with the staff from the OBON in February about this issue. A question that needs to be asked: Are we no longer using the APRN Decision Making Model regarding APRN Scope of Practice?

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OAAPN shares the consternation among the Ohio NP community regarding the Fall 2016 OBON Momentum article on primary care and acute care NP scope of practice (SOP). We are working with the Ohio APRN Director Group and Ohio Nurse Executives with the Ohio Hospital Association on rectifying this new interpretation which is not consistent with the APRN Consensus Model.

All concerned parties are well-aware of the unintended consequences that will negatively impact NPs who work in hospitals and emergency departments. To date, no NP has been reprimanded, sanctioned or had their license/COA revoked by the OBON regarding this issue. OAAPN has had preliminary discussions with the OBON on this matter. No decisions have been made on if or when the OBON will enforce this scope of practice perspective.

OAAPN recommends that all concerned NPs contact their APRN directors to express concern and urge action by the Chief Nursing Executive and system's liaison to the Ohio Hospital Association on reversing the OBON's SOP interpretation. OAAPN will update its members on this situation as new information is made available.

APRN Consensus Model Frequently-Asked Questions

Below are frequently asked questions developed by LACE (Licensure, Accreditation, Certification and Education) to clarify the APRN Consensus Model. LACE is the implementation mechanism for the APRN Consensus Model.

1. Why was the Consensus Model developed?

There is increased appreciation of the important role that APRNs can play in improving access to high quality, cost-effective care. However, the lack of common definitions regarding the APRN roles, increasing numbers of nursing specializations, debates on appropriate credentials and scope of practice, and a lack of uniformity in educational and state regulations has limited the ability of patients to access APRN care. The Consensus Model seeks to address these issues.

2. Who developed the Consensus Model?

The document is the result of the collaborative work of the APRN Consensus Work Group and National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee with extensive input from a larger APRN stakeholder community. A complete list of all the organizations that took part is found on pages 29-39 of the report.

3. How is the role of APRN defined?

The document provides a detailed definition of an APRN (pp. 6-8). There are four APRN roles defined in the document (pp. 7-8):

- certified registered nurse anesthetist (CRNA)
- certified nurse-midwife (CNM)
- clinical nurse specialist (CNS)
- certified nurse practitioner (CNP)

4. Will I still be able to practice as an APRN after the APRN Consensus Model is implemented?

The ability of an APRN to practice and the scope of that practice are determined by state law (i.e., the state's nurse practice act and Board of Nursing Rules). When a state adopts new eligibility requirements for licensure, currently practicing APRNs are expected to continue to practice within that state if they maintain an active license. In addition, the Model recommends that state boards adopt language that would allow APRNs to move from another state and be licensed in the new state if they meet the education criteria that were in place when that individual was originally licensed to practice. Model legislative language that stipulates that an APRN will be grandfathered and allowed to practice has been developed by NCSBN. It is anticipated that legislation to implement the Model in each state will employ this language. APRNs currently in practice should keep abreast of legislative efforts in their own states and engage in activities to ensure that a grandfather clause is included.

5. How must APRNs legally represent themselves after the implementation of the APRN Consensus Model?

APRNs must legally represent themselves as APRN plus the specific role (i.e., CRNA, CNM, CNS, CNP). This representation includes the legal signature. The population and specialty may also be included in addition to the role (e.g., APRN, CNP, adult oncology). APRNs prepared and licensed for more than one role would use the relevant designations.

6. How does an acute care NP fit into the APRN Consensus Model?

The certified nurse practitioner (CNP) is educationally prepared to meet core competencies for all NPs and competencies for a population focus. The competencies at the population focus may be primary care or acute care. Currently, the acute care NP preparation is available with an adult-gerontology or pediatric focus. The graduate of an adult-gerontology acute care NP program is eligible to sit for an acute care adult-gerontology NP certification exam. Similarly, the graduate of a pediatric acute care NP program is eligible to sit for an acute care pediatric NP certification exam. Graduates of acute care population focused NP programs are not eligible to sit for primary care population focused NP certification exams and vice versa. The certified NP would identify himself/herself as an APRN-CNP with either an adult-gerontology or pediatric acute care population focus.

7. What is the difference between an APRN and a nurse with a graduate degree?

An APRN is a registered nurse who has completed a graduate degree or postgraduate program that has prepared him/her to practice in one of the four advanced practice roles (i.e., CRNA, CNM, CNS, or CNP). This includes the advanced knowledge and skills to provide direct patient care in the health promotion and maintenance of individuals. Nurses with advanced education in areas of practice that do not include direct care to individuals such as public health or administration are not APRNs and do not require the additional regulatory oversight beyond the RN license.

8. Why is the APRN Consensus Model called a regulatory model?

The APRN Consensus Model is called a regulatory model based on the broad definition of regulation. According to *Webster's Dictionary*, regulation is defined as 'the control according to rule, principle or law.' For the APRN Consensus Model, this includes those entities that control the preparation and credentialing of the APRN including nurse educators, certifiers, and licensing regulators. It also includes the accreditors of nurse education programs.

9. If the APRN's legal title is APRN plus role, how will the employer know in what population focus or focus the APRN is educated?

It will be the responsibility of the employer to verify the APRN's license. The license will identify the population focus or focus.

10. Why does the APRN Consensus Model require APRN educational programs to be pre-approved?

Having APRN educational programs pre-approved will eliminate barriers of not being eligible for certification and/or licensure. By having accrediting bodies pre-approve APRN educational programs before students enter the program, accreditors can ensure that programs meet established educational standards and that graduates of the program will be eligible to sit for national certification.



11. How can APRN educational programs be sure that their graduates meet the eligibility criteria for APRN certification and licensure?

The pre-approval process conducted by the nursing accrediting bodies will help to ensure that new graduates meet eligibility requirements for certification and licensure. Existing programs should keep students informed of certification and licensure requirements.

12. I am an APRN. What will happen to my practice if I am grandfathered to practice by my state after the implementation of the APRN Consensus Model?

Because of a commonly-used regulatory mechanism called grandfathering, it is anticipated that there will be no difference in your practice. Grandfathering is a provision in a new law exempting those already in the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state of their current license. It is also anticipated that APRNs applying for licensure by endorsement in another state would be eligible for grandfathering if they meet certain criteria. In addition, it is important to remember that grandfathering is an individual process for each state, so eligibility requirements for practice may vary state by state. Employers also may establish new or separate requirements for professionals granted credentials to practice in that facility. For more information about grandfathering, see the Consensus Model report (p. 14).

13. If I want to specialize as an APRN in an area such as oncology, palliative care, or nephrology, how would I do so after the APRN Consensus Model is implemented?

Areas such as oncology, palliative care, and nephrology are among the many specialty areas of APRN practice and are not one of the population foci in the APRN Consensus Model. To be eligible for APRN licensure and certification, the APRN must complete his/her educational program in a role and population focus (or foci) as defined in the Consensus Model but can also specialize in a more specific area of practice. Preparation in a specialty area of practice is optional, but, if included in the educational program, it must build on the APRN role/population focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus. Educational programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN educational programs, including preparation in the APRN core, role, and population core competencies. A specialty area of practice is developed by the professional organization and is not regulated by boards of nursing. Professional organizations determine the expected competencies for the specialty and establish certification or assessment requirements. It is not required but recommended that the APRN practicing in a specialty area of practice seek specialty certification if available.

14. Will the Model define age parameters for each population focus?

The APRN Consensus Model does not define the age parameters for any of the population foci. Definitions may exist in other processes such as educational competencies and/or certification requirements.



15. What is the timeline for transition from adult-focused educational programs to the combined adult-gerontological population focus now included in the APRN Consensus Model?

A target date for full implementation of the Consensus Model and all embedded recommendations is the year 2015. A process is currently underway to identify the competencies for the merged adult-gerontology foci in the CNS and NP roles. When these competencies are available, the expectation is that adult and gerontology NP and CNS programs will proceed with a merger to a single adult-gerontology NP or CNS program. In fact, many programs have already begun to merge the two foci. These merged programs will prepare graduates to provide comprehensive care to the entire adult population which includes the young adult through the older adult including the frail elderly. The NP and CNS certifying bodies will also develop certification exams that comprehensively assess this merged population focus. Certification entities have indicated that they will have these expanded exams to meet the Model requirements.

16. What is the timeline for needed educational changes to be made in all APRN programs for congruence with the Consensus Model?

As identified in the in the Consensus Model a target date for full implementation is the Year 2015. To meet this target date it is anticipated that changes in many educational programs may occur before 2015 to ensure that graduates are prepared to meet certification and licensure criteria. However, it is important to note that not all APRN groups are operating on the same timeline and so there will likely be various dates when full implementation will occur for all APRNs. Educational programs must continue to monitor changes in licensure requirements in individual states, as well as, changes in certification and accreditation requirements that may occur prior to or after 2015.

17. What should the academic transcript include?

The transcript is official documentation from the academic institution and is a complete record of the individual's academic history at the institution. The transcript must specify the role and population focus of the APRN educational program as completed by the individual. The transcript should also include sufficient detail to enable verification that the individual completed core educational requirements. For example, in implementing the Consensus Model, the NCSBN APRN Model Act/Rules and Regulations specify that the transcript should include the 3 P courses. A transcript (or other similar official documentation) must be available for degree-granting and postgraduate certificate programs.

18. What can be done to move academic institutions to providing the needed transcripts?

The accrediting and certifying bodies can place such requirements on educational programs to motivate academic institutions to move forward with providing the necessary official documentation for graduates of both degree-granting and certificate programs.

19. What is LACE?

LACE is proposed as a communication network to include organizations that represent the Licensure, Accreditation, Certification, and Education components of APRN regulation. LACE is intended to be a transparent process for communicating about APRN regulatory



issues, facilitating implementation of the APRN Consensus Model, and involving all stakeholders in advancing APRN regulation.

20. Are LACE and the APRN Consensus Model the same thing?

No. The APRN Consensus Model stands alone as a product of the work done jointly by the NCSBN APRN Advisory Committee and the APRN Consensus Work Group. LACE (see # 19 above) is broader in nature and is a mechanism to include all interested stakeholders representing the components of LACE in ongoing communications and implementation of the Model.

21. How do LACE and the APRN Consensus Model relate to the DNP?

The educational criteria within the APRN Consensus Model relate to the preparation of all APRNs, regardless of whether a master's or doctoral degree is conferred. A Doctor of Nursing Practice (DNP) program that is preparing an individual for entry into an APRN role must meet all of the criteria put forth in the Model. The Model does not require or preclude the DNP as an entry level degree for APRNs.

22. Are there advocacy tools available for use in explaining the Consensus Model to others, particularly state legislators?

Organizations participating in LACE have developed presentations and other resources to address questions specific to their members/stakeholders.

23. How realistic is the 2015 target implementation date?

2015 is a target date for full implementation of the APRN Consensus Model. The organizations participating in LACE have agreed to work towards this target date. Therefore, we encourage action now towards this implementation, recognizing that some components will take longer than others to accomplish.

24. Does the Consensus Model require a graduate degree in Nursing?

No, the Consensus Model specifically states that "APRN education must be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA)" (pg 10). Although many types of nurse practitioners must have a graduate degree in nursing in order to take their national certification exams, this is not the case for nurse-midwives or nurse anesthetists. Many accredited programs in nurse-midwifery and nurse anesthesia confer graduate degrees in nursing-related fields such as midwifery or health sciences, and the national certification processes for both nurse-midwives and nurse anesthetists do not require a graduate degree in nursing. The Consensus Model recognizes the validity of these other degrees.



As an Adult NP, Can I Take a Job With Acute Care Responsibilities?

Carolyn Buppert, MSN, JD

June 05, 2015

To submit a legal/professional nursing question for future consideration, write to the editor at syox@medscape.net (Include "Ask the Expert" in subject line.)

Question

As an adult NP, can I take a job with acute care responsibilities?



Response from Carolyn Buppert, MSN, JD
Healthcare attorney

A new graduate adult/gerontologic primary care nurse practitioner (NP) asks the following question:

I am interviewing for a position as NP with a neurology practice. If I work for this practice I will be expected to see patients in the hospital and the office. I am concerned about being outside of my scope of practice when seeing acutely ill patients with strokes or seizures. Despite reassurance from other NPs and the potential employer, I am still left wondering whether this is appropriate. Although I would not be assuming the totality of care for acutely ill patients, I might still be expected to round on patients receiving tissue plasminogen activator, or titrate 3% saline or mannitol infusions, etc. Is this an acceptable position for me, even with signed agreements with the neurologist for skills outside of my scope?

Your concern is valid. Before taking the job, check your state's board of nursing for an applicable regulation, ruling, or policy on this matter. Boards of nursing differ on whether an NP certified in primary care can manage hospitalized patients. For example, here is a statement from the Arizona Board of Nursing:

While the Board does not limit the employment setting of the NP, the role within that setting must be consistent with the formal education and scope of the NP's education, certification and specialty.

Sole and independent management of the care of complex unstable patients in an acute care setting, including but not limited to an intensive care unit, is in the exclusive domain of the NP who has completed an approved acute care nurse practitioner program. A primary care NP may have a role in assisting or directing management of the acute care patient as long as the aspect of care is within the limits of their specialty and role of NP certification.^[1]

In contrast, here is a definition from the New York Board of Nursing, which indicates that the Board is comfortable with a NP certified in adult health providing acute care:

NP (Adult Health): diagnoses, treats and manages the care of adults (young adults from about age 18 to the very elderly). Adult NPs may provide primary care or acute care; they may address acute or chronic health problems or provide preventive or supportive care.^[2]

It really doesn't matter whether your employer or colleagues think you should attempt to provide services to hospitalized patients; it is the board of nursing's opinion that matters, as far as your license is concerned.

A second consideration is how you would defend yourself if something went wrong with one of the hospitalized stroke patients. If you are sued for malpractice, a plaintiff's attorney is likely to attack your credentials by pointing to such statements as those of the National Organization of Nurse Practitioner Faculties, which says:

Educational programs do not prepare NPs to provide the full range of primary and acute care services. Instead, programs are limited to either primary or acute care and certification eligibility is based on the area of preparation. Although many NPs obtain informal, post-graduate education for specialization, scope of practice is determined by formal educational preparation and certification in primary or acute care practice. Pre-NP specialization at the RN level does not expand scope of practice at the advanced practice registered nurse (APRN) level. For example, a registered nurse who practiced in critical care and then completes a primary care NP formal educational program is not prepared to practice as an acute care NP. The individual would also need the acute care NP preparation in the same area to be ready to provide APRN level care to the patient. Eligibility for certification is linked to educational preparation. Graduation scope of practice must be tied to formal APRN education and not pre-APRN education or on-the-job training.^[3]

If your state board of nursing does not take a position on whether NPs providing services in hospitals must be certified in acute care, or if, like New York, your board of nursing is comfortable with adult NPs providing acute care, one more question to ask yourself is: Is there some objective way to test my knowledge about caring for this patient population, and if so, did I perform well on the test? If the answer is yes and your state board of nursing approves, you might feel comfortable taking the job.

If the answer is no, then, in my opinion, you should stick to office practice. By taking a job with a neurology practice you already will be taking on a learning load because you are educated and certified in primary care but practicing in a specialty. By providing services for hospitalized patients you will be increasing your learning load even more. You and other NP colleagues probably could pull this off, through close mentoring, supervision, and lots of continuing education, but do you really want to take on that level of additional education for your first position in practice?

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Is it Legal for Family Nurse Practitioners to Practice in Specialty Areas?

Carolyn Buppert, NP, JD

June 01, 2004

Question

I notice many family nurse practitioners (FNPs) practicing in specialty areas. Is this legal?

Response from Carolyn Buppert, NP, JD

Yes. No state or federal laws prohibit an NP from practicing in a specialty area. As there is no nationally recognized educational or certification path for NPs to become medical specialists in such areas as cardiology, gastroenterology, and dermatology, graduate education as an FNP provides a base of knowledge and skills upon which an NP can build. For example, an FNP hired by a dermatologist likely would undergo on-the-job training with his or her employer, would take dermatology continuing-education courses, and would seek formal training in the technical skills relevant to dermatology.

Note that if there is a nationally recognized education and certification path for an NP that is more specific to a specialty than FNP preparation – such as in acute care, women's healthcare, gerontologic, neonatal, psychiatric, or oncology nurse practitioner – then it makes sense for an employer to hire the NP whose education and certification most closely match the employer's needs.

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Can a Family Nurse Practitioner Work in the ED or ICU?

Carolyn Buppert, MSN, JD

October 02, 2014

To submit a legal/professional nursing question for future consideration, write to the editor at syox@medscape.net (Include "Ask the Expert" in subject line.)

Question:

Can a family nurse practitioner work in an emergency department or intensive care unit?



Response from Carolyn Buppert, MSN, JD
Healthcare attorney

Certification of nurse practitioners (NPs) in acute care is available, so being a family nurse practitioner (FNP), where preparation focuses on primary care, is not the optimal match for emergency department (ED) or intensive care unit (ICU) practice.

The Board of Nursing for each state is the final authority on whether it is within the scope of practice of an FNP to work in acute care and/or intensive care. Boards differ in their policies. One Board said that an FNP (or another type of NP not certified specifically in acute care) may not care for patients on monitors. That would significantly curtail the usefulness of an NP working in an ED or ICU.

Some Boards take no stand on this issue. Other Boards provide decision-making tools to use to determine whether a function or set of functions are appropriately performed by an individual nurse. Questions to be answered include^[1]:

- Did I complete a program that prepared me to see this population of patients?
- Did this program include supervised clinical and didactic training focusing on this population?
- Did I complete a program that prepared me for subspecialization? If so, is the patient in question in that category?
- Do I have the knowledge to differentially diagnose and manage the conditions for which I am seeing this patient?
- What are the clinical competence/skills required to treat this condition?
- Have I been trained to differentially diagnose in this type of patient?
- Did this training include clinical and didactic training?
- How have I achieved and demonstrated competence?
- How have I maintained competence?
- What is the standard of a practitioner in this field, and do I meet it?

- Do I meet these standards on a limited or broad basis?
- Have I completed a specialty preceptorship, fellowship, or internship that qualifies me beyond my basic educational training? What are the potential consequences of accepting treatment responsibility for this patient?
- Am I prepared to accept and manage the consequences of my diagnosis and treatment, or do I have a formally established relationship with a provider who is so trained and immediately available?
- If I am not the primary care provider, will my provision of care be shared with this person?
- Is the safety of the patient at acute risk if I do not act?
- Will the safety of the patient be compromised if I do act?

Here is an additional consideration that deserves thought: If something goes wrong and the FNP working in the ED is sued, the first thing the plaintiff's attorney will ask is, "What qualifies you to provide emergency services?" An NP who is certified in acute care and/or emergency care can point to the certification. An NP certified as an FNP is going to be in a weak position, because FNP programs do not prepare NPs to provide services in EDs.

There are plenty of FNPs working in EDs and in ICUs. Because acute care certification is a relatively recent development, in years past, there was no applicable certification, and all of the NPs working in hospitals, ICUs, and EDs were adult NPs, pediatric NPs, or FNPs. All were educated in primary care. Many had critical care experience as registered nurses.

An FNP who has been practicing in an ED or ICU since 1990 will be in a better position to defend his or her competence and lack of the appropriate credential than a newer FNP. Critical care experience as a registered nurse may be a practical asset, but it does not substitute for didactic learning, supervised clinical practice, evaluation by a preceptor, and successful completion of a certification examination. Given that acute care certification has been available for 20 years, any new NP would be wise to obtain that education and certification, if working in the ICU and/or ED setting is the goal. Only if the state Board of Nursing gives the go-ahead for FNPs to practice in EDs and ICUs should an FNP without additional certification feel comfortable practicing in critical care.

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Developing an Advanced Practice Nursing Credentialing Model for Acute Care Facilities

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Credentialing of advanced practice registered nurses (APRNs) in acute care settings is an essential practice, but care must be taken to ensure that full utilization of the scope of practice and capacity of APRNs is attained. The process of credentialing and privileging involves the verification of required education, licensure, and certification to practice as an APRN along with the recognition of the scope of the individual APRN's practice based on training, education, and practice setting. Nursing administrators are challenged with ensuring that APRNs are credentialed and privileged and that appropriate mechanisms exist within the institution for promoting recognition of the scope of practice of APRNs. This article reviews concepts related to the process of credentialing and privileging for APRNs, with special considerations to acute care settings. Important considerations are highlighted to ensure that the credentialing process for APRNs promotes practice within their scope of practice. **Key words:** *advanced practice nursing, advanced practice registered nursing, credentialing, privileging*

THE credentialing and privileging process is an acknowledged component of the official recognition of advanced practice registered nursing practice within an institution. Although often referred to jointly, credentialing and privileging are separate processes. *Credentialing* refers to the process of verifying education, licensure, and certification to practice as an advanced practice registered nurse (APRN), whereas *privileging* involves the granting of authority to perform specific aspects of patient care.^{1,2} Privileging is the

process of authorizing an APRN to provide specific clinical functions, such as perform history and physical examinations, and order and perform specific diagnostic or therapeutic tests, such as electrocardiographic or radiological tests, or perform invasive procedures.

Credentialing and privileging are important to APRN practice in an acute care setting because the processes help acknowledge the scope of practice of APRNs, promote accountability for practice, enforce professional standards for practice, enable third party billing for services, and communicate the scope of practice to other clinicians. The credentialing and privileging processes help ensure that qualified practitioners are providing safe healthcare. In addition, credentialing and privileging are required to maintain compliance with federal and state laws.²⁻⁵ APRN practice is legitimized by the processes of credentialing and privileging, therefore, nursing administrators are charged with ensuring that APRNs are credentialed and privileged and that appropriate mechanisms exist within the

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institution for promoting recognition of the scope of practice of APRNs.

REQUIREMENTS FOR CREDENTIALING AND PRIVILEGING PROCESSES

The granting of credentials and privileges is based on state practice acts, license, education, training, certification, and individual institutional regulations.^{2,3} As state nurse practice legislation addresses APRN prescription authority, title recognition, education requirements, and licensing, the credentialing and privileging processes must reflect state statutes, rules, and regulations.

The Joint Commission has specified requirements for credentialing and privileging and stipulates that healthcare institutions have a process in place where applicant qualifications are reviewed systematically. The Joint Commission requires that credentialing and privileging processes enable licensed practitioners, including APRNs, physician assistants, psychologists, and chiropractors, permitted by law to practice in the organization.^{6,7}

THE CREDENTIALING AND PRIVILEGING PROCESSES

Responsibility for credentialing and privileging is commonly overseen by the medical staff. However, other organizational "entities" such as the division of nursing, an allied medical staff committee, or the human resource department may play key roles.^{5,8}

A committee-based credentialing and privileging structure is common, with a committee establishing the specific processes by which an applicant's credentials are verified and privileges granted. The credentialing and privileging processes include completion of an application with submission of proof of education, state licensure/certification, employment history summary, proof of liability insurance, immunization status including TB testing, and a photograph. The application also includes a list of practice privileges being

Table 1. Common elements of credentialing application*

Proof of education
Evidence of state licensure/certification
DEA number, if applicable
Current life-support certification
Clinical references
Summary of employment history/clinical practice experience
Membership in professional associations
Professional liability history, including proof of liability insurance
Continuing education
Written collaborative practice agreement
Collaborating physician(s)
Practice protocols
List of practice privileges being requested, including supervision parameters
Record of skill performance is helpful (type, number, complication rate)
Sponsoring MD
Disciplinary actions
Any physical, mental health, or chemical dependency problems that could affect ability to practice
Proof of immunization status/TB testing
Photograph

*Adapted from Kamajian et al³ and Hravnak and Baldisseri.²

requested, including supervision parameters, and information related to collaborative arrangements with a staff physician (Table 1).

Preparation of a professional portfolio, which outlines the applicant's qualifications, can be helpful in facilitating the credentialing and privileging processes (Table 2).

After the application is submitted, the applicant's qualifications are verified with primary source verification, often a criminal background check is performed, and a query is made to the National Practitioner Data Bank to evaluate whether licensure disciplinary actions, malpractice payments, or adverse actions affecting professional memberships have occurred. The National Practitioner Data Bank is a federal repository for information related to the professional competence of

Table 2. Components of the APN professional portfolio*

Curriculum vitae/resume Malpractice insurance DEA number Professional license Continuing education Peer evaluations Patient/family comments/evaluations Verification of certification Copies of progress notes or professional documentation
--

*Adapted from Kamajian et al³ and Hravnak and Baldisseri.²

healthcare providers to enable effective peer review.^{3,5}

If a collaborating physician is required by state practice acts, often the physician will need to verify that the applicant has successfully demonstrated competence in the skills being requested for privileges. The level of supervision is specified in the application for privileges for the performance of procedures. Tables 3 and 4 outline examples of credentialing and privileging forms.

Denial of privileges can occur and can be due to inadequate documentation of qualifications, procedures that fall outside the scope of practice of the applicant or the collaborating physician, inadequate references to support the granting of privileges, or negligence in the applicant's history. Denial of privileges can also occur if the privilege requested is not consistent with the health system's mission or available resources. Reappointment of privileges, often required in a 1- to 2-year timeframe from original appointment based on institutional guidelines, is often based on peer performance evaluation, satisfactory ratings on performance review, and continued skill competence. Knowledge of the credentialing and privileging processes, as well as the reappointment process, is important for nursing administrators to help support and promote advanced nurse practitioners in their efforts to successfully secure and retain privileges.

ADMINISTRATIVE CONSIDERATIONS

As the scope of practice of APRNs varies greatly among the different types of practitioners, it is important to know the state regulations regarding legal authority to practice, prescriptive privileges, and reimbursement.⁹ In the acute care setting, nurse practitioners and clinical nurse specialists have a different scope of practice. In addition, specialty areas of nurse practitioner practice (eg, adult, family, acute care, geriatric, neonatal) have different scopes of practice. In the acute care hospital setting, it becomes especially important that nursing administrators have a clear understanding of the scope of practice of the APRNs seeking credentialing and privileging. APRNs requesting credentialing and privileging for acute care skills require proper educational preparation and training and the requisite skills to be practicing within their scope of practice.¹⁰ Acute care nurse practitioners are specifically educated and trained to manage patients with acute and critical illnesses on interventions such as hemodynamic monitoring and ventilator weaning and to perform invasive procedures such as arterial catheter insertion in acute care settings.¹¹ APRNs who might have been educationally prepared as an adult nurse practitioner or a family nurse practitioner who are hired to work in an acute care setting may need post-master's acute care nurse practitioner education to ensure they are practicing within their scope of practice. For APRNs practicing in the acute care setting who are not trained for acute care practice, seeking credentials and privileging must be in compliance with their education and training as an APRN. Prior nursing experience in a specialty area, such as critical care or acute care, does not entitle APRNs to seek credentials and privileges for acute care practice if their APRN education and training is not acute care focused. However, obtaining a post-master's acute care certification training enables APRNs to seek credentialing and privileging for acute care practice. When seeking a post-master's acute care nurse practitioner certification, a professional portfolio can help

Table 3. Sample credentialing and privileging application*

 <div style="display: inline-block; vertical-align: middle;"> <p>RUSH UNIVERSITY MEDICAL CENTER</p> </div>	<p>FOR REVIEWERS: NPDB Check: _____ Education Verified: _____ Certification Verified: _____ Health Screening: _____ Malpractice Insurance Verified: _____</p>
<p>ADVANCED PRACTICE NURSE CREDENTIALS AND PRIVILEGES</p>	
<p>NAME _____ POSITION _____ Cost Center or Employer: _____</p>	
<p>Please submit the following:</p> <ul style="list-style-type: none"> ___ Application for Privileges ___ Job Description ___ Resume ___ Educational Verification Form/Consent ___ References 	
<p>1. New Applicant: 3 Peers (should be an APN); e.g. clinical instructor, clinical preceptor, colleague, supervisor</p>	
<p>2. Request for renewal of privileges: submit 3 peer review (should be an APN); clinical evaluation should be in personnel file and available upon request.</p>	
<ul style="list-style-type: none"> ___ Collaborative Agreement (Not applicable for CRNA) ___ Certification ___ CPR BLS card; ACLS, PALS or NRP as applicable ___ RN License ___ APN License ___ Controlled Substance License (If Applicable) ___ DEA Controlled Substance Registration Certificate (If Applicable) ___ Malpractice Insurance (If not employed by Rush) ___ Collaborating Physician Privileges (may be obtained from the Rush Intranet: Clinical Resources → Clinical Applications → Clinical Privileges); you may request only those privileges that the Collaborating Physician has. ___ Request for Clinical Privileges Form (make sure the Collaborating MD and his/her department chairman signatures are complete; the PNS peer review signature will be added by a peer review committee member upon review and approval of the application) 	

*Reproduced with permission from Rush University Medical Center.

facilitate evaluation of the APRN's education and training and what coursework or clinical experiences would be required.

A variety of post-master's educational options exist for obtaining acute care nurse practitioner certification.¹² It is essential that nursing administrators have a clear understanding of scope of practice issues related to APRN credentialing and privileging in the

acute care setting to promote APRN practice that is based on education, training, and certification. In addition to the regulation of scope of practice based on education, training, and certification, the scope of practice of APRNs is also regulated by state regulations. A recent national study of scope of practice for nurse practitioners identifies that the differing scope of practice laws among states can

Table 4. Sample privileging request form*

RUSH UNIVERSITY MEDICAL CENTER

Advanced Practice Nurse Request for Clinical Privileges

NAME _____ DATE _____

____ New Applicant ____ Reappointment ____ Additional Privileges

PRIVILEGE	CURRENT PRIVILEGE	PLACE AN "X" BY PRIVILEGE REQUESTED	* PERFORMED IN PAST 24 MONTHS	REQUESTED for LEARNING UNDER DIRECT SUPERVISION	COMPETENCY VERIFIED BY COLLABORATING PHYSICIAN	APPROVED	DENIED
NURSE PRACTITIONER CORE PRIVILEGES							
NNP CORE PRIVILEGES							
HISTORY & PHYSICAL EXAMS							
SPECIAL PROCEDURES							
Arterial puncture (radial)							
Arterial catheter placement (peripheral)							
Aspiration, needle (chest)							
Bone Marrow Aspiration (EXCLUDING sternal)							
Bone Marrow Biopsy							
Bone Marrow Harvest							
Cast Application							
Chest Tube							
a. Insertion							
b. Removal							
Central Venous Line Placement							
Central Venous Line Removal							
Code Management per ACLS							
Corneal foreign body removal							

(continues)

Table 4. Sample privileging request form* (Continued)

PRIVILEGE	CURRENT PRIVILEGE	PLACE AN "X" BY PRIVILEGE REQUESTED	# PERFORMED IN PAST 24 MONTHS	APPROVED for LEARNING UNDER DIRECT SUPERVISION	COMPETENCY VERIFIED BY COLLABORATING PHYSICIAN	APPROVED	DENIED
Digital block							
Drains removal:							
EVD							
Lumbar							
Thoracostomy tube							
Ear Irrigation							
Flexible Sigmoidoscopy							
Intraosseous Needle							
A. Placement							
B. Removal							
C. Medication administration							
Incision & Drainage of an abscess							
Intubation (endotracheal)							
Joint							
a. aspiration							
b. medication administration							
Lumbar Punctures							
Maternal Transport							
Nails:							
Curing							
Removal							

impede APRNs from practicing to their highest capacity.¹³ It therefore becomes important that the scope of practice of APRNs match competency training and education.¹³

Nursing administrators use several strategies to ensure successful completion of the credentialing and privileging processes by APRNs (Table 5). Important aspects include building organizational support for APRNs to obtain credentialing and privileging for full recognition of their practice capabilities. This includes clarifying the APRN role to key physician and administrator stakeholders and the members of the credentialing committee. Having APRN representation on the credentialing committee is advocated to ensure that an informed review of each APRN applicant is completed because credentialing is a form of peer review.^{1,2} Other strategies include having APRN representation in the development of any policies and procedures relevant to the APRN credentialing and privileging processes. Development of a communication network for APRNs for periodic update on changes or alterations in APRN credentialing and privileging practices is also helpful.

Beginning in January 2007, The Joint Commission has implemented newly revised stan-

dards for credentialing and privileging in hospitals that apply to all providers covered under the medical staff standards.¹⁴ These standards are requirements for review to go beyond assurance of technical competency and include the 6 areas of general competency disseminated by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education: patient care skills, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice. An additional change is a requirement for professional practice evaluation that is ongoing, not just at the time of the established review cycle. Also, beginning in January 2008, The Joint Commission calls for a more intense evaluation for the first year that a provider is newly credentialed and privileged by the hospital, as well as when an existing provider is requesting a new privilege. These focused professional practice evaluations may also be enacted if specific triggers that are set by the hospital are identified during the ongoing professional practice evaluation. Examples of triggers may be low volume for the privileged task, higher complication rates, and departure from evidence-based practice. The focused review can occur through several methodologies such as direct observation (which can include proctoring), medical record review, monitoring of diagnostics and treatment patterns, and discussion with other members of the treatment team (even if of other disciplines). These new requirements apply to all providers, including physicians and licensed independent practitioners, a category that contains APRNs.

Table 5. Strategies for promoting APN credentialing and privileging*

<p>Build support among key players in institution</p> <p>Lobby for APN role on committees overseeing the APN credentialing and privileging processes</p> <p>Know credentialing and privileging processes at institution</p> <p>Assist APN in completing required application forms</p> <p>Assist APN in securing a collaborating physician(s)</p> <p>Submit a reference letter addressing key areas: applicant's abilities, skill and knowledge, work ethic</p>

*Adapted from Kamajian et al³ and Hravnak and Baldisseri.²

SUMMARY

The processes of credentialing and privileging legitimize APRN practice based on their advanced education and specialty training, licensure, certification, and scope of practice. Nursing administrators are challenged with ensuring that APRNs are credentialed and privileged and that appropriate mechanisms

exist within the institution for promoting recognition of the scope of practice of APRNs. A number of strategies, including building support for the APRN role, ensuring peer representation on the credentialing committee,

and promoting an organizational culture that enables the APRNs to practice within their full scope of practice, can be used to promote credentialing and privileging of APRNs in the acute care setting.

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Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution

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Nurse Practitioners: Defining Scope of Practice

Nurse practitioners (NPs) are one of the few healthcare providers mandated by their role and practice to carry what amounts to 2 licenses to practice. All NPs must first be trained and recognized by their state of practice with the registered nurse (RN) license. They are then additionally state- and/or nationally certified in their advanced practice specialty and role. As an NP, your scope depends upon basic education as a nurse combined with additional specialized training. This entitles you to practice in areas beyond the scope of the RN, such as diagnosing and prescribing.

An NP may be held to many standards, and therein lies the confusion. Who do you turn to when you have a question regarding your scope of practice: your employer, professional association, collaborating physician, nurse practice act, Medicare provider, or insurance carrier? All can and do play a role in defining the scope of healthcare in terms of permitting what you *may* do. But what about what you are able to do, or what your patient *wants* you to do? How each state handles scope-of-practice questions varies, although general principles cross all lines of practice.

The purpose of this article is to evaluate current mechanisms for credentialing and recognizing scope of practice for NPs. Each NP, whether governed by state regulations providing for independent, supervised, collaborative, or other practice requirements, is independently responsible for his/her patient care. This article will help you sort out some of the ethical and practical questions you should ask yourself when faced with a scope-of-practice decision.

What Influences Scope of Practice?

What is scope of practice? Scope can be defined as the activities that an individual healthcare practitioner is permitted to perform within a specific profession. However, as noted by the Federation of State Medical Boards, even the wide scope of the physician is pressured by "factors including: fluctuations in the health care workforce and specific health care specialties; geographic and economic disparities in access to health care services; economic incentives for physician and non-physician providers, and consumer demand."^[1]

The Institute of Medicine (IOM), in its report titled *Health Professions Education: A Bridge to Quality*,^[2] calls for competency-based education and interdisciplinary practice models for the future. Some advanced practice nursing specialties, such as midwifery and nurse anesthesia, have decades-long histories of uniform accreditation and competency-based education. Physician assistant education has also developed under a single accrediting body, core curriculum, and board certification mechanism since the 1970s. The NP role, however, evolved in a more fragmented fashion, and curriculum standardization and accreditation standards followed, rather than directed, education.

The development in 2002-2004 of the National Organization of Nurse Practitioner Faculties core competencies for several NP specialties offers a framework for specialty education as an adult, family, gerontological, pediatric, women's health, or psychiatric mental health NP. All NPs should be familiar with these important documents. However, these competencies, although they are useful, address the entry-level NP. What about the evolution of practice as the NP expands his or her competency within his or her scope? Experience and environment can and will stretch the NP's knowledge and competency beyond that of the basic education level.

Scope of Practice: Why NPs Should Be Concerned

Scope of practice determines who you can see, who you can treat, and under what circumstance or guidance you can provide this care. Scope of practice also determines the limits and privileges of your licensure and certification as an advanced practice nurse. In the United States, scope of practice determines your ability to bill and be paid for what you do, as well as your ability to be covered by malpractice insurance. Significant liability issues are created when NPs practice outside of their scope.

According to Nurses Service Organization (NSO) claims data in 2004,^[3] practicing beyond scope accounted for 6% of all claims filed. Scope also determines the "minimum standard" of competency for a provider with like knowledge and training in a given specialty; 32% of NSO claims in the same report pertained to "failure to meet minimum standards." If you are the only NP practicing in cardiology in your state, you may have some opportunity, by virtue of your unique status, to shape the minimum standard for your specialty. More concerning, however, is the potential for physicians and physician-controlled groups to set the standards for your practice. At best, these standards may mandate physician supervision to assure and determine your competency and credentialing to practice. At worst, lacking a defined body of specialized knowledge, board certification, or other credentialing mechanism to measure the NP in their specialty, the standard of your practice could be determined to be the same as that of the cardiologist!

Although initially envisioned as a primary care role, the increasing opportunities for NPs to practice in acute-care and subspecialty settings are generating more questions in the area of credentialing. Conversely, NPs who begin their professional career in a more narrowly defined practice arena, rather than establishing broad training and competencies, may limit their scope to the degree that mobility is difficult. This has led many NPs to pursue post-Master's degrees and dual specialty certifications as a mechanism to expand practice. While academically supervised clinical and didactic training is an established route to expand scope and the competencies within a scope, the increase in training to expand scope (with its plethora of letters signifying various certifications and licenses) has served to increase rather than decrease barriers to uniform credentialing processes.

Regulatory Structure

Nursing practice is defined and regulated, first and foremost, by the Nurse Practice Act in each state. Although multistate practice privileges for RNs are now a reality in states that have adopted the Nurse Licensure Compact (22 as of October 2007),^[4] only Utah, Iowa, and Texas have approved the compact for NPs. Until this process of allowing your home state license to carry across state lines (much as a drivers' license does) is more widespread, NPs must hold an individual certificate or license to practice in each state where they see patients. Each state, in turn, has something to say about your scope of practice.

State-by-state certification or licensure creates unique issues in practice confusion. As an example: NPs in Oregon can independently prescribe Schedule II-V narcotic medications with their own DEA number and without a collaborative agreement. Between August 2001 and July 2005, NPs could prescribe Schedule II-IV drugs in Washington only if they had a mandatory joint practice agreement (JPA) with a physician. The JPA was required to be approved by the state's nursing commission. This change in the law came only after more than a decade of lobbying despite the fact that since 1979 NPs had been prescribing controlled substances independently in the bordering state of Oregon. A law passed in 2005 eliminated the JPA requirement and allows Washington NPs to prescribe all controlled substances independently as of July 24, 2005.

This begs the question: "Is mandatory collaboration a predictor of safety, or should collaboration and accountability instead be the professional standard upon which nurses (and physicians) help develop and expand their scope and competencies?" I would argue that collaboration, in itself, does not define the NP's unique scope.

Independent, Collaboration, Supervision: How is Your Scope Regulated?

According to the most recent Pearson Report published in 2007 (available at http://www.webnp.net/images/ajnp_feb07.pdf), 23 states require no physician involvement for the licensed NP to diagnose and treat, while the remainder of states require some degree of written or formal physician involvement in NP practice. All practice models require that the provider know, be accountable for, and function within their scope of practice. The umbrella of supervision, collaboration, or delegation can never be used to replace scope and individual responsibility.

The terms "independent," "collaboration," and "supervision" vary widely in interpretation and regulatory definition. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines an LIP, or Licensed Independent Provider, as "any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges."^[5] Recent acknowledgement by JCAHO in their Medical Staff Handbook of the LIP role of the NP offers support for hospital privileges based upon the NP's individual credentials, training, competency, and scope, rather than using the proxy of supervision as the primary eligibility requirement.

Collaboration. The Federation of State Medical Boards^[1] confirms that the "American Medical Association does not have an official definition of collaboration." In 1994, the American Nurses Association endorsed the statement that collaboration involves physicians and nurses working "together as colleagues, working interdependently within the boundaries of their scope of practice."^[1] Collaboration is regulated as a mandatory relationship between 2 providers, generally a physician and an NP in many states, though the structure of this regulatory relationship varies greatly. Collaboration is still the most common model of regulatory requirement for NPs practicing in the United States as of this writing.

Delegation. Delegation is still used to define NP practice in a few states. Delegation typically allows a licensed provider who practices independently to permit certain functions to be performed under his or her supervision by another person who does not have them expressly provided for in their own practice act. This is a model used to identify the legal relationship between physicians and medical assistants or other unlicensed persons. While delegation may still be the legal requirement in your state, the training and competencies inherent in your degree of education will hold you to a higher standard than a subordinate employee. The practice of delegation also does not permit you to practice in areas that are outside of your scope.

According to the Federation of State Medical Boards: "Delegated services must be ones that a reasonable and prudent physician using sound medical judgment would find appropriate to delegate and *must be within the defined scope of practice both of the physician and the non-physician practitioner* [emphasis mine]."^[1]

It would seem then, that whether your state requires you to practice under supervision, delegation, collaboration, or as an independent practitioner, you are always responsible to practice within your scope. Having a physician supervise, cosign, or otherwise endorse a practice or task that is not within your legal and professional scope does not make it within your realm of practice. This is principle number one in defining your scope of practice as an NP.

Principle 1: Scope is uniquely defined by the congruence between law and appropriate practice.

Models of Practice: Existing Scope Models

A survey of 7 state Boards of Nursing who use a Scope of Practice decision tree model to help define parameters for practice was done. States selected were Washington, Kentucky, Georgia, Maine, Louisiana, Oklahoma, and Nevada, and were accessed through their Web sites at <http://www.ncsbn.org>. These decision tree models were then compared with 2 other scope-of-practice documents from other professions: the Ontario Professional Foresters Association's Policies and Guidelines: Scope of Practice^[6] and the American Dietetics Association's The Scope of Dietetics Practice Framework.^[7] Four of the states specifically identified advanced practice in their decision tree as differentiated from the basic RN level.

Common factors were identified in all scope-of-practice decision trees. The 2 factors common to all documents were:

- Clinical competence/skill
- Knowledge/training

The second highest-ranking qualities in these models were:

- Acceptance of responsibility/consequences
- Organizational policies and procedures
- Professional standards

The third ranked mechanism offered was the option of seeking an advisory opinion from the Board or organization to clarify areas of confusion or precedence.

Despite the focus on evidence-based research and practice safety by the IOM and other national advisory groups, only 4 of the decision trees referred to the use of research to support a scope determination, usually in connection with the request for an advisory opinion. Nonetheless, as pointed out by the IOM report, *Crossing the Quality Chasm: A New Health System for the 20th Century*,

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.^[8]

NPs can anticipate that expanding practice and scope will be expected to have support from evidence-based research, such as pilot studies and federal waiver demonstration projects. Data addressing areas of practice ambiguity can also be gained from experience in other healthcare systems such as that in the United Kingdom, which uses nurses in an expanded role to provide many services.^[9]

"Supervision" was the lowest ranking mechanism stated to define individual scope of practice in the decision tree models. It was present in only 1 practice decision tree, referencing the basic level of nursing practice. This leads us to the second principle regarding scope of practice:

Principle 2: Supervision does not, in itself, define scope of practice for the professional in fields that have a specialized body of knowledge, skill, and competency.

Boards of Nursing are charged with protecting the safety of the public through the promotion of safe practice. Professional standards and associations help further define the ethics and application of practice in the appropriate setting. An ability to accept responsibility for the patient through establishment of a client/patient relationship, documentation, and follow-up is a cornerstone of practice within your scope.

Principle 3: Ethics guide scope through individual ability to accept and manage consequences, in accordance with safe standards of practice.

Scope of Practice: Models of Application

The scope of practice for the advanced practitioner does not well lend itself to the typical decision tree model. However, several principles combined with indicators already identified in the decision tree model can be used to offer a framework of questions that can help shape the unique scope of practice for the NP.

The more specific the question and the less defined the area of practice, the more likely it is that an advisory or other formal opinion should be sought from your licensing authority. Ill-defined areas of practice also offer opportunities to engage in supporting research that may clarify areas of overlapping scope or serve to define new fields of opportunity.

Lack of competency in any one of the following domains (see) excludes the practice from your scope by definition. Several sample questions will be answered at the end of this paper to illustrate the application of this guided self-inquiry.

Table. Scope of Practice: Domains and Questions

<p>Domain: Knowledge</p> <ul style="list-style-type: none"> • Did I complete a program that prepared me to see this population (family, adult, pediatric) of patients? • Did this program include supervised clinical and didactic training focusing on this population?

- Did I complete a program that prepared me for subspecialization (acute care, geriatric, neonatal)? If so, is the patient in question in that category?
- Do I have the knowledge to differentially diagnose and manage the conditions for which I am seeing this patient?

Domain: Role Validation

- Am I licensed to practice in this role?
- Is additional licensure or certification required to do this skill on an ongoing or specialized basis?
- Do professional organizations define this role through specialty scope statements and criteria or standards of practice?
- Do professional standards support or validate what I am doing?
- How do I "hold myself out" (define my role) with the public? Do my qualifications, training, and licensure match this?
- Is the information regarding my training easily accessible and can it be validated to the public, healthcare credentialing staff, facilities, and other interested parties?

Domain: Competence and Skill

- What are the clinical competence/skills required to treat this condition?
- Have I been trained to differentially diagnosis this type of patient?
- Did this training include clinical and didactic training?
- How have I achieved and demonstrated competence?
- How have I maintained competence?
- What is the standard of a practitioner in this field and do I meet it? Do I meet these standards on a limited or broad basis?
- Have I completed a specialty preceptorship, fellowship, or internship that qualifies me beyond my basic educational training?

Domain: Environment

- Does the environment that I work in support this scope or practice through structures such as staffing, consultation, policies and procedures, protocols, and community standards?
- Am I an expert, novice, or midlevel provider in this field? Do my credentialing to the public and my consultative network match this?
- Is access to care an issue? Will I be facilitating or impeding access to the best trained professional?

Domain: Ethics

- What are the potential consequences of accepting treatment responsibility for this patient?
- Am I prepared to accept and manage the consequences of my diagnosis and treatment, or do I have a formally established relationship with a provider who is so trained and immediately available?
- If I am not the primary care provider, will my provision of care be shared with this person?
- Is the safety of the patient at acute risk if I do not act?
- Will the safety of the patient be compromised if I do act?
- Is there a personal or formal relationship with this patient that would potentially affect my ability to provide or to deny care?

Scope of Practice: Common NP Questions and Answers

The following questions represent a cross-section of issues that face NPs in today's practice environment. Several are taken from actual questions submitted to Medscape. Despite the differing practice regulations from state to state, the framework of self-inquiry using principles discussed in this article can be applied to each situation.

I am a family NP (FNP) and am wondering if I can work as a non-advanced practice RN at a local nursing home? I plan to function as any other RN. Would I be held to higher liability standards?

From a regulatory standpoint, you are always legally entitled to work under your RN license, as long as it is current and you meet all RN requirements. However, insurers agree that someone with advanced practice training and certification needs to be insured at the higher level, regardless of position. See the NSO newsletter answering this topic at: <http://www.nso.com/newsletters/advisor/2000/np/npra5.php#qa>.

Role validation is a large component of scope. If you take such a job, you will need to ensure that the role validation of the RN, rather than that of the NP, is the face you hold out to the public. The setting where you are employed can also help match your role validation, by keeping your job title, job description, duties, and activities crystal clear. The most conservative advice would be to avoid working in areas that *share* the specialty of your advanced practice focus (such as a nurse midwife working as a labor and delivery nurse). Taking such a position is asking for role confusion, and that, in turn, affects your ability to practice appropriately with your patients.

Should an NP who is educationally prepared as an acute care NP work in an adult primary care setting?

The answer is no. The acute care NP program prepares graduates for a specialty focus in acute, episodic, and critical conditions that are primarily managed in a hospital-based setting. The program of study does not contain adequate clinical and didactic content to support the ACNP for a broader role in outpatient primary care diagnosis, treatment, and follow-up. Diagnosis and outpatient management of stable and unstable chronic illness, as well as directing health maintenance of a wide range of conditions, is a required competency for practice in the primary care role.

Additionally, professional licensure and certification will reflect validation that the provider has met criteria for practice in a focused, rather than broad, scope of practice. Finally, the environment of primary care is not congruent with the acute care secondary or tertiary care training focus. A lack of congruence between the practice environment and level of expertise results in a decreased level of safety for the patient and increased risk of liability for the NP.

Is it within the scope for an FNP to diagnose and treat uncomplicated mental health conditions like depression, anxiety, and ADHD?

The answer is yes, in the context of primary care, and at the level of competency and skill expected for the FNP standard of practice. The context of primary care means that you are seeing this patient for health needs and the depression or anxiety is clearly diagnosed to be situational, acute, and/or potentially responsive to medications. The competency and skill preparing the FNP for practice does not include differential diagnosis of complexities such as unipolar vs bipolar depression, or anxiety related to underlying psychiatric conditions as an example. If you are prescribing medications for a condition that you cannot clearly diagnose (or support the established diagnosis with documentation), treat, follow, and monitor to a level of stabilization and beyond, you are practicing outside of your scope. Atypical or off-label prescribing for a mental health condition would be considered a subspecialty role requiring greater expertise and competencies.

Most practice acts provide for *time-limited* stabilization of a patient or continuation of psychiatric medications that a patient has been taking for a diagnosed condition. Initiating diagnosis of a complex condition that has consequences for schooling, job, and military records, such as ADHD, is out of the scope of training and competency for the typically educated FNP. Collaboratively arriving at a diagnosis and treatment plan with a mental health provider trained and licensed to diagnose mental health conditions may be one possibility for initial diagnosis and for periodic management.

I am a psychiatric mental health NP (PMHNP), working in a VA health system. My patients wait a long time to see their primary care provider. Can I treat a rash that I see and prescribe hydrocortisone? Does it make a difference if this medication is over the counter?

The answer is a qualified perhaps. Do you have clinical and didactic training in your preparation, including physical assessment, to evaluate the differential diagnosis of the rash? Are you familiar with all of the medications the patient is taking as well as other health conditions such as liver disease? What type of follow-up visit and examination can you offer this patient if the rash is not getting better? Is the rash secondary to a condition that you are treating such as a reaction to medications you have prescribed? If so, treatment may be appropriate in the context of your care of the patient. However, since you are not available or designated as this person's provider for their other medical conditions, it would be difficult to identify on what basis you have chosen to treat (and feel yourself qualified to treat) some conditions and not others.

There have been several licensing disciplinary cases related to both FNPs treating mental health conditions and PMHNPs treating primary care conditions. In the case of the FNPs, many were not licensed or clinically trained to differentially diagnose beyond the very basic self-limited mental health conditions, yet had prescribed medications such as antipsychotics or had mistakenly given selective serotonin reuptake inhibitors to patients with mood disorders who they thought had simple self-limited depression. Lack of access to mental health providers (or primary providers) may be an issue, but it does not change the requirement to get your patient to the most appropriate provider to coordinate their care. For the PMHNP, coordinating or initiating treatment for primary care conditions without the knowledge of a primary care provider can be a significant area of risk to the patient and to your license.

I practice in a specialty area of surgical oncology and benign breast disease, and have teenage patients referred to me. Since this is a specialty area of practice, can I see patients under the age of 18 years as an adult NP?

The answer varies depending upon which state you practice in. If you had no clinical and didactic training in patients under the age of 18 years, it may be difficult to identify how you developed expertise in the presentation and management of illness in this age group. However, many programs include an adolescent practicum, and many states support practice scope for adolescents based upon this. It would also be important to be able to support how you developed expertise in differential diagnosis of breast conditions in this age group, since hormonal and physiological variations are in stark contrast to the older female patient. Your level of expertise and safety in treating the specific condition (such as fibrocystic breast disease) may enable you to be a consultant to the patient's primary care provider regarding patient management, regardless of whether the patient is 18 years or 35 years of age.

I would like to set up a practice reading x-rays. Does my license permit this?

The answer is no, unless you have additional licensure and training that qualifies you as a specialist. The NP scope of practice generally provides for ordering and evaluating laboratory results. Again, however, this is in the context of *provision of care for that patient in the specialty in which you are trained and licensed*. Specific functions, such as reading x-rays to screen for gross abnormalities, are different from the level of expertise required to read x-rays for a diagnostic outcome on a focused and ongoing basis. This would demand additional training and validation of competency. Currently, the standard of practice in this field is

established by the training and competencies of the radiologist. Meeting this standard would be extremely challenging, given the basic preparation for primary care and lack of supervised preceptorships, internships, or other specialized training mechanisms. Holding oneself out to the public as an expert in reading x-rays without a mechanism to meet the competencies for practice validation is poor clinical practice.

I am an adult NP working in a collaborative practice in allergy. The collaborating physician sees children under 13 years of age. Can I provide follow-up care or write prescriptions for these children?

The answer is no. Again, you have a certain degree of expertise in the condition and treatment of the disease specialty. However, an adult NP clearly has no academic training that would support seeing children below the age of adolescence, regardless of the presence of a collaborating or supervising physician. A physician, as per the Federation of State Medical Boards, also has no foundation to delegate care for a condition that he or she knows is not in the scope of practice for the NP. If the collaborating physician is collaborating to the extent that they are making the determination or taking the responsibility for the diagnosis, then that physician should be seeing that patient.

We would like to hire a geriatric NP to work in the ER. What is the problem if she sees a 25-year-old patient with hypertension, since she has expertise in treating this disorder?

The scope-of-practice issue in this question concerns differential diagnosis. The symptom of hypertension in an 80-year-old vs a 25-year-old signifies an entirely different list of possible etiologies and treatments. Without the foundational clinical and didactic training in this population, an NP with geriatric training cannot demonstrate validated competency and skill in safely determining what is causing this potentially worrisome symptom in a young person. Scope for the geriatric NP, based upon licensure, national certification, and standards of practice, clearly excludes this population for treatment and care regardless of setting.

I am a pediatric NP who has expertise in congenital cardiac conditions. Many of these patients are now in their 20s, seeing internists who may not be familiar with their condition. Can I still see these patients?

The answer is a qualified yes. A pediatric NP who has expertise in diagnosis and treatment of a condition that presented in a pediatric patient and for which he or she has an established relationship, should be able at minimum to serve a consultative role for that patient's medical condition in adulthood. However, managing this patient in the absence of any primary care or internal medicine provider would be clearly out of your scope of practice. If you practice in a state that bases scope of practice strictly on national guidelines that have a defined age limit for practice, you will need to discuss this issue further with your state Board. NAPNAP has supported the existence of specialty circumstances that allow for possible treatment of patients older than 21 years, through their scope and standards statements.

Expansion and Evolution of Scope

Expansion and evolution of scope is inevitable in all professions. The RN working at the entry level now performs many of the specialized procedures and patient care activities previously reserved for physicians. As the RN role evolved into more specialized nursing practice, the advanced practice nursing role expanded as a way to provide greater access to primary and preventive care. Now, opportunities continue to open up for advanced practice in acute and specialized care, including mental health. Will NPs be able to demonstrate that such training is within their scope, and will they be able to obtain what they need to expand their competencies within their scope as their expertise evolves?

The American Association of Colleges of Nursing has declared its support of the clinical doctorate as the entry standard for NP education.^[10] This expanded model acknowledges the need to include a possible internship within the educational framework. Increasing scope by adding specialty certifications and post-Master's training is one mechanism, but it can be ultimately burdensome in terms of number of credits and time spent for nondegreeed study. Other developments on the horizon include the potential for multistate licensure and practice, and recognition of the NP training and role in other countries. All of these forces will serve to drive increasing examination of scope and core competencies.

These changes will not make some of the questions NPs face any easier. A practitioner can expect more, rather than less, questioning from credentialers, consumers, and employers as they try to incorporate new degrees and new roles. The basic principles of safe and ethical practice, however, should remain a constant, whether an NP practices independently,

collaboratively, or in a rural or an urban area. Self-examination and reflective practice, through examination of the scope domains listed in this article, should help guide NPs throughout their career and in any setting in which they practice.

Links for More Practice Information

Information regarding individual Boards of Nursing and their practice acts can be found at Medscape Nurses (see Related Links) or through the National Council of State Board of Nursing Web site. The DEA also has information on NP prescriptive authority from state to state for controlled substances, as does Medscape's map of NP prescriptive authority (see Related Links).

Related Links

External Links

Institute of Medicine

National Organization of Nurse Practitioner Faculty (NONPF)

Joint Commission on Accreditation of Healthcare Organizations

Nurses Service Organization

Library/reference resources

US Nurse Practitioner Prescribing Law: A State-by-State Summary
<http://www.medscape.com/viewarticle/440315>

Boards of Nursing in the United States: State-by-State Web Links
<http://www.medscape.com/viewarticle/482270>

Resource Centers

APN Business and Law
<http://www.medscape.com/pages/editorial/resourcecenters/public/apn/rc-apn.ov>

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APRN DECISION MAKING MODEL

The Decision Making Model is a guide for APRNs to use when determining whether a specific procedure, task or activity is within the APRN scope of practice and, if so, whether the specific procedure, task or activity is consistent with standards of practice, appropriate to perform based on the individual APRN's knowledge and skills, and is appropriate based on the clinical setting.

The Board also publishes Interpretive Guidelines that address specific RN and LPN practices and these are available on the Board website at www.nursing.ohio.gov. However, since it is not possible for the Board to establish Interpretive Guidelines for every procedure, task or activity, the Decision Making Model was developed so APRNs could apply it as needed for their specific practices.

<p>First ask: Is the procedure/activity prohibited by the Ohio Revised Code or the Ohio Administrative Code? If yes, do not proceed.</p>	
<p>Guiding Questions</p>	
<p>Is the procedure/activity consistent with the Ohio Nurse Practice Act, rules regulating the practice of nursing, and Interpretive Guidelines of the Board.</p>	
<p>If NO: STOP</p>	<p>If YES, ask: Do practice guidelines of a national specialty or advanced practice organization support inclusion of this procedure/activity in your particular practice?</p>
<p>STOP</p>	<p>If YES, ask:</p> <ol style="list-style-type: none"> 1. Do you possess the depth and breadth of knowledge to perform this procedure/activity safely? AND 2. Do you possess the depth and breadth of knowledge to respond appropriately to complications or untoward effects of the procedure/activity? <p><i>At this step of the decision-making process:</i></p> <p>You must be able to provide documentation, upon request of the Board, to show evidence of your knowledge to perform the procedure/activity. Such knowledge is generally obtained through education emanating from a recognized body of knowledge relative to the care to be provided. Documentation could include:</p> <ul style="list-style-type: none"> • APRN educational programs; • Preceptorship, fellowship, or internship; and/or • Other formally organized educational experience
	<p>If NO: If YES, ask:</p>

		STOP	<p>1. Do you possess the depth and breadth of current skills and clinical competence to perform this procedure/activity consistently and safely? AND</p> <p>2. Do you possess the depth and breadth of current skills and clinical competence to respond appropriately to complications or untoward effects of the procedure/activity?</p> <p><i>At this step of the decision-making process:</i></p> <p>You must be able to provide documentation, upon request of the Board, to show evidence of your skills and abilities to perform the procedure/activity.</p> <p>Documentation could include:</p> <ul style="list-style-type: none"> • APRN educational programs; • Formally organized educational experience; and/or • Return demonstrations or skills check-off
		If NO: STOP	<p>If YES, ask:</p> <p>1. Is this an accepted standard of care? Would a reasonable, prudent APRN perform this activity in this setting and under these circumstances?</p> <p>2. Will you assume accountability for providing safe care in performing the procedure/activity?</p>
		If NO: STOP	<p>If YES, you have concluded that the procedure/activity is within your scope of practice. Proceed to agency/institutional education, competency, credentialing or privileging criteria, and other considerations.</p>
Other Considerations			
<p>Although the procedure/activity may be within your APRN scope of practice, you should be familiar with other state or federal statutes or regulations that may affect the ability of an APRN to perform the procedure/activity, including, for example, laws and rules of the Ohio State Medical Board or Ohio Board of Pharmacy; laws and rules of the Ohio Department of Health, the Ohio Department of Job and Family Services, or the Ohio Department of Medicaid; or federal Medicare regulations.</p>			
<p>It is important for APRNs to determine whether other state or federal laws establish parameters regarding a particular procedure/activity before they perform it. APRNs must also consider applicable policies and procedures of their agency or institution, as well as factors such as payer and malpractice carrier policies.</p>			

Additional Information

The Nurse Practice Act and the administrative rules are available for review in their entirety on the Board website at www.nursing.ohio.gov under the "Law and Rules" link.

- In general, the regulations governing the practice of APRNs is found in the Nurse Practice Act, Section 4723.01 and Sections 4723.41 through 4723.50, Ohio Revised Code, and in administrative rule Chapters 4723-8 and 4723-9, Ohio Administrative Code.

To access other applicable information, law and rules:

- State Medical Board of Ohio: www.med.ohio.gov
- Ohio Board of Pharmacy: www.pharmacy.ohio.gov

Board approved National Certifying Organizations for Certified Nurse Midwives, Certified Nurse Practitioners, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists, can be accessed on the Board website at www.nursing.ohio.gov under the "Practice APRN" link.

Email APRN practice questions to the Board at practiceAPRN@nursing.ohio.gov

This Model is intended to assist APRNs in determining their individual scope of practice based upon the Ohio Nurse Practice Act and administrative rules, and the individual's education, knowledge, and skills. It is not intended to provide legal advice. Those using the Model should refer to the Nurse Practice Act and the administrative rules in their entirety.



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REGISTERED NURSE PRACTITIONER (RNP) PRACTICING IN AN ACUTE CARE SETTING

October 2009

Adopted by the Board 11/19/09

Background

Registered nurse practitioner (RNP) education has progressed beyond the apprentice model of "see one, do one, teach one." (Swenson, 2006). It is no longer acceptable to substitute registered nursing experience and physician oversight for a formal nurse practitioner program consisting of didactic and clinical study informed by national standards. Authority to practice does not flow from a physician's license (Swenson, 2006) but from a rigorous credentialing process that includes verification of appropriate educational preparation including supervised clinical practice and competency testing at the advanced practice level. Similar to other professions, the **scope of registered nurse practitioner practice is based upon the didactic and clinical education obtained in a basic RNP program (Klein, 2008).**

RNP Education

Registered nurse practitioner education has evolved into a system consisting of advanced core and focused specialty courses. This educational model prepares graduates for advanced nursing practice as direct care providers **within a focused population of care** (also known as specialty area). RNP education does not follow the medical model therefore RNPs do not readily fit into the process used by facilities to credential physicians and medical residents. Care must be taken in credentialing the RNP to ensure full utilization of scope of practice based on the RNP's training, practice setting and education (Kleinpell, Hrvanek and Hinch, 2008). Administrators are challenged with ensuring that appropriate mechanisms exist to credential and privilege RNPs within the institution appropriate to their scope of practice (Kleinpell, Hrvanek and Hinch, 2008). The primary component of the RNP ability to practice is their licensure and recognition through national certification in an established population area of practice (Klein 2008). In Arizona prior to July 1, 2004, not all nurse practitioners were required to hold national certification, but all have been through a review of their education for consistency with their assigned specialty population as part of the qualification for state board certification; state board certification is required for practice in Arizona. Population is not only defined by diagnosis, gender, and age, but also by acuity and type of care needed.

There are 2 broad categories of RNP preparation: **primary care** with didactic and clinical education focused on health promotion, disease prevention and treatment of patients primarily in ambulatory and community settings; and **acute care** with didactic and clinical education focused on the management of patients with complex acute, critical and chronic health conditions primarily in acute care (hospital) settings (NONPF 2002, 2004). Within primary care, RNP practice is further specialized to a population of care (Pediatric, Adult, Gerontology, Family, Women's Health, etc). Acute care RNP specialties are currently limited to neonatal, pediatric and adult.

Additional nurse practitioner specialty areas of preparation include Adult or Family Psychiatric and Mental Health Nurse Practitioner and Certified Nurse Midwife. The educational preparation and practice in these populations of care include management of clients in both primary and acute care settings.

Additional Competencies and Overlapping Scopes of Practice

An individual RNP may enhance their competencies by learning additional skills/procedures **within their scope of practice** through additional didactic education and supervised clinical practice as specified in A.A.C. R4-19-208 (C). For example, since primary care of infants is within their scope of practice, a pediatric or family nurse practitioner could perform a circumcision after obtaining and demonstrating this competency through completion of a formal didactic and clinical instruction course. In contrast, an adult RNP, even after completion of the same course, could not perform circumcisions because care of infants is outside the scope of adult nurse practitioner practice. While the Board recognizes that there is some overlap in scopes of practice between specialties, an individual may not expand scope to a different specialty without completing a basic NP program in that specialty. For example a pediatric nurse practitioner may be qualified to follow some patients into young adulthood before transitioning their care to an adult or family practitioner, overlapping with Adult/FNP scope; and a family nurse practitioner may be qualified to treat common, self-limited depression or anxiety, overlapping with psychiatric nurse practitioner scope; but neither is qualified to practice within the full scope of the others' specialty area.

RNP's in Acute Care Settings

Due to recent limits regarding the use of physician residents, acute care facilities have sought to hire nurse practitioners to fill "hospitalist" roles with scant attention as to whether the educational preparation of the NP is consistent with the role. For example, an FNP with some pediatric ICU experience as an RN was believed to be qualified to take an acute care pediatric NP position in the pediatric intensive care unit.

While the Board does not limit the employment setting of the NP, the role within that setting must be consistent with the formal education and scope of the NP's education, certification and specialty. "An RNP shall only provide health care services within the nurse practitioner's scope of practice for which the RNP is educationally prepared and for which competency has been established and maintained" (A.A.C. R4-19-508 C) . According the National Organization of Nurse Practitioner Faculties (2004), the acute care RNP "practices in any setting in which patient care requirements include complex monitoring and therapies, high intensity nursing intervention, or continuous nursing vigilance within the range of high acuity care" (pg. 13). Acute care nurse

practitioners receive “highly focused education that includes psychomotor skill assessment and evaluation in many complex procedures. They are prepared to manage complex unstable patients similar to those managed by hospitalists” (Klein, 2008, pg 277). Therefore it is the position of the Board that an RNP who provides acute care services cannot exceed the limits of the advanced practice specialty area. Sole and independent management of the care of complex unstable patients in an acute care setting, including but not limited to an intensive care unit, is in the exclusive domain of the nurse practitioner who has completed an approved acute care nurse practitioner program. A primary care nurse practitioner may have a role in assisting or directing management of the acute care patient as long as the aspect of care is within the limits of their specialty and role of nurse practitioner certification.

Role of Primary Care RNPs in Acute Care Settings

There is a role for the primary care NP in an acute care facility if the role is consistent with the educational preparation and certification of the NP. The primary care NP may admit his/her own patients and manage referrals to appropriate specialties, as it is within scope for a primary care NP to facilitate transitions between health care settings and to provide continuity of care for individuals and family members.

Patients admitted to an acute care facility will benefit from the inclusion of a primary care RNP on the health care team to assist in the management of some aspects of care consistent with the primary care RNPs scope of practice. Primary care RNP preparation focuses on management of health promotion, disease prevention, and ongoing care of individuals and families (Klein, 2008). The National Organization of Nurse Practitioner Faculties (2002) describe the primary nurse practitioner role in managing and negotiating health care delivery systems as one of “overseeing and directing the delivery of clinical services within an integrated system of health care” (pg. 20, 24 28, 33, 38). A hospital-based primary care RNP could coordinate care between specialty physicians; plan the patient’s discharge; order and review results of diagnostic tests; initiate referrals; advocate for the patient; and monitor the patient’s progress through the system. An acute exacerbation of a chronic illness could be managed by a primary care NP if the nature of the person’s exacerbation is manageable in an ambulatory setting. If an exacerbation of a chronic illness is such that the person is unstable or critically ill, then that person’s care team should include someone with acute care credentials, at least until the situation is under control and stable.

Summary

In summary the RNP is expected to utilize appropriate judgment to determine if a specific role or procedure within a patient care situation is within the scope of practice that he or she is educationally prepared to provide. “Recognizing the limits of the nurse’s knowledge and experience, planning for situations beyond the nurse’s knowledge and expertise and consulting with or referring clients to other health care providers when appropriate,” (ARS § 32-1606 (17) (d)(vi)) are part of the legal scope and responsibilities of all registered nurse practitioners. Experience as an RN, on-the-job training, having a physician sign off orders, and the personal comfort of the RNP are not a sound basis for accepting an assignment or role beyond the RNP’s scope of practice.

Questions and Answers

1. Can a primary care nurse practitioner treat hospital patients as long as they are not in the ICU?

The primary care RNP's role in any setting must be within their scope of practice consistent with their educational preparation. An oft-quoted caveat is that the RNP can treat any condition in an acute care setting that they could treat in an office setting. While this may have some practical applicability, it will not cover the RNP for practicing outside his/her scope. The condition that led to the patient's hospital admission may influence the treatment of even the simplest condition. For example, an RNP may be very competent at treating urinary tract infections (UTI) in an office setting. However, when a patient is admitted to the hospital with a diagnosis of dehydration, diarrhea and acute renal failure and subsequently develops a UTI, that patient needs a different treatment approach than an ambulatory client with an episodic illness. The primary care RNP's educational preparation and supervised clinical practice did not include this content. Therefore, absent additional formal training, independent management of this particular patient's UTI would be considered outside the scope of primary care nurse practitioner practice.

2. How does my experience as an RN expand my RNP scope of practice?

Your experience as an RN may give you some familiarity with a particular patient population but **does not determine your scope of practice** as a nurse practitioner. Your RNP scope is based on the didactic education and clinical practice obtained in your RNP program.

3. Can a primary care RNP write hospital orders?

The Nurse Practice Act allows for primary care RNPs to write orders for hospitalized patients within their scope and limits of the specialty area. Employers may choose to be more restrictive than the nurse practice act, they cannot be less restrictive. RNPs who choose to practice in those more restrictive environments must discuss any concerns they have about practice policies that are more restrictive than the NPA with the facility administration.

4. Can a primary care RNP perform invasive procedures?

The Board does not maintain a list of approved procedures. In general, primary care RNPs may only perform primary care procedures within the limits of their scope and the demonstrated and evaluated competency of the RNP. First and foremost, the patient and procedure must be appropriate to the RNP scope of practice. The condition necessitating the procedure must be one that the RNP is educationally and experientially prepared to manage. The RNP must have demonstrated and evaluated competency in the procedure. Consistent with A.A.C. R4-19-508 (C), education should consist of formal didactic learning and supervised documented clinical practice as prescribed by an accrediting body, accredited university, or professional association. Finally the RNP must be able to recognize and manage complications including emergencies that would result from the procedure. If the patient's acuity level requires an invasive procedure and

management in an acute care setting this suggests that the sole management of the patient is beyond the scope of practice of the FNP.

5. If a procedure is illegal in AZ, but legal in other states, is it within the scope of practice for an RNP to perform the procedure in AZ?

No, the Board's authority to regulate nursing practice comes from legislatively enacted statutes. The broad scope of RNP practice is contained in the statutory definition of registered nurse practitioner (see ARS § 32-1606 (15) below). If the legislature subsequently prohibits an RNP from performing an activity, for whatever reason, that activity is clearly outside the legal scope of practice.

6. Does scope of practice change based on the scarcity of acute care RNP programs and graduates in AZ?

No. Scope of practice is based on formal education and supervised clinical practice within the basic RNP program. The scarcity of appropriate programs for training acute care nurse practitioners does not allow others without that training to assume the role.

7. Can a primary care RNP who successfully completes life-support education (ACLS, PALS or NRP) run a code in a hospital?

An RN (including NP) may provide care consistent with the recognized guidelines of the organization offering the life-support course. The provider with the highest level of training and proficiency in resuscitative procedures should direct the code.

8. I completed an acute care nurse practitioner program before there was a recognized specialty or exam so was certified as an adult NP. What is my scope of practice?

The Board recognizes that with emerging specialty populations, there is often confusion and occasionally inconsistent certification due to lack of a certification exam or approval of the specialty. RNP scope of practice is based on the didactic and clinical education obtained in the basic RNP program. Prior to the emergence of the acute care specialty, some Pediatric NP programs may have contained both a primary and acute care focus, and some Adult NP programs may have included either a primary or acute care track. Graduates of programs that included an acute care focus or track may qualify for acute care certification, and their educational preparation would support acute care practice. For consistency the Board would advise that graduates pass the acute care national certifying exam (if qualified) and seek additional Board certification. The Board recognizes that not all graduates of these programs will qualify for the exam, especially if the program was not part of a graduate degree program.

Applicable Regulations

ARS § 32-1606 Definitions

15. "Registered nurse practitioner" means a professional nurse who:
- (a) Is certified by the board.
 - (b) Has completed a nurse practitioner education program approved or recognized by the board.
 - (c) If applying for certification after July 1, 2004, holds national certification from a national certifying body recognized by the board or provides proof of competence if a certifying examine is not available.
 - (d) Has an expanded scope of practice within a specialty area that includes:
 - (i) Assessing clients, synthesizing and analyzing data and understanding and applying principles of health care at an advanced level.
 - (ii) Managing the physical and psychosocial health status of clients.
 - (iii) Analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting, implementing and evaluating appropriate treatment.
 - (iv) Making independent decisions in solving complex client care problems.
 - (v) Diagnosing, performing diagnostic and therapeutic procedures, prescribing, administering and dispensing therapeutic measures, including legend drugs, medical devices and controlled substances within the scope of registered nurse practitioner practice on meeting the requirements established by the board.
 - (vi) Recognizing the limits of the nurse's knowledge and experience, planning for situations beyond the nurse's knowledge and expertise and consulting with or referring clients to other health care providers when appropriate.
 - (vii) Delegating to a medical assistant pursuant to section 32-1456.
 - (viii) Performing additional acts that require education and training as prescribed by the Board and that are recognized by the nursing profession as proper to be performed by a nurse practitioner.

ARS § 32-1606 B. The board shall:

12. Adopt rules establishing those acts that may be performed by a registered nurse practitioner in collaboration with a licensed physician.

R4-19-508. Scope of Practice of a Registered Nurse Practitioner

- A. An RNP shall refer a patient to a physician or another health care provider if the referral will protect the health and welfare of the patient and consult with a physician and other health care providers if a situation or condition occurs in a patient that is beyond the RNP's knowledge and experience.
- B. In addition to the scope of practice permitted a registered nurse, a registered nurse practitioner, under A.R.S. §§ 32-1601(15) and 32-1606(B)(12), may perform the following acts within the limits of the specialty area of certification:
- 1. Examine a patient and establish a medical diagnosis by client history, physical examination, and other criteria;
 - 2. For a patient who requires the services of a health care facility:
 - a. Admit the patient to the facility,
 - b. Manage the care the patient receives in the facility, and
 - c. Discharge the patient from the facility;
 - 3. Order and interpret laboratory, radiographic, and other diagnostic tests, and perform those tests that the RNP is qualified to perform;
 - 4. Identify, develop, implement, and evaluate a plan of care for a patient to promote, maintain, and restore health;
 - 5. Perform therapeutic procedures that the RNP is qualified to perform;
 - 6. Prescribe treatments;
 - 7. If authorized under R4-19-511, prescribe and dispense drugs and devices; and
 - 8. Perform additional acts that the RNP is qualified to perform.
- C. An RNP shall only provide health care services within the nurse practitioner's scope of practice for which the RNP is educationally prepared and for which competency has been established and maintained. Educational preparation means academic coursework or continuing education activities that include both theory and supervised clinical practice.

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CERTIFIED NURSE PRACTITIONER: ACUTE CARE OR PRIMARY CARE IS MY PRACTICE SETTING SPECIFIC TO MY ROLE?

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**Acknowledgement is given
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for the article framework.*

Questions are routinely received about laws and regulations related to advanced practice registered nurses (APRNs), designated as nurse practitioners (CNPs), certified in either primary or acute care, as well as what settings are appropriate for their practice. Frequent inquiries are made related to whether nurse practitioners certified as family nurse practitioners may appropriately practice in a hospital emergency department or a critical care unit, or even in an inpatient hospital setting.

The APRN and employer must first consider the kinds of patients the APRN will be expected to see, as well as the patients' conditions. Then it must be determined if the nurse practitioner's graduate nursing education and national certification align with the level of patient care that will be required for individual patients, regardless of the practice setting. Although some employers may be willing to credential CNPs to practice beyond educational preparation and certification, the CNP and employer have joint responsibility for adhering to the authorized scope of practice. APRNs in Kentucky are legally authorized to provide the care and treatment of patients/conditions for which they are prepared based on their accredited education program, national certification, and licensure. (KRS 314.011 and 201 KAR 20:056). KRS 314.021(2) states: "All individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individuals' educational preparation and experience in nursing and shall practice nursing with reasonable skill and safety."

The current legal practice of advanced practice registered nurses

in Kentucky is based on the APRN Consensus Model (2008), developed with the input of the nation's nursing organizations. The Consensus document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, and describes the emergence of new roles and population foci.

In order to relate to the requirements, consider the educational preparation of the Adult-Gerontology Acute Care Nurse Practitioner who has been certified by the American Nurses Credentialing Center or the American Association of Critical Care Nurses. These certification examinations are designed to validate that the nurse practitioner has the requisite knowledge to diagnose and manage complex, acute, and critically ill patient conditions, regardless of setting. However, the national certification examinations for Family (primary care), Adult-Gerontology Primary Care, or Pediatric Primary Care, are not certifications that are designed to verify the knowledge of the nurse practitioner to manage and treat critically ill and/or unstable patient. CNPs with the named national primary care certifications should not routinely manage nor treat critically ill or unstable patients in their daily practices. It is not legally permissible for a CNP with national certification in one of the mentioned primary care areas to engage in Acute Care practice without first obtaining the requisite formal graduate education and subsequent national certification in Acute Care. Eligibility for certification is linked to educational preparation.

Questions also arise when CNPs are practicing in an emergency

department or urgent care setting. In these settings, CNPs who are nationally certified in Family (primary care), Adult-Gerontology Primary Care, or Pediatric Primary Care are educated and nationally certified to address "urgent" types of patient conditions, similar to patient conditions treated by primary health care providers in non-hospital settings. These CNPs are not prepared to manage individuals who present with critical and/or unstable conditions commonly associated with acute care. Examples of critical and/or unstable conditions include patients experiencing acute myocardial infarction, pulmonary edema, acute respiratory failure, severe traumas, amputations or near amputations. These conditions are provided as examples and do not constitute an exhaustive list.

Some hospitals hire primary care CNPs to work in the acute/critical care side of emergency departments (EDs). Given the primary care-focused NP educational preparation, a primary care CNP could see patients in ED fast track areas who present with problems that are commonly seen in primary care settings (e.g., otitis media, minor injuries, sprains). However, if the primary care CNP is expected to provide care for unstable, critical, or complex patients, then s/he would be practicing outside his/her scope of practice. The CNP must seek formal post-graduate NP education if s/he wishes to expand beyond his/her primary care or acute care CNP preparation.

National certification in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family validates knowledge regarding "primary care" practice for a generalized practice, or for further specialization in a specific area of wellness

or disease/chronic or disease/systems management within the primary care certification population foci, such as urology, dermatology, cardiology, rheumatology, etc. Practice settings may be varied, such as an urgent care clinic, a hospital based clinic or department, or an office practice/clinic as long as the conditions or level of acuity managed by the CNP remain consistent with the CNP's specific national certification.

The National Organization of Nurse Practitioner Faculty (NONPF) (2012) states that the distinction between primary and acute care should be made at the level of the population served by the CNP. Of the broad population foci (adult-gerontology, family/individual across the lifespan, pediatrics, neonatal, psychiatric-mental health, and women's health/gender-related), the acute and primary care distinctions are currently noted within the adult-gerontology and pediatrics foci. A fundamental premise of the Consensus Model is that CNP competencies are not setting specific. Historically, the acute care CNP practiced predominantly in the hospital and the primary care CNP practiced within a community setting. These setting boundaries often overlap. Regulation of APRNs in Kentucky is based on educational preparation, certification, and scope of practice and not on the type of practice setting.

Pre-APRN specialization at the RN level does not expand the scope of practice at the APRN level. For example, a registered nurse who practiced in critical care and then completes a primary care NP formal educational program is not prepared to practice as an acute care CNP. This individual would also need to complete a formal acute care NP educational program to be eligible to sit for acute care certification and to practice as an acute care CNP.

In summary, regardless of the setting, the CNP may legally only manage the care of those patients and conditions for which the

CNP is formally educated and for which the CNP is nationally certified. Many of the nurse practitioner certification test plans are available online for review through the specific national certifying agency website. Additionally, the Kentucky Board of Nursing has published the "APRN Scope of Practice Determination Guidelines" and the "APRN Scope of Practice Decision-Making Model"

which contain a decision chart providing guidance to APRNs in determining whether a selected act is within an individual APRN's scope of practice. A copy of the guidelines and decision model may be obtained from the KBN website at http://kbn.ky.gov/practice/Pages/aprn_practice.aspx. For further information, contact PamelaC.Hagan@ky.gov or at 502-429-7181.



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The Practice Lane

The Many Lanes of APRN Roles and Populations

The National Council of State Boards of Nursing (NCSBN) hosts an annual Roundtable for Advanced Practice Registered Nurse (APRN) stakeholders to discuss common issues and concerns regarding APRNs. Invitees to the 2017 meeting included nursing regulators, educators, professional societies, credentialing agencies and others interested in the grassroots work of moving toward unified elements of the 2008 Consensus Model for APRN Regulation (Figure 1).

The theme of 2017 Roundtable, *The Many Lanes of APRN Roles and Populations*, aptly embodied the current tempo of inquiries to nursing regulators regarding the alignment of APRN education and certification when the focus of practice shifts beyond role and population focus.

Advanced practice nurses commit to a specific APRN role and patient population early in the course of education and training. Board certification is the *driving lane* for practice. Successful completion of a certification examination provides a psychometric assessment of baseline competency for entry into practice for a particular role and population. Nebraska is among those states that require board certification for licensure in order to practice as an APRN. Licensure is *permission to drive* within a defined statutory scope of practice or practice lane.

Advanced Practice Registered Nurse specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus, e.g., a Certified Registered Nurse Anesthetist (CRNA) could specialize in pain management; a Certified Nurse-Midwife (CNM) could specialize in the care of postmenopausal women, a Clinical Nurse Specialist (CNS) could specialize in palliative care, or, the Nurse Practitioner (NP) could specialize in Hematology-Oncology.

Lane drift can occur when the APRN becomes distracted by patient or other circumstances in the practice environment. *Lane changes* are more significant changes in practice populations and/or required skill sets—and not surprisingly, lane changes come with greater risks if not carefully executed. The lines demarcating lane drift and lane change are not always obvious.

Lane Drift or Lane Change?

Consider the following hypothetical practice situations:

—An experienced Pediatric Nurse Practitioner (PNP) in a Pediatric Hematology-Oncology clinic agrees to provide care to a 23 year-established patient in the practice. The patient anticipates establishing with an adult provider following college graduation and relocation for employment in another city within the next 12 months.

—The PNP is offered a case management position which includes additional responsibilities for hospital rounds for the Hematology-Oncology practice to assist established clinic patients and their families in the discharge transition to home and clinic-based care.

—The PNP is informed that clinic NPs will now be required to rotate evening and week-end call for the Hematology-Oncology practice. Call will include new hospital patient referrals.

by Kathy HoebelHeinrich MSN, APRN-NP, ANP-BC, BC-ADM, CDE, Nursing Practice Consultant, NBNON

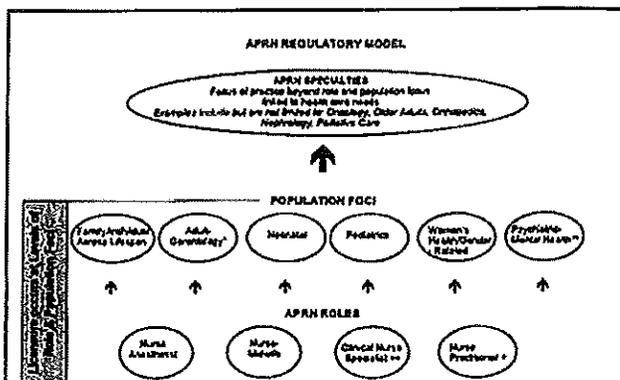


Figure 1 Consensus Model for APRN Regulation (NCSBN, 2008)

Misalignment

Misalignment of APRN practice and credentials can manifest on several fronts:

1. Payer requirements for APRN credentials for reimbursement of services, e.g., behavioral health or primary care
2. A plaintiff attorney requests a clinician/practice/facility to provide evidence for the qualifications of an APRN provider
3. Employers and/or medical credentialing staff do not understand APRN credentials
4. Providers make referrals for specialty practice consultations expecting a physician
5. Patients may not be fully informed regarding the qualifications of APRN providers
6. APRNs fail to recognize employment opportunities that are not safe practice (Buppert, 2017).

Historically, grandfathering has been the primary mechanism to exempt providers from a new law or regulation based on pre-existing requirements in order to practice. Grandfathering provisions typically assign competency on the basis of the individual having acquired national advanced certification and current practice in the role and population requested (Alexander, 2014). Additionally, in the case of NPs, the abundance of graduates prepared as adult and family practice clinicians has translated to a pipeline, one-size-fits-all supply for employers. Assumptions are made that skill sets can be shaped by the practice setting with experience or on-the-job training, or perhaps, 'jump started' if the individual has had prior experience as a RN.