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CHAPTER 3

Nursing Education, Accreditation, and Regulation

CHAPTER OBJECTIVES

At the conclusion of this chapter, the learner will be able to:

- Discuss the differences between nursing education and other types of education
- Compare the types of nursing programs and degrees
- Examine the roles of major nursing organizations that affect nursing education
- Describe the nursing education accreditation process and explain its importance marked in previous pass
- Explain requirements and issues related to quality nursing education
- Discuss the faculty shortage problem and the need for more sites for student clinical experiences
- Discuss the importance of regulation and the regulatory process, and identify critical issues related to them

CHAPTER OUTLINE

- Introduction
- Nursing Education
  - A Brief History of Nursing Education
  - Major Nursing Reports: Improving Nursing Education
  - Entry into Practice: A Debate
  - Differentiated Nursing Practice
- Types of Nursing Programs
  - Diploma Schools of Nursing
  - Associate Degree in Nursing
  - Baccalaureate Degree in Nursing
  - Additional Clinical Experiences
  - Master's Degree in Nursing
  - Doctoral Degree in Nursing
  - Doctorate of Nursing Practice
- Nursing Education Associations
  - National League for Nursing
  - American Association of Colleges of Nursing
  - National Organization for Associate Degree Nursing
- Quality and Excellence in Nursing Education
  - Nursing Education Standards
  - NLN Excellence in Nursing Education Model
  - Focus on Competencies
  - Curriculum
- Critical Problems: Faculty Shortage and Access to Clinical Experiences
  - Faculty Shortage
  - Access to Clinical Experiences

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CHAPTER OUTLINE (CONTINUED)

  - A Response and Innovation: Laboratory Experiences and Clinical Simulation
- Transforming Nursing Education
- Accreditation of Nursing Education Programs
  - Nursing Program Accreditation
  - Nursing Program Accreditation: How Does It Work?
- Regulation
  - Nurse Practice Acts
  - State Boards of Nursing
  - National Council of State Boards of Nursing
  - Licensure Requirements
  - National Council Licensure Examination
  - Critical Current and Future Regulation Issues
- Conclusion
- Chapter Highlights
- Discussion Questions
- Critical Thinking Activities
- Electronic Reflection Journal
- Linking to the Internet
- Case Studies
- Words of Wisdom
- References

KEY TERMS

Accreditation
Advanced practice nurse
Apprenticeship
Articulation
Associate degree in nursing
Baccalaureate degree in nursing
Continuing education
Curriculum
Diploma schools of nursing
Distance education
Master's degree in nursing
Nurse practice act
Practicum
Preceptor
Prescriptive authority
Regulation
Self-directed learning
Standard
Training

INTRODUCTION

This chapter focuses on three critical concerns in the nursing profession: (1) nursing education, (2) accreditation of nursing programs, and (3) regulatory issues such as licensure. These concerns are interrelated because they change and require input from the nursing profession. Even after graduation, nurses should be aware of educational issues, such as appropriate and reasonable accreditation of nursing programs and ensuring that regulatory issues support the critical needs of the public for quality health care and the needs of the profession. The Tri-Council for Nursing—an alliance of four nursing organizations (American Association of Colleges of Nursing [AACN], American Nurses Association [ANA], American Organization of Nurse Executives [AONE], and National League for Nursing [NLN])—issued a consensus policy statement in 2010 following Congress's passage of healthcare reform legislation. In part, this policy statement reads as follows:

> Current healthcare reform initiatives call for a nursing workforce that integrates evidence-based clinical knowledge and research with effective communication and leadership skills. These competencies require increased education at all levels. At this tipping point for the nursing profession, action is needed now to put in place strategies to build a stronger nursing workforce. Without a more educated nursing workforce, the nation's health will be further at risk. (Tri-Council for Nursing, 2010, p. 1)

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This statement is in line with the Institute of Medicine (IOM) recommendations for healthcare professions education. **Figure 3-1** highlights the components of the education-to-practice process.

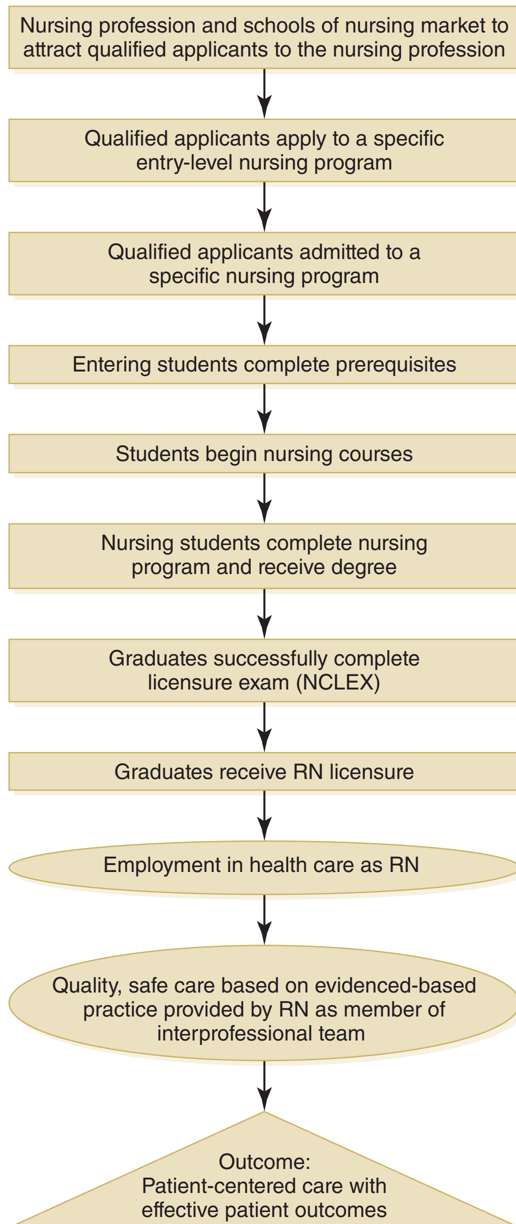

Figure 3-1 From Education to Practice

Nursing Education

A nursing student might wonder why a nursing text has a chapter that includes content about nursing education. By the time students are reading this text, they will have selected a nursing program and enrolled. This content is not included here to help someone decide whether to enter the profession, or which nursing program to attend. Rather, it is essential because education is a critical component of the nursing profession. Nurses need to understand the structure and process of the profession's education, quality issues, and current issues and trends. **Exhibit 3-1** provides an extensive glossary of nursing education terms.

Data from 2013 indicate that nursing students represent more than half of all healthcare professionals (AACN, 2014). The number of students enrolling in entry-level baccalaureate programs increased by 2.6% from 2012 to 2013. Although there was growth over this one-year period, it represented the lowest increase in enrollment in the past five years. Enrollment in baccalaureate nursing programs reached 259,100 in 2013, an increase from 238,799 in 2010. Over the same period, AACN reports, there were enrollment increases of 4.4% in master's programs and 8.3% in other graduate nursing programs. Doctor of nursing practice (DNP) programs experienced a 21.6% enrollment increase, and the number of students in research-focused doctorate programs grew by 1.7%.

A key concern for nurse educators is not only the need to increase enrollment and completion rates, but also the need to reduce the number of qualified applicants who are not able to enroll because nursing programs do not have places for them, typically due to faculty shortages, lack of clinical placement sites, and/or limited funding. For 2013, preliminary data indicate that 53,667 qualified applicants could not enroll in 610 entry-level baccalaureate programs (AACN, 2014). The percentage of minorities enrolling

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Exhibit 3-1 Definition of Nursing Education Terms

Nonbaccalaureate Programs

Licensed practical nursing (LPN or LVN) program: A program that requires at least 1 year of full-time equivalent coursework and awards the graduate a diploma or certificate of completion as an LPN/LVN.

LPN (LVN) to associate degree in nursing program: A program that admits licensed practical nurses and awards an associate degree in nursing at completion.

Diploma nursing program: Offers the required curriculum for a registered nurse but does not offer an associate or baccalaureate degree; take same registered nurse licensure exam as associate degree or baccalaureate degree graduate. Many of these programs have closed, and those that remain open now often partner with community colleges and in some cases universities to offer academic degrees.

Associate degree in nursing: A program that requires at least 2 academic years of college academic credit and awards an associate degree (ADN) in nursing. Graduates take the same registered nurse licensure exam as baccalaureate graduates.

Baccalaureate Programs

Generic (basic or entry-level) baccalaureate program: Admits students with no previous nursing education and awards a baccalaureate nursing (BS or BSN) degree. Program requires at least 4 but not more than 5 academic years of college academic credit.

Accelerated baccalaureate/direct entry for non-nursing college graduates program: Admits students with baccalaureate degrees or higher in other disciplines and no previous nursing education and awards a baccalaureate nursing degree. The curriculum is designed for completion in less time than the generic baccalaureate program, usually through a combination of bridge or transition courses.

LPN/LVN to baccalaureate in nursing program: Admits licensed practical nurses and awards a baccalaureate nursing degree.

RN to baccalaureate in nursing (RN baccalaureate; RN completion) program: Admits RNs with associate degrees or diplomas in nursing and awards a baccalaureate nursing degree.

Master's Programs

Master of science (MS/MSN) in nursing program: Admits students with baccalaureate nursing degrees and awards a master of science in nursing degree. This degree typically focuses on advanced practice in a specialty area—for example, acute care adult nurse practitioner, primary care pediatrics nurse practitioner—but it can also include specializations such as nursing anesthesia (CRNA), nurse–midwifery (CNM), nursing administration, and nursing education.

Accelerated baccalaureate to master's program: Admits students with baccalaureate nursing degrees and awards a master's in nursing degree. The curriculum is designed for completion in less time than a traditional master's program, usually through a combination of bridge or transition courses and core courses.

Master of arts in nursing program: Admits students with baccalaureate nursing degrees and awards a master of arts degree in nursing.

Master of science with a major in nursing program: Admits students with baccalaureate nursing degrees and awards a master of science degree with a major in nursing.

LPN/LVN to master's degree program: Admits RNs without baccalaureate degrees in nursing and awards a master's degree in nursing. Graduates meet requirements for a baccalaureate nursing degree as well.

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Exhibit 3-1 *(continued)*

RN to master's degree program: Admits RNs without baccalaureate degrees in nursing and awards a master's degree in nursing. Students may or may not receive a BSN degree, although they complete the coursework related to BSN.

Master's degree for non-nursing college graduates (accelerated or direct entry/entry-level/second-degree master's) program: Admits students with baccalaureate degrees in other disciplines and no previous nursing education. The program prepares graduates for entry into the profession and awards a master's degree in nursing. Although these programs generally require a baccalaureate degree, a few programs admit students without baccalaureate degrees. Students must complete baccalaureate nursing degree requirements in addition to master's requirements.

Dual-degree master's programs: Admits RNs with baccalaureate degrees in nursing and awards a master's degree in another field (e.g., master of business administration, master of public health degree, master of public administration degree, master of hospital administration degree, master of divinity degree, or Juris Doctor); graduates may also receive a master's degree in nursing.

Doctoral Programs

Doctor of nursing practice (DNP): Admits nurses who want to pursue a doctoral degree that focuses on practice rather than research. This practice-focused doctoral program prepares graduates for the highest level of nursing practice beyond the initial preparation in the discipline and is a terminal degree. This degree program may admit students with a master's degree or, in some cases, with a BSN. For example, CRNA programs are transitioning from master's programs to BSN-DNP programs.

Doctoral (research-focused) program: Admits RNs with a master's degree in nursing and awards a doctoral degree. This program prepares students to pursue intellectual inquiry and conduct independent research for the purpose of extending knowledge. In the academic community, the PhD (doctor of philosophy degree) is the most commonly offered research-focused doctoral degree. However, some schools, for a variety of reasons, may award a doctor of nursing science (DNS or DNSc) degree as the research-focused doctoral degree, although most of these programs have closed. Some doctoral programs are now admitting students with BSN degrees; these students complete all graduate-level requirements and receive a PhD.

Other Programs

Clinical nurse specialist program: A graduate, master's-level program in which a defined curriculum includes theory, research, and clinical preparation for competency-based specialty practice.

Nurse practitioner program: A graduate, master's-level preparation in which a defined curriculum includes theory, research, and clinical preparation for competency-based primary care or acute care. Graduates are awarded a master's degree in nursing and are eligible to sit for a national nurse practitioner certification examinations offered for a wide variety of specializations.

Clinical nurse leader program: A graduate, master's-level program in which a defined curriculum includes leadership content focused on direct patient care.

Post-master's nurse practitioner certificate program: A formal postgraduate program for the preparation of nurse practitioners that admits registered nurses with master's degrees in nursing. At completion, students are awarded a certificate or other evidence of completion, such as a letter from the program director. These students are eligible to sit for the national NP examinations.

(continues)

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Exhibit 3-1 *(continued)*

Nurse practitioner: A registered nurse who, through a graduate degree program in nursing, functions in an independent care provider role and addresses the full range of patient/client health problems and needs within an area of specialization.

Nursing students: Students who have been formally accepted into a nursing program regardless of whether they have taken any nursing courses.

Pre-nursing students: Students who have not yet been formally accepted into an entry-level nursing program.

Source: American Association of Colleges of Nursing. (2007). *2006–2007 enrollment and graduations in baccalaureate and graduate programs in nursing.* Washington, DC: Author.

in such programs has increased (2013). Nursing students from minority backgrounds represented 28.3% of students in entry-level baccalaureate programs, 29.3% of master's students, and 27.7% of students in research-focused doctoral programs.

The lack of clinical placement settings continues to be a major problem (NLN, 2013a).

This snapshot of data indicates that there has been improvement in the number of applicants to the various nursing degree programs and in enrollment rates, but much work remains to reach the desired levels so as to meet the needs of the healthcare delivery system for qualified nurses. **Figure 3-2** illustrates the current distribution of RNs in the United States according to initial nursing degree.

Given the critical issues of a changing nursing shortage and the consequent need to attract more students to nursing programs, this section focuses on nursing education to facilitate a better understanding of current and future concerns. The nursing shortage has been a recurring issue throughout the modern history of nursing.

A Brief History of Nursing Education

It is impossible to discuss the history of nursing education without reflecting on the history of the

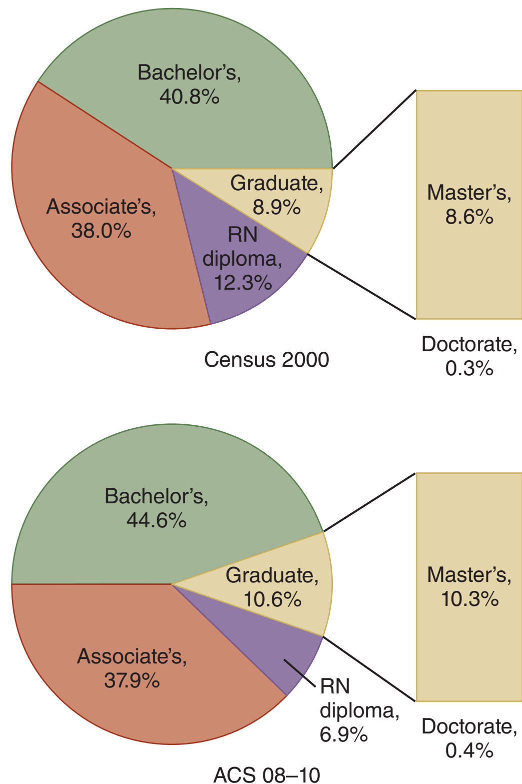

Figure 3-2 Highest Degree Held by RNs, Census 2000 and ACS 2008 to 2010

Source: Reproduced from Health Resources Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis. (April, 2013). *The U.S. Nursing Workforce: Trends in Supply and Education.* Retrieved from http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf

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profession and the history of health care. All three are interconnected.

A key historical nursing leader was Florence Nightingale. She changed not only the practice of nursing but also nursing **training**, which eventually came to be called education rather than training. Training focuses on fixed habits and skills; uses repetition, authority, and coercion; and emphasizes dependency (Donahue, 1983). Education focuses more on self-discipline, responsibility, accountability, and self-mastery (Donahue, 1983). Up until the time that Nightingale became involved in nursing, there was little, if any, training for the role. **Apprenticeship** was used to introduce new recruits to nursing, and often it was not done effectively. As nursing changed, so did the need for more information and skills, leading to increasingly structured educational experiences. This did not occur without debate and disagreement regarding the best approach. What did happen, and how does it impact nursing education today?

In 1860, Nightingale established the first school of nursing, St. Thomas, in London, England. She was able to do this because she had received a very good education in the areas of math and science, which was highly unusual for women of her era. With her experience in the Crimean War, Nightingale recognized that many soldiers were dying not just because of their wounds but also because of infection and failure to place them in the best light for healing. In turn, she devoted her energies to upgrading nursing education; she placed less focus on on-the-job training and more focus on a structured educational program of study, creating the training school. This training school and those that quickly followed also became a source of cheap labor for hospitals. Students were provided with some formal nursing education, but they also worked long hours in the hospitals and were the largest staff source. The apprenticeship model, as it was called, continued, but it became more structured and included a more formal educational component. This educational component was far from ideal, but over time, it expanded and improved. During the same era, similar programs opened in the United States. These programs were called diploma schools, and some of the first schools in the United States were Johns Hopkins (Baltimore, Maryland), the New England Hospital for Women and Children (Boston, Massachusetts), Women's Hospital (Philadelphia, Pennsylvania), and Bellevue Hospital (New York City). During this period, Canada also developed similar programs.

Hospitals across the United States began to open schools as they realized that students could be used as staff in the hospitals. The quality of these schools varied widely because there were no standards aside from what the individual hospital wanted to do. A few schools recognized early on the need for more content and improved teaching; some of these schools were creative and formed partnerships with universities so that students could receive some content through an academic institution. Despite these small efforts to improve, the schools continued to be very different, and there were concerns about the quality of nursing education.

Major Nursing Reports: Improving Nursing Education

In 1918, an important step was taken through an initiative supported by the Rockefeller Foundation to address the issue of the diploma schools. This initiative culminated in the *Goldmark Report*, the first of several major reports about U.S. nursing education. This report included the following key points (Goldmark, 1923):

- Hospitals controlled the total education hours, offering minimal content and, in some cases, no content even when that content was needed.
- Science, theory, and practice of nursing were often taught by inexperienced instructors with few teaching resources.
- Students were supervised by graduate nurses who had limited experience and time to assist the students in their learning.

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- Classroom experiences frequently occurred after the students had worked long hours, even during the night.
- Students typically were able to only get the experiences that their hospital provided, with all clinical practice being located in one hospital. As a consequence, students might not get experiences in specialties such as obstetrics, pediatrics, and psychiatric–mental health.

The *Goldmark Report* had an impact, particularly through its key recommendations: (1) separating university schools of nursing from hospitals (this represented only a minority of the schools of nursing); (2) changing the control of hospital-based programs to schools of nursing; and (3) requiring a high school diploma for entry into any school of nursing. These recommendations represented major improvements in nursing education.

Changes were made, but slowly. The National League for Nursing started developing and implementing standards for schools, but it took more than 20 years to accomplish this mission. New schools opened based on the Goldmark recommendations, such as Yale University (New Haven, Connecticut) and Case Western Reserve University (Cleveland, Ohio).

A second report that had a major impact on improving nursing education was the *Brown Report* (Brown, 1948), which also focused on the quality and structure of nursing education. This report led to the establishment of a formalized process, to be conducted by the NLN, to accredit nursing schools. Accreditation is discussed in more detail later in this chapter. It represented a critical step toward improving schools of nursing and the practice of nursing because it established standards across schools.

The third report on the assessment of nursing education was published in 2010, *Educating Nurses: A Call for Radical Transformation* (Benner, Sutphen, Leonard, & Day, 2010). This report addressed the need to better prepare nurses to practice in a rapidly changing healthcare system in order to ensure quality care. The conclusion of this qualitative study of nursing education was that there is need for great improvement. Students should be engaged in the learning process. There needs to be more connection between classroom experience and clinical experience, with a greater emphasis on practice throughout the nursing curriculum. Students need to be better prepared to use clinical reasoning and judgment and to understand the trajectory of illness. To meet the recommendations of this landmark report, nursing education must make major changes and improvements. **Exhibit 3-2** describes the report's recommendations.

The most recent report released by the Institute of Medicine (IOM), *The Future of Nursing: Leading Change, Advancing Health* (2010), delineated several key messages for nurses and nursing education. Nurses should practice to the fullest extent possible based on their level of education. There should be mechanisms for nurses to advance their education easily, to act as full partners in healthcare delivery, and to be involved in policy making especially as it relates to the healthcare workforce. This report, along with the Carnegie report by Benner and colleagues (2010), is transforming nursing's role in health care and calling for radical changes in nursing education.

Entry into Practice: A Debate

The challenges in making changes in the entry into practice debate were great when one considers that a very large number of hospitals in communities across the country had diploma schools based on the old model, and these schools were part of, and funded by, their communities. It was not easy to change these schools or to close them without major nursing and community debate and conflict. These schools constituted the major type of nursing education in the United States through the 1960s, and some schools still exist today. The number of diploma schools has decreased primarily because of the critical debate over what type of education

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Exhibit 3-2 Recommendations from *Educating Nurses: A Call for Radical Transformation*

Entry and Pathways

- Come to agreement about a set of clinically relevant prerequisites.
- Require the BSN for entry to practice.
- Develop local **articulation** programs to ensure a smooth, timely transition from ADN to BSN programs.
- Develop more ADN-to-MSN programs.

Student Population

- Recruit a more diverse faculty and student body.
- Provide more financial aid, whether from public or private sources, for all students, at all levels.

The Student Experience

- Introduce pre-nursing students to nursing early in their education.
- Broaden the clinical experience.
- Preserve post-clinical conferences and small patient-care assignments.
- Develop pedagogies that keep students focused on the patient's experience.
- Vary the means of assessing student performance.
- Promote and support learning the skills of inquiry and research.
- Redesign the ethics curricula.
- Support students in becoming agents of change.

Teaching

- Fully support ongoing faculty development for all who educate student nurses.
- Include teacher education courses in master's and doctoral programs.
- Foster opportunities for educators to learn how to teach students to reflect on their practice.
- Support faculty in learning how to coach students.
- Support educators in learning how to use narrative pedagogies.
- Provide faculty with resources to stay clinically current.
- Improve the work environment for staff nurses, and support them in learning to teach.
- Address the faculty shortage.

Entry to Practice

- Develop clinical residencies for all graduates.
- Change the requirements for licensure.

National Oversight

- Require performance assessments for licensure.
- Cooperate on accreditation.

Source: Summary of Recommendations from Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass. Reprinted with permission of John Wiley & Sons, Inc.

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nurses need for entry into practice. The drive to move nursing education into college and university settings was great, but there was also great support to continue with the diploma schools of nursing.

In 1965, the National League for Nursing and the American Nurses Association came out with strong statements endorsing college-based nursing education as the entry point into the profession. The ANA (1965) stated that "minimum preparation for beginning technical (bedside) nursing practice at the present time should be associate degree education in nursing" (p. 107). The situation was very tense. The two largest nursing organizations at the time—one primarily focused on education (NLN) and the other more on practice (ANA)—clearly took a stand. From the 1960s through the 1980s, these organizations tried to alter accreditation, advocated for the closing of diploma programs, and lobbied all levels of government (Leighow, 1996). This was a very emotional issue, and even today it continues to be a tense topic because it has not been fully resolved, although stronger statements were made in 2010–2011 to change to a baccalaureate entry level (Benner et al., 2010; IOM, 2010).

Since 1965, many changes have been made in the educational preparation of nurses:

- The number of diploma schools gradually decreased, but they still exist.
- The number of associate degree in nursing (ADN) programs grew. However, there was, and continues to be, concern over the potential development of a two-level nursing system—ADN and bachelor of science in nursing (BSN)—with one viewed as technical and the other as professional. However, this really has not happened. In fact, ADN programs continue to increase, and there has been no change in licensure for any of the nursing programs. All graduates of diploma programs, associate degree programs, and baccalaureate programs continue to take the same exam that made nursing the first healthcare profession to have a single national exam.
- BSN programs continued to grow but still have not outpaced ADN programs.

The two major current reports on nursing, *Nursing Education* (Benner et al., 2010) and *The Future of Nursing* (IOM, 2010) both recommend that entry to practice require the BSN. The IOM report recommended that the proportion of practicing nurses with BSN increase by 80% by 2020—a call that has led to an increase in the number of RN-BSN programs and increased enrollment in these programs, many of which are offered online.

In addition, because of the movement of many nursing schools into the university setting, nursing programs lost their strong connection with hospitals. Rather than establish different educational models with hospitals, the nursing education community sought to get away from the control of hospitals and move to an academic setting; however, now nursing educators and students are visitors in hospitals with little feeling of partnership and connection. This has had an impact on clinical experiences, in some cases limiting effective clinical learning.

Differentiated Nursing Practice

Another issue related to entry into practice is differentiated nursing practice. According to Rick (2003), "[L]eaders have yet to fully step up to the plate to determine and articulate what is really needed for nursing in the full spectrum of practice environments. Practice settings should offer differentiated nursing roles with distinct and complementary responsibilities" (p. 11). Differentiated practice is not a new idea; it has been discussed in the literature since the 1990s. Differentiated practice is described as a "philosophy that structures the roles and functions of nurses according to their education, experience, and competence," or "matching the varying needs of clients with the varying abilities of nursing practitioners" (American Organization of Nurse Executives, 1990, as cited in Hutchins, 1994, p. 52). This is clearly not a new issue, but it is an issue that is still not resolved.

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How does this actually work in practice? Does a clinical setting distinguish between RNs who have a diploma and those who have a BSN degree? Does this impact role function and responsibilities? Does the organization even acknowledge degrees on name badges? Most healthcare organizations do note differences when it comes to RNs with graduate degrees, but many do not necessarily note degrees for other nurses. This approach does not recognize that there are differences in the educational programs that award each degree or diploma. The ongoing debate remains difficult to resolve because all RNs, regardless of the type and length of their basic nursing education program, take the same licensing exam. Patients and other healthcare providers rarely understand the differences or even know that differences exist.

In 1995, a joint report was published by the AACN in collaboration with the American Organization of Nurse Executives and the National Organization (AONE) and the National Organization for Associate Degree Nursing (N-OADN). This document described the two roles of the BSN and the ADN graduate (p. 28):

- The BSN graduate is a licensed RN who provides direct care that is based on the nursing process and focused on patients/clients with complex interactions of nursing diagnoses. Patients/clients include individuals, families, groups, aggregates, and communities in structured and unstructured healthcare settings. The unstructured setting is a geographical or a situational environment that may not have established policies, procedures, and protocols and has the potential for variations requiring independent nursing decisions.
- The ADN graduate is a licensed RN who provides direct care that is based on the nursing process and focused on individual patients/clients who have common, well-defined nursing diagnoses. Consideration is given to the patient's/client's relationship within the family. The ADN functions in a structured healthcare setting, which is a geographical or situational environment where the policies, procedures, and protocols for provision of health care are established. In the structured setting, there is recourse to assistance and support from the full scope of nursing expertise.

Despite increased support, such as from AONE, for making the BSN the entry-level educational requirement, this question continues to be one of the most frustrating issues in the profession and has not been clearly resolved (AACN, 2005a). The AACN believes that:

> education has a direct impact on the skills and competencies of a nurse clinician. Nurses with a baccalaureate degree are well-prepared to meet the demand placed on today's nurse across a variety of settings and are prized for their critical thinking, leadership, case management, and health promotion skills. (AACN, 2005a, p. 1)

Since 2001, there has been an increase in the number of students enrolling in entry-level BSN programs, and the number of RNs returning to school for their BSN also continues to increase. The result has been nine years of steady growth in the number of RNs with baccalaureate degrees (ANA, 2011). A study by Aiken, Clarke, Cheung, Sloane, and Silber (2003) indicates that there is a "substantial survival advantage" for patients in hospitals with a higher percentage of BSN RNs. Other studies (Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005) support these outcomes. McHugh and Lake (2010) examined how nurses rate their level of expertise as a beginner, competent, proficient, advanced, and expert and how often they were selected as a preceptor or consulted by other nurses for their clinical judgment. The survey, which was actually done in 1999, included 8611 nurses. More highly educated nurses rated themselves as having more expertise than less educated nurses, and this correlated with how frequently they were asked to be preceptors or consulted by other nurses. The

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long-term impact of these types of studies on the entry into practice is unknown, but there is more evidence now to support the decision made in 1965 along with recommendations from major reports (Benner et al., 2010; IOM, 2010).

Aiken and colleagues published a study in 2014 addressing nurse staffing and hospital mortality in nine European countries. This study received major recognition by healthcare organizations and through the media. The sample included discharge data for 422,730 patients aged 50 years or older who had common surgeries in the nine countries. The survey included 26,516 nurses in the study hospitals. The findings indicate that increasing a nurse's workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7%; in contrast, every 10% increase in the number of nurses with bachelor's degrees was associated with a 7% decrease in the likelihood of an inpatient dying within 30 days of admission. These associations imply that patients receiving care in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients. Thus there is value in using BSN-prepared nurses in these hospitals, whereas reducing nursing staff may have a negative impact on patient outcomes.

In the last few years, some hospitals have implemented initiatives to hire only RNs with BSN degrees and to encourage staff members without a BSN degree to return to school. This decision by hospitals is highly dependent on the availability of RNs with the BSN degree.

Types of Nursing Programs

Nursing is a profession with a complex education pattern: It has many different entry-level pathways to licensure and many different graduate programs. The following content provides descriptions of the major nursing education programs. Because several types of entry-level nursing programs exist, this complicates the issue and raises concerns about the best way to provide education for nursing students.

Diploma Schools of Nursing

Diploma schools of nursing still exist, though many now have partnerships with colleges or universities where students might take some of their courses. Many of these schools have closed, some have been converted into associate degree programs and even to baccalaureate programs, and some have partnered with BSN programs. However, there has been a slight increase in these programs because employers feel that their need for staff nurses is so great and degree programs are not meeting these needs. The Association of Diploma Schools of Professional Nursing represents these schools. Diploma schools are accredited by the NLN. Graduates take the same licensing exam as graduates from all the other types of nursing programs. The nursing curriculum is similar; the graduates need the same nursing content for the licensing exam. However, the students typically have fewer prerequisites, particularly in the liberal arts and sciences, though they do have some science content. There is variation in these schools because students may take some of their required courses in local colleges.

Associate Degree in Nursing

Programs awarding an **associate degree in nursing** (AD/ADN) began when Mildred Montag published a book on the need for a different type of nursing program—a 2-year program that would be established in community colleges (Montag, 1959). At the time that Montag created her proposal, the United States was experiencing a shortage of nurses after World War II. For students, ADN programs are less expensive and shorter. The programs are accredited by the NLN. The curriculum includes some liberal arts and sciences at the community

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college level and focuses more on technical nursing. Graduates take the same licensing exam as graduates from all other prelicensure nursing programs.

Recently, a variety of models and opportunities for ADN students and graduates have been introduced. Montag envisioned the ADN as a terminal degree; this perception has since changed, with the degree now being viewed more as part of a career mobility path. The RN-BSN or BSN completion programs that are found throughout the United States are a way for ADN graduates to complete the requirements for a BSN. Typically, these graduates work and then go back to school, often on a part-time basis, to complete a BSN in a university-level program. Typically, some prerequisite courses must be taken before these students enter most BSN programs. Additional nursing courses that these students may take are health assessment, public/community health with clinical practice, leadership and management, research/evidence-based practice, and health policy. Until recently, these students rarely took additional clinical courses, as this is not the major focus of the RN-BSN programs; now, however, all programs accredited by AACN must include clinical experiences or a **practicum**. The content typically included for the clinical experience is public/community health, focusing on what these students did not cover in their ADN program. Today, many of the RN-BSN programs are offered online, and greater efforts are made to facilitate the transition from the ADN program to the BSN program. The overall goal is to guide all ADN graduates back to school for a BSN, though this has not yet been accomplished. These graduates do not have to take the licensure exam because they are already RNs, but they are expected to be licensed to participate in a RN-BSN program.

Another change that has been taking place is the development of partnerships with ADN and BSN programs. In these partnerships, the ADN program has a clear relationship with a BSN program. This allows for a seamless transition from one program to the other. Students spend their first 2 years in the ADN program and then complete the last 2 years of the BSN degree in the partner program. In these types of programs, both the participating ADN and BSN programs collaborate on the curriculum and determine how to best transition the students. One benefit of this model is that students pay the community college fees, which are less costly than the university fees, for the first 2 years. If there is no BSN program in a community, students can stay within their own community for the first 2 years before transitioning to a more distant BSN program.

Baccalaureate Degree in Nursing

The idea for the **baccalaureate degree in nursing** was introduced in the *Goldmark Report* (Goldmark, 1923), although it took many years for this recommendation to have an impact on nursing education. The original programs took 5 years to complete, with the first 2 years being spent in liberal arts and sciences courses, followed by 3 years in nursing courses. The programs then began to change to a 4-year model, with variations of 2 years in liberal arts and sciences and then 2 years in nursing courses, though some 5-year programs still exist. Some schools introduce students to nursing content during the first 2 years, but typically the amount of nursing content is limited during this period. In many colleges of nursing, students are not admitted to the college/school of nursing until they complete the first 2 years, although the students are in the same university. These programs may be accredited by the NLN or through the AACN, both of which have accrediting services. (More information about accreditation appears later in the chapter.) BSN graduates take the same licensure exam as all other prelicensure nursing program graduates.

In the 1960s, BSN programs and enrollment grew rapidly. As discussed, the question of the educational level for entry into the profession continues to be unresolved, although since 1965, major nursing

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organizations have clearly stated that it is the BSN. The RN-BSN programs have grown in the last few years. A BSN is required for admission to a nursing graduate program. "Articulation agreements are important mechanisms that enhance access to baccalaureate level nursing education. These agreements support education mobility and facilitate the seamless transfer of academic credit between associate degree (ADN) and baccalaureate (BSN) nursing programs" (AACN, 2005c, p. 1). State law may mandate these agreements, which may be between individual schools, or they may be part of statewide articulation plans to facilitate more efficient transfer of credits. This helps students who want to take some courses in an ADN program or who have an ADN degree to enter BSN programs. However, as described earlier, there are several routes for students with degrees (undergraduate and graduate) in other areas to enter nursing programs.

Master's Degree in Nursing

Graduate education and the evolution of the **master's degree in nursing** have a long history. Early on, it was called postgraduate education, and the typical focus areas were public health, teaching, supervision, and some clinical specialties. The first formal graduate program was established in 1899 at Columbia University Teachers College (Donahue, 1983). The NLN supported the establishment of graduate nursing programs, and these programs were developed in great numbers. For example, some of the early programs, such as Yale School of Nursing, admitted students without a BSN who had a baccalaureate degree in another major. Today, this is very similar to the accelerated programs or direct entry programs in which students with other degrees are admitted to a BSN program that is shorter, covering the same content but with an accelerated approach. These students are typically categorized as graduate students because of their previous degree. Even so, they must complete prelicensure BSN requirements before they can take nursing graduate courses, and in some cases, they are not admitted to the nursing graduate program automatically.

The master's programs in nursing have evolved since the 1950s. The typical length for a master's program is 2 years, and students may attend full time or part time. These programs are accredited by the NLN or AACN and, in some cases, by nursing specialty organizations, as discussed in this chapter. The following are examples of master's degree programs:

- Advanced practice nursing (APRN): This master's degree can be offered in any clinical area, but typical areas are adult health, pediatrics, family health, women's health, neonatal health, and psychiatric–mental health. Graduates take APRN certification exams in their specialty area and must then meet specific state requirements, such as for **prescriptive authority**, which gives them limited ability to prescribe medications. These nurses usually work in independent roles. The American Nurses Credentialing Center (ANCC) provides national certification exams for **advanced practice nurses** in a variety of areas.
- Clinical nurse specialist (CNS): This master's degree can be offered in any clinical area. Specialty exams may also be taken. These nurses usually work in hospital settings. The ANCC provides national certification for CNSs in a variety of areas, as discussed later in this chapter.
- Certified registered nurse anesthetists (CRNA): This master's degree is not offered at all colleges of nursing. It takes 2 years to complete and focuses on preparing nurses to deliver anesthesia. This is a highly competitive graduate program. The Council on Accreditation of Nurse Anesthesia Educational Program, as part of the American Association of Nurse Anesthetists, focuses on accreditation of these programs and certification. This educational program is now moving to the level of doctor of nursing practice (DNP); all

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master's-level programs will be converted to DNP programs or closed by 2025.

- Certified nurse–midwife: This master's degree focuses on midwifery—pregnancy and delivery, as well as gynecologic care of women and family planning. These programs are accredited by the American College of Nurse–Midwives.
- Clinical nurse leader (CNL): This is one of the newer master's degrees, which prepares nurses for leadership positions that have a direct impact on patient care.

> The CNL is a provider and a manager of care at the point of care to individuals and cohorts. The CNL designs, implements, and evaluates patient care by coordinating, delegating and supervising the care provided by the healthcare team, including licensed nurses, technicians, and other health professionals. (AACN, 2007, p. 6)

- Master's degree in a functional area: This type of master's degree focuses on the functional areas of administration or education. It was more popular in the past, but with the growing need for nursing faculty, there has been a resurgence of master's programs in nursing education. In some cases, colleges of nursing are offering certificate programs in nursing education. In these programs, a nurse with a nursing master's degree may take a certain number of credits that focus on nursing education and then, if the nurse successfully completes the NLN certification exam, the nurse will be a certified nurse educator. This provides the nurse with additional background and experience in nursing education.

Doctoral Degree in Nursing

The doctoral degree (doctor of philosophy—PhD) in nursing has had a complicated development history. The doctorate of nursing science (DNSc) was first offered in 1960, but most of these degree programs have since transitioned to PhD programs. There were PhD programs in education in nursing as early as 1924, and New York University started the first PhD program in nursing in 1953. Not enough students are entering these programs, and this has had an impact on nursing faculty. Someone with a PhD is not always required to teach, but is encouraged to do so. Nurses with PhDs usually are involved in research because it is considered a research degree, although a nurse at any level can be involved in research and may or may not teach. Study for a PhD typically takes place after receiving a master's degree in nursing and includes coursework and a research-focused dissertation. This process can take 4 to 5 years to complete, and much depends on completion of the dissertation. Nurses with PhDs may be called "doctor"; this is not the same as the "medical doctor" title, but rather a designation or title indicating completion of doctoral work in the same way that an English professor with a doctorate is called "doctor."

Both types of doctoral programs are now offered as BSN-PhD or BSN-DNP options in some schools of nursing. This means the student does not have to obtain a master's degree prior to entering the program. The goal is to increase the number of nurses with doctoral degrees. In addition, the specialty of nurse anesthesia requires that all nurses pursuing this specialty do so via a BSN-DNP degree by 2015, so many nurse anesthesia master's programs have changed or are in the process of changing to conferring a BSN-DNP degree. The same is true for other specialties that have established the goal of a career pathway through the BSN-DNP by 2025, though nurse anesthesia has moved noticeably more quickly toward this change.

Doctor of Nursing Practice

The DNP is the newest nursing degree. The DNP is not a PhD program, although nurses with a DNP degree are also called "doctor." However, this does

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not represent the same title as someone with a PhD or a doctor or medicine. The DNP is a practice-focused doctoral degree program. This position has been controversial within nursing and within health care, particularly among physicians. Because this position is new, it is difficult to know what its long-term impact will be on the profession and on health care. The AACN has described the purpose of the DNP as follows:

> Transforming healthcare delivery recognizes the critical need for clinicians to design, evaluate, and continuously improve the context within which care is delivered. The core function of healthcare is to provide the best possible clinical care to individuals, families and communities. The context within which care is delivered exerts a major impact on the kinds of care that are provided and on the satisfaction and productivity of individual clinicians. Nurses prepared at the doctoral level with a blend of clinical, organizational, economic and leadership skills are most likely to be able to critique nursing and other clinical scientific findings and design programs of care delivery that are locally acceptable, economically feasible, and which significantly impact healthcare outcomes. (AACN, 2004, p. 7)

Practice-focused doctoral nursing programs prepare leaders for nursing practice. The long-term goal is to make the DNP the terminal practice degree for APRN preparation, including for CNSs, certified registered nurse anesthetists, certified nurse–midwifes, and nurse practitioners (AACN, 2004). This means that by 2015—a date identified by the AACN—and by 2025—a date identified by the American Association of Nurse Anesthetists—advanced practice registered nurses (APRNs) would not get master's degrees but rather DNP degrees. At this time it does not appear that the 2015 goal will be met, but many programs are in the midst of a transition toward that goal. Some of the reasons that the DNP degree was developed relate to the process for obtaining an APRN master's degree, which requires a large number of credits and clinical hours. It was recognized that students should be getting more credit for their coursework and effort. Going on to a DNP program allows them to apply some of this credit toward a doctoral-level program. Practice-focused doctoral programs offer a number of benefits (AACN, 2004, pp. 7–8):

- Development of needed advanced competencies for increasingly complex clinical, faculty, and leadership roles
- Enhanced knowledge to improve nursing practice and patient outcomes
- Enhanced leadership skills to strengthen practice and healthcare delivery
- Better match of program requirements and credits and time with the credential earned
- Provision of an advanced educational credential for those who require advanced practice knowledge but do not need or want a strong research focus (e.g., clinical faculty)
- Parity with other health professions, most of which have a doctorate as the credential required for practice
- Enhanced ability to attract individuals to nursing from non-nursing backgrounds
- Increased supply of faculty for clinical instruction
- Improved image of nursing

Because the DNP is a new degree and represents a new nursing role, it is not clear at this time what its long-term impact will be on nursing and on healthcare delivery. Some have questioned the decision to confer such a degree in light of the need for a greater number of APRNs for primary care (Cronenwett, Dracup, Grey, McDauley, Meleis, & Salmon, 2011); others have questioned it because there is need for nurses with PhDs. There is concern that nurses who might have once considered a PhD will instead seek a DNP; indeed, data indicate that there is now greater enrollment in DNP programs,

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so this prediction has proved correct. As of 2011, there were no professional regulations that required a DNP in place of a master's degree, but this is now changing. For example, the master's in nurse anesthesia is moving to a DNP only. Advanced practice master's will, over time, migrate to DNP degrees. Regulation also will have an impact on final decisions about degree entry.

Nursing Education Associations

There are three major nursing education organizations, each with a different program focus. These organizations are the NLN, the AACN, and the N-OADN.

National League for Nursing

The NLN is an older organization than the AACN. It "promotes excellence in nursing education to build a strong and diverse nursing workforce" (NLN, 2007a, p. 2). The NLN's goals for 2013 can be summarized as follows (NLN, 2013b):

1. *Leader in nursing education*: Enhance the NLN's national and international impact as the recognized leader in nursing education.
2. *Commitment to members*: Build a diverse, sustainable, member-led organization with the capacity to deliver the NLN's mission effectively, efficiently, and in accordance with its values.
3. *Champion for nurse educators*: Be the voice of nurse educators and champion their interests in political, academic, and professional arenas.
4. *Advancement of the science of nursing education*: Promote evidence-based nursing education and the scholarship of teaching.

The major difference between the AACN and the NLN is that the AACN represents only university-level nursing education programs (baccalaureate to doctoral degrees). The NLN represents all nursing programs (ADN, BSN, master's) other than doctoral programs. The NLN accredits nursing programs through the Accreditation Commission for Nursing (ACEN); accreditation is discussed in a later section of this chapter. The NLN offers educational opportunities for its members (individual membership and school of nursing membership) and addresses policy and standards issues related to nursing education.

American Association of Colleges of Nursing

The AACN is the national organization that represents university and baccalaureate programs in nursing. It has approximately 725 members (schools/colleges of nursing). Its activities include educational research, government advocacy, data collection, publishing, and initiatives to establish standards for baccalaureate and graduate degree nursing programs, including implementation of the standards. Its goals for 2012–2014 are threefold: (1) provide strategic leadership that advances professional nursing education, research, and practice; (2) develop faculty and other academic leaders to meet the challenges of changing healthcare and higher education environments; and (3) leverage AACN's policy and programmatic leadership on behalf of the profession and discipline (AACN, 2013). The AACN is also involved in accreditation of university nursing programs through its Commission on Collegiate Nursing Education (CCNE; BSN including RN-BSN, master's, DNP).

National Organization for Associate Degree Nursing

The N-OADN is the organization that advocates for associate degree nursing education and practice (N-OADN, 2013). Its major goals are as follows:

1. *Collaboration*: Advance associate degree nursing education through collaboration with a diversity of audiences.

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2. *Education*: Advance associate degree nursing education.
3. *Advocacy*: Advocate for issues and activities that support N-OADN's mission.

N-OADN began in 1952 when Mildred Montag proposed the ADN—a degree in nursing that took less time to acquire than the BSN, which is a 2-year program often based in a community college. The first programs opened in 1958. As of 2008, 63.2% of RN graduates were from ADN programs and 50% from BSN programs (ANA, 2011). In 2012, there were 59 diploma programs, 696 ADN programs, and 1084 BSN programs. This breakdown represented a change from the previous year marked by an increase of 19 BSN and 24 ADN programs (NLN, 2013b).

The N-OADN organization does not offer accreditation services. Accreditation of ADN programs is done through the NLN accrediting organization (ACEN).

Nursing Education Standards

Nursing education **standards** are developed by the major nursing professional organizations that focus on education: NLN, AACN, and N-OADN. The accrediting bodies of the NLN and the AACN also set standards. State boards of nursing are involved as well. In addition, colleges and universities must meet certain standards for non-nursing accreditation at the overall college or university level. Standards guide decisions, organizational structure, process, policies and procedures, budgetary decisions, admissions and progress of students, evaluation/assessment (program, faculty, and student), curriculum, and other academic issues. Critical standard documents published by the AACN are *The Essentials* covering baccalaureate, master's, and DNP degrees (AACN, 2006, 2008, 2011).

NLN Excellence in Nursing Education Model

Recognition by the NLN as a Center of Excellence in Nursing Education identifies schools of nursing that demonstrate "sustained, evidence-based, and substantive innovation in the selected area; conduct ongoing research to document the effectiveness of such innovation; set high standards for themselves; and are committed to continuous quality improvement" (NLN, 2007b). These schools make a commitment to pursue excellence in (1) student learning and professional development, (2) development of faculty expertise in pedagogy, or (3) advancing the science of nursing education. This award is given to a school—not a program in a school—and remains in effect for 3 years. After this period, the school must be reviewed again for the Center of Excellence recognition. This NLN initiative is an excellent example of efforts to improve nursing education.

Another initiative to recognize excellence, also undertaken by the NLN, is the Academy of Nursing Education, which inducted its first nurse education fellows in 2007. The purpose of the Academy of Nursing Education is to foster excellence in nursing education by recognizing and capitalizing on the wisdom of outstanding individuals who have made enduring and substantial contributions to nursing education in one or more areas (teaching/learning innovations, faculty development, research in nursing education, leadership in nursing education, public policy related to nursing education, or collaborative education/practice/community partnerships) and who will continue to provide visionary leadership in nursing education and in the academy (NLN, 2007a). Nurses who are selected as fellows must document distinguished contributions in one or more areas: (1) teaching/learning innovations, (2) faculty development, (3) research in nursing education, (4) leadership in nursing education, (5) public policy related to nursing education, and (6) collaborative education/practice/community partnerships.

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Focus on Competencies

The nursing curriculum should identify the competencies expected of students throughout the nursing program. There is greater emphasis today on implementing healthcare professions competencies, as noted by the IOM recognition that all healthcare professions should meet five core competencies: (1) provide patient-centered care; (2) work in interdisciplinary/professional teams; (3) employ evidence-based practice; (4) apply quality improvement; and (5) utilize informatics (IOM, 2003). This does not mean that profession-specific competencies are not relevant, but rather recognizes the existence of basic competencies that all healthcare professions should demonstrate.

You need to know what the expected competencies are so that you can be an active participant in your own learning to reach these competencies. The competencies are used in evaluation and to identify the level of learning or performance expected of the student. Nursing is a profession—a practice profession—so performance is a critical factor. Competency is "the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare, and safety" (National Council of State Boards of Nursing [NCSBN], 2005, p. 1). The ANA defines competence as "an expected and measurable level of nursing performance that integrates knowledge, skills, abilities, and judgment, based on established scientific knowledge and expectations for nursing practice" (ANA, 2010, p. 64). Competencies should clearly state the expected parameters related to the behavior or performance. The curriculum should support the development of competencies by providing necessary prerequisite knowledge and learning opportunities to meet the competency. The ultimate goal is a competent RN.

Curriculum

A nursing program's **curriculum** is the plan that describes the program's philosophy, levels, terminal competencies for students (or what they are expected to accomplish by the end of the program), and course content (described in course syllabi). Also specified are the sequence of courses and a designation of course credits and learning experiences, such as didactic courses (typically offered in a lecture/classroom, seminar setting. or both venues) and clinical or practicum experiences. In addition, simulation laboratory experiences are included either at the beginning of the curriculum or throughout the curriculum. The nursing curriculum is very important. It informs potential students what they should expect in a program and may influence a student's choice of programs, particularly at the graduate level. It helps orient new students and is important in the accreditation of nursing programs. State boards of nursing also review the program curricula of schools of nursing in their state. To keep current, it is important that curricula are reviewed regularly by the faculty and in a manner that allows changes to be made as easily and quickly as possible.

The *Essentials of Baccalaureate Education for Professional Nursing* Practice provides guidelines for baccalaureate education, and CCNE accreditation requires that these guidelines be used to develop BSN curricula (AACN, 2008). This document was revised in 2008. The following paragraphs provide some history on this change.

The IOM published an important report, *Health Professions Education* (2003) that addressed the need for education in all major health professions to meet several common competencies to improve care. The development of this report was motivated by grave concerns about the quality of care in the United States and the need for healthcare education programs to prepare professionals who provide quality, safe care. "Education for health professions is in need of a major overhaul. Clinical education [for all healthcare professions] simply has not kept pace with or been responsive enough to shifting patient demographics and desires, changing health system expectations, evolving practice requirements and staffing arrangements, new information, a focus

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on improving quality, or new technologies" (IOM, 2001, as cited in IOM, 2003, p. 1). The IOM core competencies were also emphasized in the *Essentials of Baccalaureate Education* (AACN, 2008); however, schools of nursing need to make changes to include the competencies, and in some cases add new content to meet these needs.

Along with the call from the IOM to make major changes in health professions education, there is recognition that nursing education needs improvement and changes to make it more current with practice today. The NLN (2007a) has stated:

> Student-centered, interactive, and innovative programs and curricula should be designed to promote leadership in students, develop students' thinking skills, reflect new models of learning and practice, effectively integrate technology, promote a lifelong career commitment in students, include intra- and inter-professional learning experiences, and prepare students for the roles they will assume.

Didactic or Theory Content

Nursing curricula may vary as to titles of courses, course descriptions and objectives/learning outcomes, sequence, and number of hours of didactic content and clinical experiences, but there are some constants even within these differences. Nursing content needs to include the following broad topical areas:

- Adult health or medical–surgical nursing
- Psychiatric–mental health nursing
- Pediatrics
- Maternal–child nursing (obstetrics, women's health, neonatal care)
- Public/community health
- Gerontology
- Leadership and management
- Pharmacology
- Health assessment
- Evidence-based practice
- Research
- Health policy
- Legal and ethical issues
- Professional issues and trends

Many schools also offer courses in informatics and in genetics. Quality improvement content is often weak, even though it is now considered critical knowledge that every practicing nurse needs to have if care is to be improved.

Nursing content may be provided in clearly defined courses that focus on only one topical area, or it may be integrated with multiple topics. Clinical experiences/practicums may be blended with related didactic content—for example, pediatric content and pediatric clinical experience—such that they are considered one course; alternatively, the clinical/practicum and didactic content may be offered as two separate courses, typically in the same semester. Faculty who teach didactic content may or may not teach in the clinical setting.

Practicum or Clinical Experience

The hours for the practicum can be highly variable within one school and from school to school (i.e., the number of hours per week and sequence of days, such as practicum on Tuesdays and Thursdays from 8 a.m. to 3 p.m.). Many schools are now offering 12-hour clinical sessions. Twelve-hour work shifts may lead to fatigue and an increased number of errors. Some schools offer clinical experiences in the evenings, at night, and on weekends. It is important for students to understand the time commitment and scheduling, which have a great impact on students' personal lives and employment. In addition, these clinical experiences require preparation time. The types of clinical settings are highly variable and depend on the objectives and the available sites. Typical types of settings are acute care hospitals (all clinical areas); psychiatric hospitals; pediatric hospitals; women's health (may include obstetrics) clinics; community health clinics and other health agencies; home health agencies and patients' homes; hospice centers, including freestanding sites, hospital-based

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centers, and patients' homes; schools; camps; health-oriented consumer organizations such as the American Diabetes Association; health mobile clinics; homeless shelters; doctors' offices; clinics of all types; ambulatory surgical centers; emergency centers; Red Cross centers; businesses with occupational health services; and many more. In some of these settings—for example, in acute care—faculty remain with the students for the entire rotation time. In other settings, particularly public/community healthcare settings, faculty visit students at the site because typically only 1 to 4 students are in each site, compared with the larger group (8 to 10 students) usually assigned to a faculty member for hospital experiences. The number of hours per week in clinical experiences increases in a nursing program, with the most hours assigned at the end of the program.

Most schools of nursing use preceptors as part of the nursing curriculum at some time, in both undergraduate and graduate programs. In entry-level programs, preceptor experiences are typically used toward the end of the program, but some schools use preceptors throughout the program for certain courses such as master's programs. A **preceptor** is an experienced and competent staff member (an RN or a nurse practitioner or medical doctor for APRN, nurse anesthesia, and nurse–midwife graduate nursing students) who has received formal training to function in this role. The preceptor serves as a role model and a resource for the nursing student and guides learning. The student is assigned to work alongside the preceptor. Faculty provide overall guidance to the preceptor regarding the nature of, and objectives for, the student's learning experiences; monitor the student's progress by meeting with the student and the preceptor; and are on call for communication with the student and preceptor as needed. The preceptor participates in evaluations of the student's progress, along with the student, but the faculty member has the ultimate student evaluation responsibility. The state board of nursing may dictate how many total hours in the undergraduate nursing program may be devoted to preceptorship experiences. At the graduate level, the number of preceptorship hours is much higher.

Distance Education

Distance education or online education has become quite common in nursing education, although not all schools offer courses in this manner. The AACN recognizes distance education as "a set of teaching and/or learning strategies to meet the learning needs of students separate from the traditional classroom and sometimes from traditional roles of faculty" (Reinert & Fryback, 1997). This definition is still applicable today, and distance education technologies have expanded over the last few years as technology developed. Some of the common distance education technologies that are used are email, fax, audiotaped instruction, audiocassette, conference by telephone or via Internet, CD-ROM, email lists (such as LISTSERV), interactive television, desktop video conference, and Internet-based programming. There is no doubt that these methods will continue to expand. The most common and increasingly more widely adopted education approach is online courses.

Distance education can be configured in several ways, including the following:

- Self-study or independent study
- Hybrid model—distance education combined with traditional classroom delivery (the most common configuration)
- Faculty-facilitated online learning with no classroom activities (the approach that is growing the most rapidly)

As stated by the AACN, "When utilizing distance learning methods, a program provides or makes available resources for the students' successful attainment of all program objectives" (2005b, p. 1). For schools to effectively offer courses or entire programs using technologies for distance education, they must ensure that the following supports are provided: registration, student affairs support, technology support, library access, and other support services such as tutoring.

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Students who participate in distance education must have certain characteristics to be successful in this type of educational program. Most notably, they need to be responsible for their own learning, with faculty facilitating their learning. Computer competencies are critical for completing coursework and reducing student stress. Students must have required hardware and software. Students who are organized and able to develop and meet a schedule will be able to handle the course requirements. If students are assertive, ask questions, and ask for help, they will be more successful. Effective online learning also requires active, engaged competent faculty.

Self-directed learning is important for all nursing students because it leads to greater ability to achieve lifelong learning as a professional. There are a variety of definitions of self-directed learning, most of which are based on Knowles's (1975, p. 18, as cited in O'Shea, 2003, p. 62) definition: "a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies and evaluating learning outcomes." Student-centered learning approaches can assist students—for example, problem-based learning or team-based learning. This type of approach means that the faculty must also change how they teach. Faculty members assume the role of a facilitator of learning, which requires establishing a more collaborative relationship between faculty and students. Faculty work with students to develop active participation and goal setting: helping students to work on setting goals, making plans with clear strategies to meet the goals, and encouraging self-assessment. Flipped classroom approach is also new to nursing, for example with content provided online, in textbooks, etc. and the expectation that students come to class prepared so that they can actively participate in learning activities in the classroom rather than listening to lectures. Distance education typically emphasizes adult teaching and learning principles more than the traditional classroom approach does, and approaches such as the flipped classroom focus more on these principles. Knowles (1984) originally described principles that emphasized how learners engage with this type of educational program:

- Accept responsibility for collaborating in the planning of their learning experiences
- Set goals
- Actively participate
- Pace their own learning
- Participate in monitoring their own progress; perform self-assessment

As noted in the 2010 report on nursing education (Benner et al., 2010), there is need for greater student engagement in the classroom.

The quality of distance education is as important as the quality of traditional classroom courses. Syllabi that provide the course description, credits, objectives or learning outcomes, and other information about the course should ensure that the same general structure is followed whether a course is taught using a traditional approach or through distance education. Student evaluation must be built into a distance education course just as it is nondistant courses; however, more details are typically provided in distance education course materials and teaching–learning practices may be different. Schools should ensure that students provide anonymous evaluations of the course and faculty.

Critical Problems

Faculty Shortage and Access to Clinical Experiences

Today, two critical problems that concern participants in nursing education programs are the growing faculty shortage and the need to find clinical experiences for students, particularly as efforts are made to increase enrollment. These complex problems require more than one solution, and they have a great impact on the quality of nursing education and student outcomes.

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Faculty Shortage

The faculty shortage is part of the nursing shortage problem, because it means that fewer new nurses can enter the profession. "A particular focus on securing and retaining adequate numbers of faculty is essential to ensure that all individuals interested in—and qualified for—nursing school can matriculate in the year they are accepted" (Americans for Nursing Shortage Relief, 2007, p. 2). Aside from having a limited number of faculty, nursing programs struggle to provide space for clinical laboratories and to secure a sufficient number of clinical training sites at healthcare facilities.

A school's faculty should reflect a balance of expert clinicians who can teach, expert researchers and grant writers who can teach and meet research obligations, and expert teachers who are pedagogical scholars (NLN, 2007b). Today, schools of nursing, regardless of the type of program, are struggling to meet the demand for greater enrollment of students because of the limited number of faculty. Schools of nursing are having problems recruiting experienced faculty, and thus many faculty are new to teaching. This shortage comes at a time when there already is a fluctuating nursing shortage. Some of the same factors that affect the nursing shortage have an impact on the faculty shortage, such as retirement. This challenge will only increase in the future because a large number of nursing faculty members are approaching retirement age. It is also difficult to attract nurses to teaching because the pay is lower than for nursing practice; for this reason, nurses with graduate degrees often opt to stay in active practice. Attracting nurses to graduate school is an issue, particularly at the doctoral level. It is hoped that the DNP degree will attract more nurses to such advanced degree programs, but these nurses may not be interested in teaching—and the DNP program is not designed to prepare faculty but rather to prepare practitioners. However, even if more students do apply to DNP programs, many are likely to be denied admission due to the lack of sufficient faculty to teach in the programs. The Health Care Reform legislation of 2010 (Patient Protection and Affordable Care Act) offers some opportunities to expand nursing faculty by providing funding for education so that nurses can prepare for the faculty role.

Access to Clinical Experiences

With the drive to increase student enrollments, securing enough clinical sites to meet course objectives has proved a challenge for schools of nursing. If a number of nursing schools are located in the same area, there will also be competition for clinical slots. This is particularly pronounced in specialties that have fewer patients, which translates into tight demand for clinical slots—such is the case in pediatrics, obstetrics, and mental health, for example.

Schools of nursing have to be more innovative and recognize that every student may not get the same clinical experiences. For example, there has been increasing use of non–acute care pediatric settings. Some communities do not have pediatric hospitals and may have limited beds assigned to pediatric care. Other sites that might be used are pediatrician offices, pediatric clinics, schools, daycare centers, and camps. For obstetrics, possible clinical sites are birthing centers, obstetrician offices, and midwifery practices. Mental health clinical experiences may take place in clinics, at homeless shelters, in mental health emergency and crisis centers, and at a mental health association site.

This difficulty in getting sites has meant that some schools have been forced to move away from the traditional clinical hours offered—Monday through Friday during the day. Some schools are recognizing that operating on a 9-month basis with a long summer break affects the availability of clinical experiences. To accommodate the needs of all schools of nursing and the need to increase student enrollment, community-area healthcare providers are working with schools to determine how all these needs can be met effectively.

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A Response and Innovation: Laboratory Experiences and Clinical Simulation

Laboratory and simulation experiences have become important teaching–learning settings for developing competencies, partly because of problems in accessing clinical experiences, but also as a result of the recognition that they provide effective learning experiences for students with no risk of harm to patients. The NCSBN (2005) defines simulation as "activities that mimic reality of a clinical environment and are designed to demonstrate procedures, decision making and critical thinking through techniques such as role playing and the use of devices such as interactive videos or mannequins" (p. 11). Simulation helps students develop confidence in their skills in a safe setting before they begin caring for real patients and can help students to develop teamwork abilities. The simulated environment provides opportunities for teams of nurses or, ideally, interprofessional students to work together to solve simulated clinical situations. Students can be evaluated and provided with feedback in more structured learning situations. Simulated experiences should be as close to real life as possible—although they are not, of course, totally real. However, this does not mean that these learning situations are not very helpful for student learning. Laboratories that are not as high-tech as simulation centers may be used to learn basic skills. Most schools do not have their own full simulation laboratories due to the expense of setting up and running such labs. Often the simulation laboratory is established through a partnership of multiple health practice education programs and/or hospitals to reduce the financial burden on each institution and to offer simulation to a variety of students, often in an interprofessional experience, and staff.

A simulation lab is expensive to develop and maintain. Students need to respect the equipment and supplies and follow procedures so that costs can be managed. Faculty supervision in the simulation lab may be based on a higher ratio of students to faculty than the required ratio for clinical experiences, providing more cost-effective teaching and learning. With the development of more sophisticated technology, computer simulation can even be incorporated into distance education.

The IOM reports on quality in healthcare delivery have resulted in greater urgency to institute changes in nursing education. In fact, the 2010 nursing education report identified preparation of nurses to meet these quality demands as a critical topic (Benner et al., 2010). Thus quality improvement relies, in part, on improvement of nursing education. Nursing students need to be included in the evaluation of nursing education and changes. As a student, you can help meet this need by providing course feedback and participating in curriculum committees when requested. Nursing education leaders should always review content and improve curriculum, but must have methods to do this in a timely, effective manner. When accreditation surveyors come to schools of nursing, they talk to students to get their feedback.

> What is needed by nursing today is to uphold the true spirit of innovation and overhaul traditional pedagogies to reform the way the nursing workforce is educated. This call to action will be accomplished through new pedagogies that are most effective in helping students learn to practice in rapidly changing environments where short stays in acute care facilities are common and where complex care is being provided in a variety of settings. These new pedagogies must be research-based, pluralistic and responsive to the unpredictable nature of the contemporary healthcare system. (Ben-Zur, Yagi, & Spitzer, 1999, as stated in NLN, 2003, p. 2)

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Accreditation of Nursing Education Programs

Accreditation is important in assessing and maintaining standards to better ensure effective programs for students that meet practice requirements. Potential nursing students may not be as aware of accreditation of the schools they are considering, but they should be.

Nursing Program Accreditation

Accreditation is a process in which an organization is assessed regarding how it meets established standards. Minimum standards are identified by an accrediting organization, and nursing schools incorporate these standards into their programs. The accrediting organization then reviews the school and its programs. This is supposedly a voluntary process, but in reality it is not; to be effective, a school of nursing must be accredited. Nursing education programs should be accredited by the recognized organizations that provide standards and accreditation for nursing programs. Attending a program that is not accredited can lead to complications in licensure, employment, and opportunities to continue on to higher degree programs. Currently, two organizations offer accreditation of nursing programs: NLN and ANCC through their accrediting services ACEN and CCNE.

Nursing Program Accreditation: How Does It Work?

What is accreditation, and how does it work? Accreditation is based on minimum standards that schools of nursing must meet to obtain accreditation. The process is complex and takes time. Schools of nursing must pay for the review. Schools may or may not receive initial accreditation, and when they do, programs may be required to make changes; they may also later be found to not be in compliance with the expected standards and may lose accreditation. Accreditation is not a legal requirement, but state boards of nursing require this type of accreditation from the NLN or ANCC to maintain state accreditation. Some specialty organizations accredit specific graduate programs within a school, such as the American College of Nurse Midwifery and the American Association of Nurse Anesthetists. A school may choose which organization (ACEN or CCNE) accredits the program unless mandated by state agency or law; however, schools with diploma and associate degree programs can be accredited only by the ACEN. The state board of nursing in each state is involved in this requirement and in the state accreditation process. During the accreditation process, the review team assesses the schools for the following:

- Mission and vision
- Structure and governance
- Resources and physical facilities, including budget
- Faculty and faculty outcomes
- Curriculum and implementation
- Student support services
- Admissions process and other academic processes
- Policies and procedures
- Ongoing assessment process (continuous quality improvement, student and program outcomes)

After the school of nursing completes a self-study based on the accreditation standards established by the accrediting organization, the written self-study results are submitted to the accrediting organization. The next step in the accreditation process is the on-site survey at the school. Surveyors visit the school and view classes and clinical experiences/practicums, review documents, and meet with school administrative staff; if the school of nursing is part of a university, they also meet with university administrative staff. In addition, surveyors meet with faculty, students, and alumni. They typically remain at the school for several days. Students

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have an obligation to participate in this survey and provide feedback. The goal is maintenance of minimum standards to ensure an effective learning environment that supports student learning and meets the needs of the profession.

REGULATION

How are professional regulation and nursing regulation for practice licensure related? **Regulation** for practice or licensure is clear, though problematic in some cases. This type of regulation is based on state laws and regulations and leads to licensure. However, this is different from the professional regulation, in which the profession itself regulates its practice. State boards of nursing are not nursing professional organizations, but rather state government agencies. This distinction can make it difficult to make changes in a state's practice of nursing. Professional organizations do have an impact on practice through the standards they propose and other elements of support and data that they provide. "For effective nursing workforce planning to occur and be sustained, Boards of Nursing must collaborate with nursing education and practice to support the safe and effective evolution of nursing practice" (Damgaard, VanderWoude, & Hegge, 1999, as cited in Loquist, 2002, p. 34).

"In 1950, nursing became the first profession for which the same licensure exam, the State Board Test Pool (now called NCLEX), was used throughout the nation to license nurses. This increased the mobility for the registered nurse and resulted in a significant advantage for the relatively new profession of nursing" (Lundy, 2005, pp. 21–22). The major purpose of regulation is to protect the public, and it is based on the 10th Amendment of the U.S. Constitution, the states' rights amendment. Each state has the right to regulate professional practice, such as nursing practice, within its own state.

In general, the regulatory approach selected should be sufficient to ensure public protection. The following criteria are still relevant today in providing a framework for professional licensure (NCSBN, 1996, pp. 8–9):

- *Risk of harm for the consumer.* The evaluation of a profession to determine whether unregulated practice endangers the public should focus on recognizable harm. That harm could result from the practices inherent in the nature of the profession, the characteristics of the clients/patients, the settings, or supervisory requirements, or a combination of these factors. Licensure is applied to a profession when the incompetent or unethical practice of that profession could cause greater risk of harm to the public unless there is a high level of accountability; at the other extreme, registration is appropriate for professions where such a high level of accountability is not needed.
- *Skill and training needed.* The more highly specialized the services of the professional, the greater the need for an approach that actively inquires about the education and competence of the professional.
- *Level of autonomy.* Licensure is indicated when the professional uses independent judgment and practices independently with little or no supervision. Registration is appropriate for individuals who do not use independent judgment and practice with supervision.
- *Scope of practice.* Unless there is a well-demarcated scope of practice for the profession that is distinguishable from other professions and definable in enforceable legal terms, there is neither basis nor need for licensure. This scope may overlap other professions in specific duties, functions, or therapeutic modalities.
- *Consumer expectation.* Consumers expect that those professions that have a potentially high impact on the consumer or on their physical, mental, or economic well-being

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will be subject to regulatory oversight. The costs of operating regulatory agencies and the restriction of practitioners who do not meet the minimum requirements are justified to protect the public from harm.

- *Alternative to regulation.* There are no alternatives to the selected regulatory approach that would adequately protect the public. It should also be the case that when it is determined that regulation of the profession is required, the least restrictive level of regulation consistent with public protection is implemented.

Eight guiding principles apply to nursing regulation: (1) protection of the public, (2) competence of all practitioners regulated by the board of nursing, (3) due process and ethical decision making, (4) shared accountability, (5) strategic collaboration, (6) evidence-based regulation, (7) response to the marketplace and healthcare environment, and (8) globalization of nursing (NCSBN, 2007).

Nurse Practice Acts

Each state has a **nurse practice act** that determines the nature of nursing practice within the state. The nurse practice act is a state law passed by the state legislative body. Nurse practice acts for each state can be found state government websites. Every nurse who has a license should be knowledgeable about the nurse practice act that governs practice in the state where the nurse practices under the RN license. Typically, nurse practice acts do the following for their state (Masters, 2005, p. 166):

- Define the authority of the board of nursing, its composition, and its powers
- Define nursing and boundaries of the scope of practice
- Identify types of licenses and titles
- State the requirements for licensure
- Protect titles
- Identify the grounds for disciplinary action

The most important function of the nurse practice act is to define the scope of practice for nurses in the state to protect public safety.

State Boards of Nursing

State boards of nursing implement the state's nurse practice act, which is the statutory law governing nursing practice within a state or territory, and recommend state regulations and changes to this act when appropriate. This board is part of state government, although how it fits into a state's governmental organization varies from state to state. RNs serve on state boards of nursing, and the governor typically selects board members who serve for a specific term of office. Licensed practical nurses (LPNs), laypersons, or consumers (non-nurses) may also have representation on the board. The primary purpose of the state board of nursing is to protect the health and safety of the public (citizens of the state). A board of nursing has an executive director who runs the business of the board, along with staff who work for the board (state). The size of the state has an impact on the size of the board of nursing and its staff. Boards are not only involved in setting standards and licensure of nurses (RNs and LPNs/licensed vocational nurses [LVNs]), but also are responsible for monitoring nursing education (RN and LPN) programs in the state. Such a board serves a regulatory function; as part of this function, it can issue administrative rules or regulations consistent with state law to facilitate the enforcement of the nurse practice act.

The board of nursing in each state also reviews problems with licensure and is the agency that administers disciplinary actions. If a nurse fails to meet certain standards, participates in unacceptable practice, or has problems that interfere with safe practice, and any of these violations are reported to the board, the board can conduct an investigation and review and determine actions that might need to be taken. Examples of these issues are assault or causing harm to a patient; having a problem with illegal

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drugs or with alcohol (substance abuse); conviction of, or pleading guilty to, a felony (examples of felonies are murder, robbery, rape, and sexual battery); and having a psychiatric illness that is not managed effectively and interferes with safe functioning. A nurse may be reprimanded by the board or denied a license, may be subject to suspended or revoked licensure, or may face licensure restriction with stipulations (for example, the nurse must attend an alcohol treatment program to retain licensure).

The board must follow strict procedures when taking any disciplinary action, which must first begin with an official complaint to the board. Anyone can make a complaint to the board—another nurse, another healthcare professional, a healthcare organization, or a consumer. The state nursing practice act identifies the possible reasons for disciplinary action. Boards of nursing publish their disciplinary action decisions because they are part of the public record. When nurses obtain a license in another state, they are asked to report any disciplinary actions that have been taken by another state's board of nursing. Not reporting disciplinary board actions has serious consequences for obtaining (and losing) licensure. A key point is that licensure is a privilege, not a legal right. It is important to consider this point as a student because the same rules apply when getting the first license—even if a student graduates from a nursing program this does not mean they have a right to take the NCLEX exam or to be given a license.

National Council of State Boards of Nursing

The NCSBN is a not-for-profit organization that represents all of the boards of nursing in the 50 states, the District of Columbia, and four U.S. territories (American Samoa, Guam, Northern Mariana Islands, and Virgin Islands). Through this organization, all boards of nursing work together on issues related to the regulation of nursing practice that affect public health, safety, and welfare, including the development of licensing examinations in nursing. Although the NCSBN cannot dictate change to individual state boards of nursing, it can make recommendations, which often carry significant weight. Individual state boards of nursing, unlike the NCSBN, are part of, and report to, state government.

The NCSBN performs the following functions (NCSBN, 2013a):

- Develops the NCLEX-RN, NCLEX-PN, NNAAP, and MACE examinations
- Monitors trends in public policy, nursing practice, and education
- Promotes uniformity in relationship to the regulation of nursing practice
- Disseminates data related to the licensure of nurses
- Conducts research on nursing practice issues
- Serves as a forum for information exchange for members
- Provides opportunities for collaboration among its members and other nursing and healthcare organizations by maintaining the Nursys database, which coordinates national publicly available nurse licensure information

Licensure Requirements

Each state's board of nursing determines its state's licensure requirements; however, all require passage of the NCLEX-RN, which is a national exam. Other requirements include criminal background checks for initial licensure and **continuing education** (CE) for renewal, though the latter requirement varies from state to state. Many nurses hold licenses in several states or may be on inactive status in some states. An RN should always maintain one license, even if not practicing, to make it easier to return to practice. Fees are paid for the initial license and for license renewal. States in which a nurse is licensed notify the nurse when the license is up for renewal. It is the nurse's responsibility to complete the required forms and submit payment, and many states now do this electronically.

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Examples of licensure requirements and renewal requirements, which vary from state to state, include the following:

- Fee (always required, though the amount varies and depends on whether the nurse has active or inactive licensure status)
- Passage of NCLEX (required for first licensure and then covered for renewals or change of license)
- CE contact hours within a specified time period (number of contact hours varies from state to state, and some states do not require any CE for licensure renewal)
- Criminal background check (required typically for initial licensure in a state)
- Active employment for a specific number of hours within a specified time period (varies from state to state)
- Number of hours of professional nursing activities (varies from state to state)

Ultimately, each RN is responsible for maintaining competency for safe practice. Any person who practices nursing without a valid license commits a minor misdemeanor. If licensed in one state, the nurse can typically do the following in another state in which the nurse is not licensed:

- Consult
- Teach as guest lecturer
- Conduct evaluation of care as part of an accreditation process

National Council Licensure Examination

The NCLEX is developed and administered through the NCSBN (2013a). There are two forms of the exam: NCLEX-RN for RN licensure and NCLEX-PN for practical nurse licensure. In each jurisdiction (state) in the United States and its territories, licensing authorities regulate entry into practice of nursing. To ensure public protection, each jurisdiction requires a candidate for licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level RN (NCSBN, 2013a). Content relates to the following patient/client needs categories: safe effective care environment (management of care, safety, and infection control), health promotion and maintenance, psychosocial integrity, and physiological integrity (basic care and comfort, pharmacologic and parenteral therapies, reduction of risk potential, physiological adaptation).

The examination is offered online. Most of the questions are written at the cognitive level of application or higher, requiring the candidate to use problem-solving skills to select the best answer. The exam is a computerized adaptive test. In this type of exam, the computer adjusts questions to the individual candidate so that the exam is then highly individualized, offering challenging questions that are neither too easy nor too difficult. The NCLEX-RN has a range of questions, numbering from 75 to 265. The exam ends when the computer determines with 95% certainty that the person's ability is either below or above the passing standard. The exam can also end when the time runs out or there are no more questions. Because of these factors, all candidates do not receive the same number of questions. The exam includes the following types of questions:

- *Multiple-response items:* The candidate is required to select one or more responses.
- *Fill-in-the-blank items:* The candidate is required to type numbers in a calculation item.
- *Hot spot items:* The candidate identifies an area on a picture or graphic.
- *Chart/exhibit format:* The candidate is presented with a problem and then must read information in a chart/exhibit to answer the question.
- *Drag-and-drop items:* The candidate ranks, orders, or moves options to provide the correct answer.

If a candidate does not pass the exam, he or she may take the NCLEX again. Most schools of nursing provide some type of preparation (for example,

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throughout the nursing program, or near the end); some may recommend that students complete a prep course on their own. These prep courses require a fee and are of varying length. Many publications are also available to assist with NCLEX preparation. The exam preparation takes place every day in the nursing programs—in courses and in clinical practice.

How the Process Works

Students are asked by their school to complete an application for NCLEX in the final semester before graduation. This application is sent to the state board of nursing in the state where the student is seeking licensure. After a student completes the nursing program, the school must verify that the student has graduated. At this point, the student becomes an official NCLEX candidate. The student receives an authorization to test and exam instructions and information about scheduling the exam. The authorization to test is the nursing graduate's pass to take the exam, so it is important to keep it. Students then schedule their own exam within the given time frame.

On the scheduled date, the student goes to the designated exam site to take the computerized exam. Candidates are fingerprinted and photographed to ensure security for the exam. Testing sites are available in every state, and a candidate may take the exam in any state. Licensure, however, is awarded by the state in which the candidate has applied for licensure.

An exam session lasts a maximum of 6 hours, but because of the computerized adaptive test method, the amount of time that an individual candidate takes on the exam varies; that time does not affect passing or failing. Every candidate must answer a minimum of 75 questions. This means that the exam is completed when one of the following occurs: (1) results measure a level of competency above or below the standard, and a minimum of 75 questions have been answered; (2) the candidate completes the maximum number of 265 questions; or (3) the candidate has used the maximum time of 6 hours. Candidates are provided an orientation and a brief practice session prior to taking the exam.

Passing scores are the same for every state and are set by the NCSBN. Candidates are usually informed of their results within 4 weeks; the result is pass or fail, with no specific score provided. Schools of nursing receive composites of student results. Data on individual school pass rates are available on state board of nursing websites and open to the public. Results from the NCLEX are an important element in a school of nursing's evaluation/assessment process. The first-time pass rate is reviewed routinely and must be reported to the school's accreditation organization; in addition, the state board monitors these results.

Critical Current and Future Regulation Issues

Compact Licensure

There has been a growing need to find licensure methods that address the following situations: a nurse lives in one state but works in an adjacent state; a nurse works for a healthcare company in several states; and a nurse works in telehealth, by which care might be provided via technology in more than one state. To address these types of issues, the NCSBN created a new model for licensure called mutual recognition or compact licensure. Each state in a mutual recognition compact must enact legislation or regulation authorizing the nurse licensure compact and also adopt administrative rules and regulations for implementation of the compact. Each compact state must also appoint a nurse licensure compact administrator to facilitate the exchange of information between the states that relates to compact nurse licensure and regulation. Twenty-four states have adopted this model. Other states have decided that this model is unconstitutional in their states because it delegates authority for licensure decisions to other states. A list of current states offering this multistate licensure is available from NCSBN (https://www.ncsbn.org/nlc.htm).

The same type of licensure questions apply to advanced practice nurses. In 2002, the NCSBN Delegate Assembly approved the adoption of model

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language for a licensure compact for APRNs. Only those states that have adopted the RN and LPN/LVN licensure compact may implement a compact for APRNs. From 2004 to 2007, three states—Utah, Iowa, and Texas—passed legislation. These states are now working on the implementation regulations, which must be put into effect prior to implementation of the compact. The APRN compact offers states the mechanism for mutually recognizing APRN licenses and authority to practice (NCSBN, 2013b).

Mandatory Overtime

A critical concern in practice today is requiring nurses to work overtime. Employers make this decision, and it is called mandatory overtime. This policy impacts the quality of care and has affected staff satisfaction and burnout. Boards of nursing in other states have become involved in state legislative efforts related to mandatory overtime.

Although legislative and regulatory responses have provided nurses with additional support for creating safer work environments, each of these legislative responses has a significant effect on the numbers and types of nursing personnel that will be required for care delivery systems in the future as well as the cost of care. Clearly, there is concern at the state and national levels regarding the impact that fewer caregivers will have on the health and safety of patients (Loquist, 2002, p. 37).

As students and new graduates interview for their first positions, they should ask about mandatory overtime if they are not in a state that has a law to protect them from it. Research is now being done regarding sleep deprivation and its connection to the rising number of medical errors (Girard, 2003; Manfredini, Boari, & Manfredini, 2006; Montgomery, 2007; Sigurdson & Ayas, 2007). This area of research is fairly new, and researchers will need to continue to provide concrete evidence of the links among sleep deprivation, long work hours, and medical errors. The aviation industry has cut back the number of hours that flight crews can work without sleep, and the number of hours that medical residents can work consecutively has been decreased because of concern about fatigue and errors.

Foreign Nursing Graduates: Entrance to Practice in the United States

The number of nurses from other countries coming to the United States to work and/or study has increased. Some nurses want to work here only temporarily; others want to stay permanently. This movement of nurses internationally typically increases during a shortage, and today there is a worldwide shortage and a lot of nursing migration (International Centre on Nurse Migration, 2007).

> The NCSBN recently passed a new position statement regarding international nurse immigration, reaffirming that foreign-educated nurses need to comply with standards of approved or comparable education, hold a verified valid and unencumbered state license, and be proficient in their written and spoken English language skills. There still is the ethical question of "poaching" nurses from one country to another that results in the reduction of a scarce national resource in this worldwide shortage. (NCSBN, 2001, as cited in Loquist, 2002, p. 37)

What do these nurses have to do to meet practice requirements in the United States? The Commission on Graduates of Foreign Nursing Schools (CGFNS, 2007) is an organization that assists these nurses in evaluating their credentials and verifies their education, registration, and licensure. This is an internationally recognized, immigration-neutral, nonprofit organization that protects the public by ensuring that these nurses are eligible and qualified to meet U.S. licensure and immigration requirements. These nurses must also take the English as a foreign language exam to ensure that their English language ability is at an acceptable level. This requirement also applies to students who want to enter

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U.S. nursing programs. A nurse who is licensed in another country must successfully complete the NCLEX and meet the state licensure requirements where the nurse will practice. If the nurse wants to enter a graduate nursing program, the nurse needs to get a U.S. RN license for clinical work that would be done as part of the educational program. This is not required for a prelicensure program in nursing.

Global Regulatory Issues

With the development of the Internet, telehealth and global migration have been forcing nursing to confront changes related to interstate nursing practice. Globalization has had a similar impact on migration (Fernandez & Hebert, 2004). This migration phenomenon supports the need for an international credentialing of immigrant nurses to ensure public safety as defined by the International Council of Nurses (Schaefer, 1990).

> New models for practice will continue to emerge to manage change, care, and plan for the future. Electronic technologies provide an opportunity to develop a new identity for nursing practice. New regulatory requirements will emerge to meet the need of practitioners to ensure public safety. As a new paradigm for ensuring competencies and self-regulation in a global market evolves, the need to explore global licensure will emerge. The future belongs to those who will accept the challenge to make a difference in a global marketplace and take the necessary risks to make things happen. (Fernandez & Hebert, 2004, p. 132)

The Global Alliance for Leadership in Nursing Education (GANES, 2011) is a nursing organization that focuses on getting nurse educators from around the world to work together to develop and facilitate nursing education and research in order to improve care globally. These new efforts to recognize the need for international standards in nursing education and regulation represent a significant step; nursing has moved from a focus on individual hospitals, to the state level, to the national level, and now to a global level.

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Conclusion

This chapter has described critical issues related to nursing education, accreditation of nursing education programs, and regulation and nursing practice. All these elements interact to better ensure quality patient care, from education to practice.

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Chapter Highlights

1. The evolution of nursing education influences how nursing is taught.
2. There is a need to improve nursing education to better meet patient care needs.
3. Different levels of nursing prelicensure education have different competencies and expectations, yet nurses at all levels take the same licensure examination.
4. Accreditation of nursing programs ensures quality education.
5. Licensure and the regulation of nursing practice set standards and rules for nursing education.
6. Examples of critical concerns related to education, regulation, and practice are compact licensure, mandatory overtime, and global migration of nurses.

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Discussion Questions

1. Why do you think it is important that nursing now emphasizes education over training? Consider Donahue's definitions for education and training found in the chapter.
2. Compare and contrast the types of entry programs in nursing: diploma, ADN, BSN, and accelerated or direct entry programs.
3. Select one of the following graduate nursing programs (master's—any type; DNP or PhD) and find, through the Internet, two different universities that offer the program. Compare and contrast admission requirements and the curricula.
4. Visit the NCLEX website (https://www.ncsbn.org/nclex.htm). Review the "Candidates" section and describe the exam process and what happens on exam day. Go to https://www.ncsbn.org/1287.htm and review the current NCLEX-RN detailed test plan for candidates. Which type of information is included in the plan? How might this information help you, both now and closer to the time when you take the NCLEX?
5. Does your state participate in the nurse licensure compact? Visit https://www.ncsbn.org/158.htm to find out. Why might this be important to you when you become licensed in your state after graduation?

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Critical Thinking Activities

1. Conduct a debate in class with one other classmate. Take the side of diploma, associate degree, or both levels of entry into practice, with the other classmate supporting the BSN as the entry into practice level. The class should then vote on the side that presents the best support for one of the perspectives. You will need to research your issue and present a substantiated rationale for your side of the issue.
2. Conduct a debate in class with one other classmate. Take the side supporting the PhD in nursing, with the other classmate supporting the DNP. The class should then vote on the side that presents the best support for one of the perspectives. You will need to research your issue and present a substantiated rationale for your side of the issue.

ELECTRONIC *Reflection Journal*

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The NLN published an article discussing the future of nursing education (by Heller, Oros, and Durney-Crowley; the article can be accessed at http://www.nln.org/nlnjournal/infotrends.htm). Ten trends are discussed in this article. Review the trends, which are all associated with healthcare delivery, and then consider their implications for nursing. In your self-reflection activity for this chapter, describe what you think about each one. Save this reflection and return to it at the end of your nursing program. Then save it and check it again in 5 and 10 years: Were the predictions right? What has changed?

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Linking to the Internet

- American Academy of Nurse Practitioners (AANP): http://www.aanp.org
- American Association of Colleges of Nursing (AACN): http://www.aacn.nche.edu
- American Association of Nurse Anesthetists (AANA): http://www.aana.com/
- American College of Nurse Midwives: http://www.midwife.org
- American Nurses Association (ANA): http://nursingworld.org
- Commission on Graduates of Foreign Nursing Schools (CGFNS): http://www.cgfns.org
- National Association of Clinical Nurse Specialists (NACNS): http://www.nacns.org
- National Council of State Boards of Nursing (NCSBN): http://www.ncsbn.org
- National Council of State Boards of Nursing, NCLEX Exam: https://www.ncsbn.org/nclex.htm
- National League for Nursing (NLN), National Council of State Boards of Nursing Residency Program: https://www.ncsbn.org/441.htm

CASE STUDIES

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Case Study 1

The Student Nurses' Association (SNA) executive committee in your school is meeting to plan a program for the membership. A lively discussion is going on to select the topic. One board member mentions the need to have a program about nursing education accreditation because the school will have an accreditation survey visit next semester. The SNA chapter president speaks up and says, "Many of us are getting ready to take NCLEX, and we have many questions about licensure." Both of these topics are important topics. Consider the questions that follow.

Case Questions

1. Which topic would you choose and why?
2. If someone said to you, "Accreditation is the business of the faculty," what would you say?
3. Which type of content might you include in the content for a program on accreditation and a program on licensure for your membership?
4. What are the short-term and long-term issues related to licensure that would be important to consider by every nurse?

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CASE STUDIES (CONTINUED)

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Case Study 2

Nursing education and the profession in general have experienced a very long disagreement about the appropriate entry-level degree for nursing. This debate first emerged in 1965, as noted in this chapter. In addition, studies supporting the BSN as the entry-level degree have been identified by authors such as by Kutney-Lee, Sloane, and Aiken (2013). A response was made to this study by Cynthia Maskey, PhD, RN, CNE, in the March 2013 issue of *Health Affairs*. Dr. Maskey also is quoted on the N-OADN website, and she is an N-OADN board member. The following are her comments:

> At a point in time when national nursing leaders in both education and practice are working together to support and recognize the contributions of nurses at all educational levels, Dr. Aiken and her colleagues are releasing a study that is focused on problems rather than solutions. True leaders in nursing are focused on the future by encouraging their nursing colleagues to practice to the full extent of their education to improve the care of patients. Nursing leaders assist their colleagues in education and practice to achieve higher levels of education through deliberative academic progression, as was set forth in the report from the Institute of Medicine referenced by Dr. Aiken and her colleagues. The authors' focus on nursing education level as the single variable related to surgical patient mortality is too simplistic within Pennsylvania's complex health care delivery system, but it is also divisive within the nursing community. This study—conducted in a single state using a retrospective design with the admitted underlying assumptions with only two data collection points and selected nursing variables—asks the reader to concur that the researchers chose an accurate research model and did not omit or were able to control for all other intervening variables. This reader is left with questions related to the variables of surgeon qualifications, patient comorbidities, and overall hospital quality standards, among others. This is a retrospective, two-panel study with many intervening variables for which no statistical procedures can control within the complexity of the health care environment.
>
> This particular study design does not support the conclusion of causation between educational level and patient mortality and regretfully resurrects old debates at a time when nurse leaders needs to be focused on collaboration, innovation, and academic progression at all levels. It is antithetical to the spirit and intent of the Institute of Medicine report, which is to advance a highly proficient, well-educated nursing workforce from associate degree and baccalaureate programs, with the goal of exceptional patient outcomes. (National Organization for Associate Degree Nursing, 2013)

Go to the website for *Health Affairs* at http://content.healthaffairs.org/content/32/3/579/reply#healthaff_el_476350 to read the full debate.

Case Questions

After reading these articles, consider the following questions.

1. What is your view of the entry-level disagreement?
2. Does it surprise you that this issue is a cause for disagreement? If so, why does it surprise you?
3. What is your opinion of the response from the ADN perspective?
4. What are the possible negative results from such a disagreement in the profession?

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Words of Wisdom

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Nursing school taught me essential clinical skills to care for clients as an LPN. At this level of education, we are taught how to give quality health care. I decided to continue my education in an LPN-BSN program to learn in more depth about why things are done a certain way. I was delighted to learn this program focuses on holistic care as well as the leadership skills needed to work effectively as a team. It is imperative to function as a team when caring for members of the community. The healthcare field is constantly changing. We as nurses must strive to reach our full potential to keep up with these changes. Nursing is an exciting and rewarding field with new things to learn every day.

My Journey from LPN to BSN

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Student in LPN-to-BSN Program

During LPN school, I felt at times if I could just survive the year, that was as far as I cared to excel in my nursing education. After my first year working as an LPN on a medical/surgical unit, I realized the importance of continuing to the RN level, but was uncertain whether to go for my AD [associate degree] or BSN. The University of Oklahoma College of Nursing LPN-BSN program allows me to obtain my BSN in about the same time frame as the local associate degree program. I believe the more credentialed a nurse is, the more employable, and the more amplified the nurse's voice becomes when areas in the workplace perhaps need to be changed/modified. It was not an easy decision, because most LPNs choose the local ADN program, and I was intimidated about stepping out on my own. (It did not help that a local college counselor tried to discourage me and told me, "You're flying by the seat of your pants.") Thanks to the kind words and encouragement from another LPN in this program, my decision was made, and I have absolutely loved the LPN-BSN program. The most awesome thing about being a nurse is the fact that going to work does not feel like a burden, but more like a privilege that has been entrusted to me. The only downside to nursing is the nursing shortage, which can affect quality of time spent in patient care.

Lessons Learned the Hard Way

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Professor

University of Oklahoma College of Nursing

Member of the Oklahoma Board of Nursing

1. **The license belongs to me (the nurse) to safeguard … not to the doctor or the supervisor or the RN.**

I've learned that this is a difficult concept for some people to acknowledge. New graduates, those individuals who are quick to try to shift responsibility to others, and those individuals who don't think critically but simply react reflexively to an order have particular difficulty with this idea.

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Words of Wisdom (*continued*)

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Example: A new nurse practitioner, educated in Texas, took her first position in a hospital in Oklahoma. The nurse practitioner was told by a physician that she did not need a Drug Enforcement Agency number for prescribing narcotics. Since he was her supervising physician, he said his Drug Enforcement Agency number would cover her. She didn't bother to check Oklahoma law regarding prescriptive authority. As a result, this nurse was required to take a course in nursing jurisprudence, a course in critical thinking, and a course in roles and responsibilities in prescribing controlled and dangerous substances, and pay a fine; she also received a reprimand in her file at the board of nursing.

2. Use equipment as the manufacturer intended it to be used.

"Necessity is the mother of invention" is a great saying if you're out of buttermilk for your cake and substitute whole milk with a little vinegar because you have both of these on hand. Invention is not always good in a hospital setting.

Example: A nurse mistakenly attached a nasogastric tube feeding of Crucial to a patient's triple-lumen, peripherally inserted central venous catheter. When the supervisor asked how this could possibly happen when feeding tubing is specifically designed not to fit into vascular tubing, three important errors were discovered: (1) The nurse was hanging a feeding prepared by a second nurse. The second nurse could not find any feeding tubing, so to save time and avoid delaying the patient's feeding, she substituted IV tubing in the tube feeding setup. (2) The first nurse did not know what Crucial was. (3) The first nurse did not check the orders or ask for clarification, but simply went in and attached the tubing to patient. Thereafter, the patient died.

3. The function of the board of nursing is to protect the public, not to protect the nurse.

This is perhaps one of the most difficult lessons a nurse who is serving on the board of nursing has to learn. Too often after hearing a case, the "nurse's cap" takes over and the board member begins to rationalize the nurse's actions—maybe the shift was extremely busy, maybe there were lots of new admissions that night, maybe the staffing was short, or maybe there were two critical patients down the hall. We're all too familiar with the many possibilities. But the bottom line is that each and every patient deserves and must be assured of receiving the best possible nursing care. This is one of the major criteria of a profession—that the members regulate their own. The public trusts us to carry out this monitoring and take corrective actions when patient safety is violated. I don't think all nurses really appreciate this fact.

Example: A nurse was caring for a patient with diabetes in a long-term care facility. She obtained finger stick blood sugar readings as follows: at 8:30 p.m. it was 535; at 8:45 p.m. it was 539; and at 9:15 p.m.it was 542. At 9:30 p.m., she reported the patient's status to one of the oncoming nurses. At 10:30 p.m., the blood sugar reading was 39. An ambulance was called, the nursing director was notified, and the patient was taken to the hospital and later died of hypoglycemic shock. The nurse responded that the wrong time was noted on the chart because the clock on the wall was 1 hour off. She indicated she had given the patient orange juice and sugar but didn't have the patient's chart with her, so she didn't write it down. The nurse surrendered her license and received a fine.

(*continues*)

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Words of Wisdom (*continued*)

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4. It's great to be a patient advocate, but advocacy has to be done according to protocol.

There's a right way to do things, and there's a wrong way to do things. All nursing students learn early in their nursing school days that an important role of the nurse is to be a patient advocate. No nurse would deny this critical role. However, how to go about being an advocate is not often made clear. It's important to remember that there is a chain of command in reporting to follow, and there are facility policies and procedures to which the nurse must adhere or go through the proper steps to change. In an effort to take action as quickly as possible on the patient's behalf, these steps are often brushed aside for the nobler goal. When something goes wrong in the process, the nurse often finds herself out on a limb with no legal defense.

Example: A nurse working in a nursing home discovered gross neglect regarding wound care a particular patient was receiving. She discussed this situation with her supervisor, who commented that he remembered a similar case when he was in nursing school. The solution in that case had been to irrigate the decubitus ulcer with hydrogen peroxide (a wound care practice no longer recommended).

After 2 days off, the nurse returned on the night shift to find the patient decubitus in even worse shape. She decided to irrigate the ulcer with hydrogen peroxide without a physician order and in the process found bits of old dressing deep within the wound. Outraged with this discovery, the nurse first called the physician to report the situation. Receiving no response from the doctor, she next called the patient's family and told them they needed to have the patient transferred to another facility right away. The daughter of the patient had the patient transferred in the middle of the night. The next morning, the physician was very disturbed the patient had been transferred and filed a complaint with the facility against the nurse for failing to follow facility protocol regarding patient transfer.

The facts and circumstances in all the previous examples have been changed and do not reflect exact cases heard by the board. Every case must be examined to determine what, if any, violation of the nursing practice act occurred and what discipline should or should not be imposed.

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