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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.
- Critique examples of methods used to better ensure quality and excellence in nursing education.
- Discuss critical problems in nursing education.
- Examine the need to transform nursing education and possible methods to do so.
- Examine the implications of interprofessional healthcare education.
- Discuss the importance of regulation and critical issues related to the nursing profession.

CHAPTER OUTLINE

- Introduction
- Nursing Education
    - A Brief History of Nursing Education
    - Major Nursing Reports: Improving Nursing Education
    - Entry into Practice: A Long Debate
    - Differentiated Nursing Practice
- Types of Nursing Education Programs
    - Diploma Schools of Nursing
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- Nursing Education Associations
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    - NLN Excellence in Nursing Education
    - Focus on Competencies
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        - Didactic or Theory Content
        - Practicum or Clinical Experience
        - Distance Education

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- Accreditation of Nursing Education Programs
- Critical Nursing Education Problems
  - Faculty Shortage
  - Access to Clinical Experiences
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  - Transforming Nursing Education
  - Interprofessional Healthcare Education
- 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
  - Nurse Licensure Compact
  - Mandatory Overtime
  - Foreign Nursing Graduates: Entrance to Practice in the United States
  - Global Health Regulatory Issues
- Chapter Highlights
- Engaging in the Content
- Discussion Questions
- Critical Thinking Activities
- Electronic Reflection Journal
- Case Studies
- Working Backward to Develop a Case
- References

KEY TERMS

Academic health center
Academic nursing
Accelerated program
Accreditation
Advanced practice registered nurse
Apprenticeship
Articulation agreement
Associate degree in nursing
Baccalaureate degree in nursing
Clinical experiences
Continuing education
Curriculum
Differentiated practice
Diploma schools of nursing
Direct entry program
Distance education
Doctor of nursing practice
Education
Master's degree in nursing
Nurse licensure compact
Nurse migration
Nurse practice act
Practicum
Preceptor
Prescriptive authority
Regulation
RN-BSN
Research-based doctorate
Self-directed learning
Standard
Training

Introduction

This chapter focuses on three critical concerns in the nursing profession: (1) nursing education, (2) quality of nursing education, and (3) regulatory issues such as licensure. These concerns are interrelated because they change, are dependent on each other (for example, graduating from an accredited program is required for licensure), and require regular 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

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consensus policy statement in 2010 following Congress's passage of the Patient Protection and Affordable Care Act (ACA). This demonstrates the engagement of the nursing professional in health policy and its collaborative efforts with other healthcare professionals. 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). This statement is in line with the Institute of Medicine (IOM, 2003) recommendations for healthcare professions education. **Figure 3-1** highlights the components of the education-to-practice process.

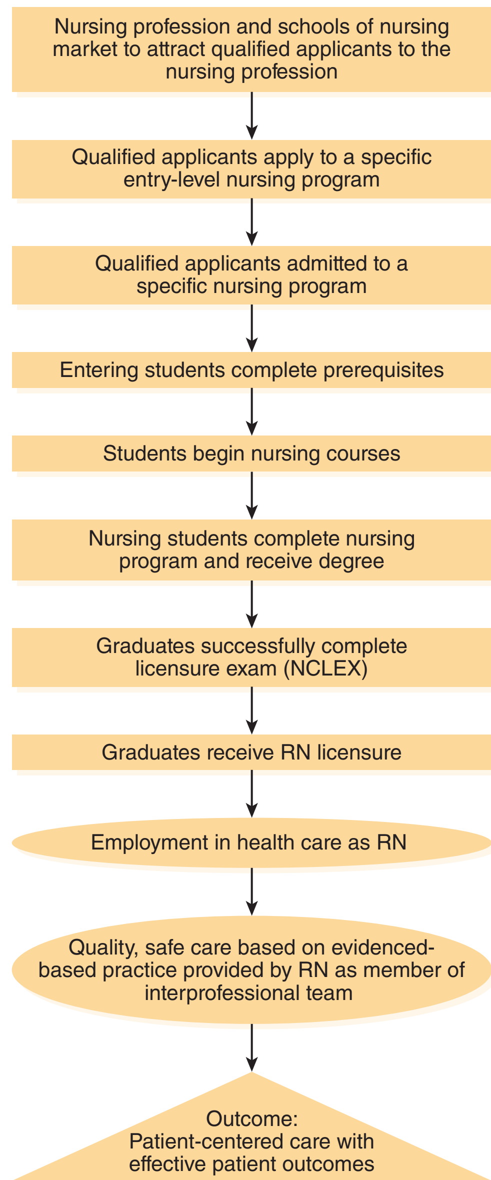

Figure 3-1 From Education to Practice

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 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, education quality issues, and current issues and trends.

Data from 2014 indicate that nursing students represent more than half of all healthcare professionals (American Association of Colleges of Nursing [AACN], 2015a). The number of students enrolling in all levels of nursing programs increased in 2014: 4.2% increase in entry-level baccalaureate programs (BSN); 10.4% increase in RN-BSN programs (degree completion programs); 6.6% increase in master's programs; 3.2% in research-focused (PhD); and 26.2% practice-focused (DNP) doctoral

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programs. There was also an increase in RN-BSN program enrollment and graduates, which is very positive, supporting *The future of nursing* report recommendation to increase the proportion of RNs with baccalaureate degrees to 80% by 2010 (IOM, 2010), but the goal has not yet been reached though there has been improvement. As of 2014, 55% of registered nurses held a BSN (AACN, 2015a).

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. Data from the AACN 2014 survey of 816 schools of nursing indicate that 68,936 qualified applicants could not enroll in entry-level baccalaureate programs and 15,288 to master's and doctoral programs (AACN, 2015a). Over the past few years, the common reasons for programs turning away students have been insufficient clinical sites, lack of qualified faculty, limited classroom space, insufficient preceptors, and budget cuts. The percentage of minorities enrolling in such programs has increased (AACN, 2015a). Nursing students from minority backgrounds increased in 2014: 30.1% of students in entry-level baccalaureate programs, 31.9% in master's programs, 29.7% in research-focused doctoral programs (PhD), and 28.7% in practice-focused doctoral programs (DNP). RN workforce diversity, nurses who are working (2014 AACN data), however, continues to be a problem, though it is slowly improving: 73% White, 11% African American, 9% Asian, 7% Hispanic, and 1% other (Robert Wood Johnson Foundation [RWJF], 2016).

This snapshot of data indicates that there has been improvement in the number of applicants to the various nursing degree programs, in enrollment rates, and in student diversity, but much work remains to reach the desired levels so as to meet the needs of the healthcare delivery system for qualified nurses. Reported data are typically behind the current year, and the AACN website periodically provides updated data as does the NLN.

A Brief History of Nursing Education

It is impossible to discuss the history of nursing education without reflecting on the history of the profession and the history of health care, as discussed in other chapters—all three are interconnected.

A key historical nursing leader was Florence Nightingale. She changed not only the practice of nursing, but also nurses' **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, and **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 knowledge 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 situation for healing. To improve care, she devoted her energies to upgrading nursing education, placing less focus on on-the-job training and more focus on a structured educational program of study, creating a nurse training school. This training school and those that quickly followed also became a source of cheap labor for hospitals. Students were provided

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with some formal nursing education, but they also worked long hours in the hospitals and were the largest staff source. The apprenticeship model 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 or hospital schools of nursing.

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. Over time, 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 from one another, and there were concerns about the lack of standardized quality 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 (*Nursing and nursing education in the United States*), the first of several major reports about U.S. nursing education. This report included the following key points, which provide a view of some of the common concerns about nursing education in the early 1900s (Goldmark, 1923):

- Hospitals controlled the total education hours, offering minimal content and, in some cases, no content even when that content was needed.
- Inexperienced instructors with few teaching resources often taught science, theory, and practice of nursing.
- Graduate nurses had limited experience and time to assist the students in their learning supervised students.
- 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 experiences 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) separate university schools of nursing from hospitals (this represented only a minority of the schools of nursing); (2) change the control of hospital-based programs to schools of nursing; and (3) require a high school diploma for entry into any school of nursing. These recommendations represented suggestions for major improvements in nursing education. New schools opened based on the Goldmark recommendations, such as Yale University (New Haven, Connecticut) and Case Western Reserve University (Cleveland, Ohio).

In 1948, the Brown report was also critical of the quality of nursing education (Brown, 1948). This led to the implementation of an accreditation program for nursing schools, which was conducted by the NLN. **Accreditation** is a process of reviewing what a school is doing and its curriculum based on established standards. Movement toward the university setting and away from hospital-based schools of nursing and establishment of standards with an accreditation process were major changes for the nursing profession. The ANA and the NLN continue to establish standards for practice and education and to support implementation of those standards. In addition, the AACN developed a

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nursing education accreditation process, as discussed later in this chapter. Changes were made, but slowly. The NLN started developing and implementing standards for schools, but it took more than 20 years to accomplish this mission.

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 should be better prepared to use clinical reasoning and judgment and understand the trajectory of illness. To meet the recommendations of this landmark report, nursing education must make major changes and improvements. **Exhibit 3-1** describes the report's recommendations.

The most recent report on the nursing profession, published by the IOM (2010), *The future of nursing: Leading change, advancing health*, delineates 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, act as full partners in healthcare delivery, and be involved in policy making especially as it relates to the healthcare workforce. This report, along with the report by Benner and colleagues (2010), is transforming nursing's role in health care and calling for radical changes in nursing education. In late 2015, a progress report was published to assess the current status of *The future of nursing* recommendations (National Academy of Medicine, 2015). This report is discussed further in other chapters; however, it is important to note in this discussion about nursing education, accreditation, and regulation that many of the recommendations require more work. For example, the recommendation to double the number of doctoral degrees by 2020 was not progressing as of 2015 in a manner expected to reach this objective.

Entry into Practice: A Long 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 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 NLN and the ANA made strong statements endorsing college-based nursing education as the entry point into the profession. In 1965, the ANA 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). It was an emotional issue, and even today it continues to be a tense topic because it has not been fully resolved, although stronger statements were made

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Exhibit 3-1 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.

Data from Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses. A call for radical transformation*. San Francisco, CA: Jossey-Bass.

in 2010 to change to a baccalaureate entry level (Benner, Sutphen, Leonard, & Day, 2010; IOM, 2010). Since 1965, however, there have been many changes in the educational preparation of nurses:

- The number of diploma schools have gradually decreased, but they still exist.
- The number of associate degree in nursing (ADN) programs has increased. However, there was, and continues to be, concern over the potential development of a two-level nursing system—ADN and baccalaureate degree in nursing (BSN)—with one viewed

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as technical and the other as professional. In fact, this did not happen. ADN programs continue to increase, and there has been no change in licensure for any of the nursing programs—graduates of all RN pre-licensure programs continue to take the same exam and receive the same license.

- BSN programs continue to grow but still have not outpaced ADN programs, though there has been some decrease in ADN programs.

Differentiated Nursing Practice

Another issue related to entry into practice is differentiated nursing practice. **Differentiated practice** is not a new idea; it has been discussed in the literature since the 1990s. It 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 [patients] with the varying abilities of nursing practitioners" (AONE, 1990, as cited in Hutchins, 1994, p. 52).

How does this actually work in practice? Does a clinical setting distinguish among RNs who have a diploma, associate degree, and BSN degree? Does this affect 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, and many do not necessarily note other degrees such as the BSN. 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. A difference in salaries due to degrees is the highest level of recognition, and this is done in some healthcare organizations.

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 (now known as the Organization for Associate Degree Nursing or 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

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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 done in 1999 and then the data used in this 2010 study, included 8,611 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 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, Sutphen, Leonard, & Day, 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 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 a patient dying within 30 days of admission by 7%; in contrast, every 10% increase in the number of nurses with baccalaureate degrees was associated with a 7% decrease in the likelihood of a patient dying within 30 days of admission. These associations imply that patients receiving care in hospitals in which 60% of nurses had baccalaureate degrees and nurses cared for an average of six patients would have almost a 30% lower mortality than patients in hospitals in which only 30% of nurses had baccalaureate degrees and nurses cared for an average of eight patients. The results indicate 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, many more hospitals have implemented initiatives to hire only RNs with BSN degrees and to encourage staff members without a BSN degree to return to school. Studies such as the ones mentioned here have had an impact on increasing hospital support for RNs with BSN degrees. This decision by hospitals, however, is highly dependent on the availability of RNs with the BSN degree in the local area and has also been influenced by the Magnet Recognition Program®, which supports the BSN degree as a requirement for initial practice, though it does make this a requirement to receive Magnet recognition.

Stop and Consider #1

The nursing degree required for entry into practice continues to be a problem.

Types of Nursing *Education Programs*

Nursing is a profession with a complex education pattern: It has many different entry-level pathways to the same license to practice 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.

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Diploma Schools of Nursing

Diploma schools of nursing still exist, now representing less than 10% of all entry-level nursing programs. Many of these programs have transitioned to other types of degree programs—for example, by forming 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 and baccalaureate programs, and some have partnered with ADN and BSN programs. These programs still interest some employers when they are short of staff 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. The students, however, typically have fewer prerequisites, particularly in liberal arts and sciences, though they do have some science content. Curricula requirements may vary in these schools because some schools allow students to 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). The first programs opened in 1958. At the time Montag created her proposal, the United States was experiencing a shortage of nurses. For students, ADN programs are less expensive and shorter. The percentages of ADN and BSN programs vary from state to state—for example, in California, 61% of RNs completed a BSN or higher degree; however, more than half the students entering nursing are still doing so in ADN programs (RWJF, 2015). The big difference is the increase in RN-BSN programs pushing the number of nurses with a BSN up. In 2014, there were 67 diploma programs and 1,092 ADN programs identified in the NLN Survey of Schools of Nursing (NLN, 2014). From 2005 to 2014, the NLN data indicate there was a slight fluctuation in the data for these two programs. Associate degree programs are accredited by the NLN's accrediting services. The ADN curriculum includes some liberal art and science courses at the community college level and focuses more on technical nursing. Graduates take the same licensing exam as graduates from all other pre-licensure 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, but this perception has since changed, with the degree now typically viewed as part of a career mobility path. The **RN-BSN** or BSN completion programs are a way for ADN graduates to complete the requirements for a BSN. There are also LPN-ADN and LPN-BSN programs to assist staff in their career paths. Typically, in all of these programs, nurses work for a time and then go back to school, often on a part-time basis, to complete a BSN in a university-level program. Some prerequisite courses must be taken before these students enter most BSN programs. Examples of additional nursing courses these students may take in the RN-BSN program 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; however, all programs accredited by AACN must now include **clinical experiences** or a **practicum**. The Commission on Collegiate Nursing Education (CCNE, 2013), accrediting body for the AACN, defines *clinical practice experiences* as "planned learning activities in nursing practice that allow students to understand, perform, and refine professional

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competencies at the appropriate program level" (p. 21). The content typically included for the clinical experience is public/community health, focusing on what these students typically do not cover in an ADN program. Today, many of the RN-BSN programs offer courses online. The type of clinical experiences can vary greatly; however, not having any clinical experiences in a RN-BSN program may be a problem for students who want to continue on to a graduate degree.

Greater efforts are now 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 to participate in a RN-BSN program, they are expected to maintain an active registered nurse license. ADN and BSN programs have increased their efforts to partner with each other to provide a seamless transition from one program to the other. Establishing an **articulation agreement** describing the responsibilities of the partners, benefits to the students, and how the students will meet the expected BSN outcomes or competencies clarifies these partnerships. "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). Academic progression supports "life long learning through the attainment of academic credentials" (Organization for Associate Degree Nursing & American Nurses Association, 2015, p. 5). State law may mandate these agreements, which may be partnerships between individual schools or may be part of statewide articulation plans to facilitate more efficient transfer of credits. Typically, in these partnerships, students spend their first 2 years in the ADN program and then complete the last 2 years of the BSN degree in the partner BSN 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 for the first 2 years students pay the community college fees, which are less costly than the university fees. Another advantage is if there is no BSN program in a community students have the option of staying within their own community while they pursue a nursing degree and then transition to a more distant BSN program or complete the BSN online.

Baccalaureate Degree in Nursing

The idea for the **BSN**, an entry-level degree, 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 focused on liberal arts and sciences courses, followed by 3 years in nursing courses. Most BSN programs have changed to a 4-year model, with various configurations of liberal arts and sciences and then 2 years in nursing courses. 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 formally admitted to the school/college 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.) The licensure exam is taken after successful completion of the BSN program. A BSN is required for admission to a nursing graduate program, and this has influenced more nurses to return to school to get a BSN degree.

The movement of many nursing schools into the university setting was not all positive. Nursing programs lost their strong connection with hospitals. Rather than establish different educational models

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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 an impact on clinical experiences, in some cases limiting effective clinical learning.

Master's Degree in Nursing

Graduate education and the evolution of the **master's degree in nursing (MSN)** have a long history. Early in the development of graduate-level nursing, it was called postgraduate education, and the typical focus areas were public health, teaching, supervision, and a few 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 and developed new models. 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 basic entry-level nursing content but with an accelerated approach. These students are typically categorized as graduate students because of their previous degree even though the degree is not in nursing. Even so, they must complete pre-licensure BSN requirements, including successful completion of the licensure exam before they can take nursing graduate clinical courses, and in some cases, they are not admitted to the nursing graduate program automatically until completion of a direct entry program. They must apply to the program in same manner as any student who wants to attend a graduate program in nursing.

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. The following are examples of master's degree programs:

- *Advanced practice registered nurse (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 registered 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 has been a master's degree and is not offered at all colleges of nursing. 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 master's-level programs must transition to entry-level DNP programs by 2022, and thereafter, all new programs must be entry-level DNP programs. The data indicate that the programs are rapidly moving in this direction. As of December 2016, 53 programs have been approved for

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entry-level doctoral degrees; 27 programs offer post-master's doctoral degree completion programs for CRNAs; and 63 programs remain to be approved for entry-level doctoral degrees by the deadline of January 1, 2022 (Council on Accreditation, 2017).

- *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 serves as a nurse leader and 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, and advocates for patients (AACN, 2013). Certification is available for CNLs.
- *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; then, if the nurse successfully completes the NLN certification exam, the nurse is then a certified nurse educator. This provides the nurse with additional background and experience in nursing education.

Research-Based Doctoral Degree in Nursing

The doctoral degree (doctor of philosophy—PhD) (**research-based doctorate**) in nursing has had a complicated development history. The doctorate of nursing science (DNSc) was first offered in 1960, but this degree program has since transitioned to other types of doctoral programs. There were PhD programs in nursing education as early as 1924, and New York University started the first PhD program in nursing in 1953. Today, not enough students are entering these programs, and this has an impact on nursing faculty because schools of nursing want faculty with doctoral degrees. Someone with a PhD is not always required to teach but is encouraged to do so. Nurses with PhDs usually are involved in research, 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 academic doctoral work in the same way that an English professor with a doctorate is called "doctor."

Some schools of nursing now offer BSN-PhD or BSN-DNP options. This means the student does not have to obtain a master's degree prior to entering the program, and the students typically enter the process as BSN students and complete with a PhD or DNP degree. The goal is to increase the number of nurses with doctoral degrees (terminal degree) by encouraging nursing students to make this career decision early.

Doctor of Nursing Practice

The DNP is the newest nursing degree. The DNP is not a traditional PhD program, although nurses

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with a DNP degree are also called "doctor." However, this does 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. The ANCC defines *advanced nursing practice* as "any form of nursing intervention that influences outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and health organizations, and the development and implementation of health policy" (AACN, 2015b, p. 11). This description is important due to transition of the requirement of master's programs for APRNs to the DNP degree. APRN refers to the nursing role for a nurse who meets certain qualifications; some refer to this also as advanced practice nurse.

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 clinical nurse specialists, certified registered nurse anesthetists, certified nurse–midwifes, and nurse practitioners. This means that by 2015—a date identified by the AACN—and by 2022—a date identified by the American Association of Nurse Anesthetists—APRNs would be required to have a DNP degree or an entry-level DNP for advanced practice nursing. As of 2017 much more needs to be done to meet this 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 degree. As of April 2016, there are 289 DNP programs, with 128 in the planning stages; 62 are post-baccalaureate and 66 are post-master's programs (AACN, 2016a). Our healthcare system and healthcare service needs demand the highest level of scientific knowledge and expertise for quality care. The change is based on "the rapid expansion of knowledge underlying practice; increased complexity of patient care; national concerns about the quality of care and patient safety; shortages of nursing personnel which demands a higher level of preparation for leaders who can design and assess care; shortages of doctoral-prepared nursing faculty; and increasing educational expectations for the preparation of other members of the healthcare team" (AACN, 2016a, p. 1).

Because the DNP is a relatively new degree and has led to the development of new roles, 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 et al., 2011); others have questioned it because there is need for nurses with research-focused degrees (PhDs). There is concern that nurses who might have once considered pursuing a PhD would instead seek a DNP; indeed, data indicate that there is now greater enrollment in DNP programs, so this prediction has proven correct.

Stop and Consider #2

We have confusion when it comes to our prelicensure degree programs.

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 OADN.

National League for Nursing

The NLN is an older organization than the AACN. It "promotes excellence in nursing education to build

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a strong and diverse nursing workforce to advance the health of our nation and the global community," and the NLN's goals are as follows (NLN, 2017a):

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

The NLN represents several types of registered nurse programs (diploma, ADN, BSN, master's) and vocational/practical nurse programs. Accreditation of nursing education programs 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 baccalaureate and graduate programs in nursing, including doctoral programs. 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 2017–2019 are as follows: (1) The AACN is the driving force for innovation and excellence in academic nursing; (2) the AACN is a leading partner in advancing improvements in health, health care, and higher education; (3) the AACN is a primary advocate for advancing diversity and inclusivity within academic nursing; and (4) the AACN is the authoritative source of knowledge to advance academic nursing through information (AACN, 2017). The organization also offers accreditation of baccalaureate and master's degree nursing programs as described in another section in this chapter.

Organization for Associate Degree Nursing

The Organization for Associate Degree Nursing (OADN) began in 1984 after Mildred Montag proposed the ADN degree in 1952. The OADN, formerly known as N-OADN, is the organization that advocates for associate degree nursing education and practice. Its major goals are as follows (OADN, 2017):

- *Education:* Advance associate degree nursing education.
- *Leadership:* Develop leadership within associate degree nursing to create meaningful change.
- *Inclusivity:* Foster an environment in associate degree nursing that advances inclusivity.
- *Collaboration:* Further associate degree nursing education through collaboration with a diverse group of stakeholders.
- *Advocacy:* Advocate for associate degree nursing as it relates to the delivery of quality health care.

The organization supports academic progression of its graduates so that they can reach their potential. The organization does not offer accreditation services. Accreditation of ADN programs is done through the NLN accrediting organization (CNEA).

Stop and Consider #3

We have three nursing education organizations; maybe due to the confusion over our degree programs.

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Quality and Excellence in *Nursing Education*

There is greater emphasis today on quality health care, as discussed in this text, but also, for us to have quality care, we need to have healthcare providers who meet standards for quality performance. This requires us to consider the quality of our nursing education programs.

Nursing Education Standards

Nursing education standards are developed by the major nursing professional organizations that focus on education: NLN, AACN, and OADN. The accrediting bodies of the NLN and the AACN also set nursing education 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). The baccalaureate *Essentials* emphasizes the three roles of the baccalaureate generalist nurse: provider of care; designer/manager/coordinator of care; and member of a profession, which includes advocating for the patient and profession by applying the *Essential* standards. These standards include student learning outcomes expected for nursing pre-licensure graduates related to the following topical areas and associated percentage of the outcomes: 25% nursing across the lifespan, 25% professional identity/communication, 25% leadership, 13% population health, and 12% evidence-based practice/quality improvement (Godfrey & Martin, 2016). These authors also note, "in today's healthcare environment, nurses must be able to not only deliver care but also intentionally design care, assign care, and supervise others who provide care. To achieve desired patient outcomes, nurses must be proficient in understanding how to establish and maintain healthy work environments; use research-based knowledge to adjust their standards of practice; collect, interpret, and recommend changes to care on the use of established quality improvement" (2016, p. 396). In addition, as noted in the outcome categories, there is need for community understanding and focus and inclusion of systems at all levels and professional input through professional organizations.

NLN Excellence in Nursing Education

The NLN Hallmarks of Excellence© identifies 30 hallmarks or indicators, which are posed as questions focusing on students, faculty, continuous quality improvement, curriculum, teaching/learning evaluation strategies, resources, innovation, educational research, environment, and leadership (NLN, 2017c). These indicators are applied in two of its programs that recognize excellence.

The NLN 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, 2017d). These schools make a commitment to pursue excellence in (1) student learning and professional development, (2) development of faculty expertise in pedagogy, and/or (3) advancing the science of nursing education. The award is given to a school or college of nursing—not a program within a school—and remains in effect for 3 years. After this period, the school must be reviewed again to retain the Center of Excellence recognition. This NLN initiative is an excellent example of efforts to improve nursing education.

Another NLN initiative to recognize excellence is the Academy of Nursing Education. The

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purpose of the Academy of Nursing Education is to "foster excellence in nursing education by recognizing and capitalizing on the wisdom of outstanding individuals in and outside the profession who have contributed to nursing education in sustained and significant ways" (NLN, 2017d). It selects nurse educator fellows that demonstrate significant 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 continue to provide visionary leadership in nursing education and in the academy (NLN, 2017d, 2017e). It inducted its first nurse education fellows in 2007, and continues to do so annually.

Focus on Competencies

In 2003, the IOM published the *Health Professions Education* report to address the need for education in all major health professions describing critical common competencies. 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 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 on improving quality, or new technologies" (IOM, 2001, as cited in IOM, 2003, p. 1). The core competencies are 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.

The nursing curriculum should identify the competencies expected of students throughout the nursing program. There is greater emphasis today on implementing healthcare professions competencies, particularly the core competencies for all healthcare professions: (1) provide patient-centered care, (2) work in interdisciplinary/interprofessional 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, such as the Quality and Safety Education for Nurses (QSEN, 2017) competencies, but rather recognizes the existence of basic competencies that all healthcare professions should demonstrate. See **Table 3-1** comparing the core competencies and QSEN competencies.

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 (2015) defines *competency* 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" (p. 86). 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 who can provide quality care.

Curriculum

A nursing program's **curriculum** is the plan that describes the program's philosophy, levels, student

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Table 3-1 Comparing the Five Healthcare Professions Core Competencies and the QSEN Competencies for Nurses

Healthcare Professions Core Competencies*	QSEN Competencies for Nurses**
Provide patient-centered care.	Patient-centered care: knowledge, skills, attitudes
Work on interdisciplinary [interprofessional] teams.	Teamwork and collaboration: knowledge, skills, attitudes
Employ evidence-based practice.	Evidence-based practice: knowledge, attitudes, skills
Apply quality improvement.	Quality improvement: knowledge, skills, attitudes
Utilize informatics.	Safety: knowledge, skills, attitudes
	Informatics: knowledge, skills, attitudes

Data from *Institute of Medicine (IOM). (2003). *Health Professions Education. A Bridge to Quality*. Washington, DC: The National Academies Press;

**QSEN Institute (2015). *Pre-licensure competencies.* Retrieved from http://qsen.org/competencies/pre-licensure-ksas/ and graduate level competencies retrieved from http://qsen.org/competencies/graduate-ksas/

terminal competencies (outcomes or what students 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; in some cases in online format) 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 nursing 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 curricula of schools of nursing in their state. To keep current, faculty need to review the curriculum regularly, in a manner that allows changes to be made as easily and quickly as possible and includes student input. Standards for nursing education accreditation also have an impact on the curriculum; for example, *The essentials of baccalaureate education for professional nursing practice* provides guidelines for baccalaureate curricula (AACN, 2008).

Didactic or Theory Content

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

- Professional issues and trends
- Health assessment
- Pharmacology
- Adult health or medical–surgical nursing
- Psychiatric/mental health nursing
- Pediatrics
- Maternal–child nursing (obstetrics, women's health, neonatal care)
- Public/community health

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- Gerontology
- Leadership and management
- Palliative care and care of the dying patient
- Communication, collaboration, and coordination
- Teamwork
- Evidence-based practice
- Research
- Health policy
- Legal and ethical issues
- Quality improvement

Many schools offer courses focused on other topics, such as informatics and 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 overall topical area, or it may be integrated with multiple topics. Clinical experience/practicum 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

Clinical experience or practicum is a critical component of a nursing curriculum. These experiences must be planned; correlate with the curriculum; require intensive faculty supervision to facilitate effective learning; and focus on active student engagement in the experiences, requiring extensive time and effort.

Extensive faculty effort and coordination with clinical sites is required for effective planning, implementing, and evaluating of student clinical experiences. A critical issue today for many schools is access to clinical sites. This has led to various methods to alleviate the problem to ensure effective clinical experiences for students—some have been more successful than others. The hours for the practicum or clinical experiences can be highly variable within one school and from school to school (for example, 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. There is greater acknowledgment that 12-hour work shifts may lead to staff fatigue and an increased number of errors, but this has not stopped some schools from offering this time schedule for student practica. 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 related to clinical experience requirements, which have a great impact on students' personal lives, time with family, and social relationships. If a student is employed while going to school, scheduling will be complex. 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); mental health/psychiatric hospitals; pediatric hospitals; women's health (may include obstetrics) clinics; public/community health clinics and other health agencies; home health agencies; hospice centers, including freestanding sites, hospital-based 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, and the clinical group might include as many as 10 students at different sites—which is different from acute care, when a group (8 to 10 students) is

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usually assigned to a faculty member in on clinical area for hospital experiences. The ratio of students to faculty in clinical settings may vary depending on the state board of nursing requirements. The number of hours per week in clinical experiences increases each year in the program, with the most hours assigned at the end of the program.

During some part of a nursing program, schools of nursing use preceptors in the clinical settings, 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 in master's programs. A **preceptor** is an experienced and competent staff member (for example, an RN for undergraduate students; APRN graduate or medical doctor for APRN students; certified registered nurse anesthetist or a certified nurse–midwife for graduate nursing students in these specialties). Preceptors should have 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 may be assigned to preceptor experiences for undergraduate students. At the graduate level, the number of preceptor hours is much higher.

Distance Education

Distance education, which is often offered online, has become quite common in nursing education, although not all schools offer courses in this manner. The AACN describes *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" (AACN, 2005b; Reinert & Fryback, 1997). This definition is still applicable today. Distance education technologies have expanded over the past few years as technology developed. Some of the common distance education technologies that are used are email, audiotaped instruction, conference by telephone or via Internet, desktop videoconference, and Internet-based programming or online format. There is no doubt that these methods will continue to expand as new ones are added and some discarded as not effective or efficient. 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; an example is the flipped classroom)
- Faculty-facilitated online learning with no classroom activities (the approach that is growing most rapidly)

Distance education courses must require students to meet the same course competencies or outcomes as described in the program curriculum. Students who participate in distance education typically have certain characteristics that lead to success 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. Nursing programs must be clear about required hardware and software needed to complete course work. 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

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request help when they need it 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 assist effective student learning by helping students apply learning—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: help students in setting goals, make plans with clear strategies to meet the goals, and encourage self-assessment. The flipped classroom approach is also used, for example, with content provided online, in textbooks, and so on 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. Compared to the traditional classroom approach, distance education typically emphasizes adult teaching and learning principles more, and approaches such as the flipped classroom also 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 report on nursing education (Benner, Sutphen, Leonard, & Day, 2010), there is need for greater student engagement in the classroom, which emphasizes adult principles of learning.

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 and expectations are followed whether a course is taught using a traditional approach or through distance education—ensuring this is part of a school's evaluation process. Student evaluation must be built into a distance education course just as it is in traditional courses; however, more details are typically provided in distance education course materials and teaching–learning practices may be different. Students and faculty also need access to timely technology support. Schools should ensure that students provide anonymous evaluations of the course and faculty, as required for traditional course format.

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. **Accreditation** is a process in which an organization is assessed regarding how it meets established standards. The focus here is on education accreditation; in other chapters, accreditation of healthcare organizations is discussed. The accrediting organization identifies minimum standards that guide the process, and nursing schools incorporate these standards into their programs. The accrediting

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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—to attract faculty, students, funding for education programs and research grants, and so that their graduates can attend other nursing programs such as graduate programs. Attending a nursing 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 CNEA and CCNE.

What is 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. During the time period in which they are accredited, the accrediting body may determine that a school is not in compliance with the expected standards; therefore, the school may lose accreditation or additional reviews may be required. Accreditation is not a legal requirement, but state boards of nursing require this type of accreditation from the NLN or ANCC to maintain state board of nursing 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 (CNEA or CCNE) accredits its school unless mandated by state agency or law; however, schools with diploma and associate degree programs can be accredited only by the CNEA (NLN, 2017b). The state board of nursing in each state is involved in this requirement and in its own state accreditation process.

During the accreditation process, the review team assesses the schools of nursing for the following, based on the accrediting organization's standards:

- 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)

The standards are periodically reviewed and revised; for example, in 2016, the CNEA revised its standards (NLN, 2016). The NLN accrediting standards support diversity in schools' missions, curricula, students, and faculty as well as support continuous quality improvement in education; in doing so, the NLN has an impact on a caring and competent nursing workforce (NLN, 2017b).

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 onsite survey at the school. Surveyors visit the school: They observe classes and clinical experience/practicum, meet with staff at clinical sites, review documents (for example, curriculum, completed student assignments, budget, faculty organization, grants, and so on), 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 have an obligation to participate in accreditation surveys 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. Schools must undergo reviews after they receive initial accreditation to continue their accreditation status, typically at a designated time period, but such reviews may occur if changes in the school or problems arise.

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Stop and Consider #4

Continuous improvement is not only needed in healthcare delivery, but also in nursing education.

Critical Nursing *Education Problems*

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.

Faculty Shortage

The faculty shortage has an impact on the availability of graduates to practice because it means that fewer new nurses can enter the profession. As noted earlier in this chapter, one of the reasons that potential qualified students cannot enroll in a nursing program is the shortage of qualified faculty. 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, 2016). 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. They have problems recruiting experienced faculty, and thus many faculty are new to teaching. Some of the same factors that affect the fluctuating nursing shortage have an impact on the faculty shortage, such as faculty retirement (for example, 2013–2014 data indicate average ages of doctoral-prepared faculty range from 61.6 to 51.4 years; master's prepared range is 57.1 50 51.2 years [AACN, 2015a]). 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 attend graduate school is an issue, particularly at the doctoral level. The DNP degree has attracted more nurses to these advanced degree programs, but these nurses may not be interested in teaching—and the DNP program was not intended to prepare faculty but rather to prepare practitioners. However, even if more students apply to DNP programs, they may be denied admission due to the lack of sufficient faculty to teach in the programs. The ACA offers some opportunities to expand nursing faculty through provisions supporting funding for education so that nurses can prepare for the faculty role, and this has improved the situation. Changes in the law may impact these provisions.

Access to Clinical Experiences

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 sites at healthcare facilities—all of this requires a certain number of faculty to meet standards for quality education and faculty–student ratios. With the drive to increase student enrollment, securing enough clinical sites to meet course objectives is a challenge for schools of nursing. If a number of nursing schools are located in the same area, there is also competition for clinical slots. This is particularly a problem in healthcare specialties that may have fewer patient services in a location, which translates into tight demand for clinical slots—such as pediatrics, obstetrics, and mental health. Schools of nursing need to be more innovative and recognize that every student may not get the same clinical experiences. For example, there is increasing use of non–acute care pediatric settings. Some communities do not have pediatric hospitals and may have limited beds assigned to

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pediatric care in other hospitals. 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, homeless shelters, mental health emergency and crisis centers, and may even use a mental health association or other type of community organization focused on health needs.

This difficulty in getting sites has forced some schools 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 often collaborate with schools to determine how all these needs can be met effectively.

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. A new simulation dictionary developed and published by the Agency for Healthcare Research and Quality (AHRQ) defines *healthcare simulation* as: "A technique that creates a situation or environment to allow persons to experience a representation of a real healthcare event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions; the application of a simulation activity to training, assessment, research, or systems integration toward patient safety" (Lopreiato, 2016, p. 15). 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 competencies. This is supported by the NCSBN study on the role and outcomes of simulation in pre-licensure programs, which indicates that, "up to 50 percent of traditional clinical experiences under conditions comparable to those described in the study" may be used instead of clinical experiences (NLN, 2015, p. 2; Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffires, 2014). The simulated environment provides opportunities for teams of nurses, or ideally, interprofessional students to work together to respond to simulated clinical situations. Student evaluation and real-time feedback can be done in a simulated structured learning situation. Simulated experiences should be as close to real life as possible—although they are not, of course, totally real. This does not, however, mean that these learning situations are not very helpful for student learning. Clinical training 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. The simulation laboratory may be established through a partnership of multiple health practice education programs and/or hospitals to reduce the financial burden on each institution and offer simulation to a variety of students, often as an interprofessional student and/or staff experience.

A simulation laboratory 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 laboratory 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. State boards of nursing may have requirements as to the number of simulation hours that can be substituted for clinical hours.

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Stop and Consider #5

The critical problems in nursing education are interrelated.

Transforming Nursing *Education*

Recent reports on quality in healthcare delivery indicate an urgent need to institute changes in nursing education. In fact, the most recent major nursing education report identified preparation of nurses to meet these quality demands as a critical topic (Benner, Sutphen, Leonard, & Day, 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 they 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, as there is recognition that students need to be engaged in the transformation of nursing education.

One aspect of transforming health care related to nursing education was addressed in a recent report sponsored by the AACN focusing on academic health centers (AHCs) and nursing education (academic nursing) and practice—noting that nurses are the primary care givers and advocates for patients (Manatt Health Project Team, 2016). The report clarifies two key terms. An **AHC** is a center of multiple health profession schools, accredited, and connected to a teaching healthcare organization, such as a hospital or health system. **Academic nursing** is the integration of practice, education, and research associated with baccalaureate and graduate schools of nursing—academic nursing faculty demonstrate "a commitment to inquiry, generate new knowledge for the discipline, connect practice with education, and lead scholarly pursuits that improve health and health care" (Manatt Health Project Team, 2016, p.5). The findings from the report indicate that academic nursing is not currently positioned as a real partner in healthcare transformation—for example, nursing has limited participation in governance and faculty leadership roles in the AHCs. This needs to change, though resources will be needed to increase this participation and collaboration. An example that was given as a barrier is lack of nursing faculty practices that bring in income and the over-reliance on tuition for academic nursing budgets. The AACN (2016b)report's recommendations are to "embrace a new vision for academic nursing, enhance the clinical practice of academic nursing, partner in preparing the nurses of the future, partner in the implementation of accountable care, invest in nursing research programs and better integrate research into clinical practice, and implement the advocacy agenda in support of a new era for academic nursing" (p. 1).

Stop and Consider #6

Transforming nursing education is connected to nursing practice.

Interprofessional *Healthcare Education*

One of the healthcare professions core competencies is focused on interprofessional teams; an important competency for nursing education and has impact on patient care (IOM, 2003). Emphasis on this competency has stimulated collaboration toward better understanding of interprofessonal collaborative practice. The interprofessional education collaborative (IPEC) established key competencies in 2009 and published updates in 2011 and 2016. Initially, IPEC identified four topical areas or domains as values and

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ethics, roles and responsibilities, interprofessional communication, and teams and teamwork; however, a fifth domain has been added as the central domain: interprofessional collaboration supported by four competencies (IPEC, 2016, p. 11):

- Work with individuals of other professions to maintain a climate of mutual respect and shared values (values and ethics domain).
- Use the knowledge of one's own role and those of other professions to assess and address the healthcare needs of the patients and populations served (roles and responsibility domain).
- Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to health maintenance and the treatment of disease (interprofessional communication domain).
- Teams and teamwork: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable (teams and teamwork domain).

Figure 3-2 describes a model for interprofessional collaboration and its associated domains.

These efforts strongly support the need for "safe, high-quality, accessible, patient-centered care" for all and interprofessional collaboration is required to accomplish this" (IPEC, 2016, p. 4). Not only are healthcare profession education programs including more on interprofessional content and experiences with interprofessional teams, but also there is more faculty development on the topic. This emphasis on interprofessional teams is also now included in accreditation of education programs. Interprofessional education occurs, "when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (World Health Organization, 2010). To meet these needs, nursing education must work to provide effective learning experiences for nursing students so that they are prepared to work on interprofessional teams. Nursing students, pre-licensure and graduate, also have responsibilities, such as to actively engage in the learning activities planned by faculty and to seek out learning situations that support interprofessional competencies. Students might do this by observing work teams in clinical, asking to join an interprofessional activity in clinical, and working to increase communication with and respect of other healthcare professionals.

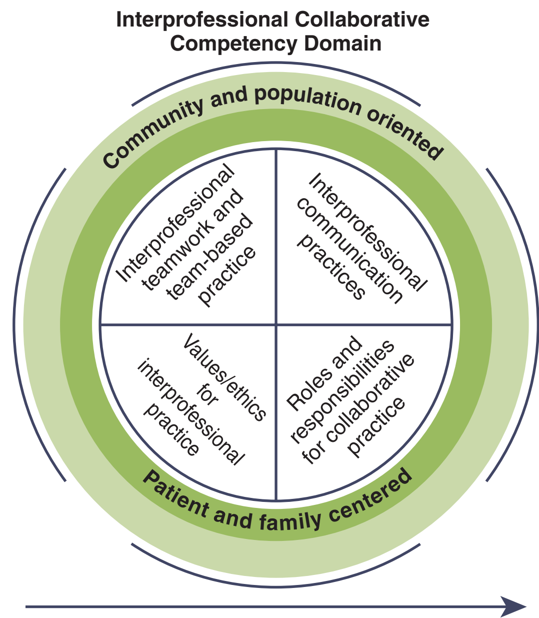

Figure 3-2 The Learning Continuum Pre-Licensure through Practice Trajectory

Reproduced with permission from Interprofessional Education Collaborative. (2016). Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative. p. 9. Retrieved from https://ipecollaborative.org/uploads/IPEC-2016-Updated-Core-Competencies-Report__final_release_.PDF

Stop and Consider #7

Interprofessional education is critical for effective interprofessional teams.

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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, which requires state legislative changes. 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, [state] 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 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 Tenth 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 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

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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.

Influenced by the above, today 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 on state government websites. Every licensed nurse should be knowledgeable about the nurse practice act that governs practice in the state where the nurse practices under his or her RN license, and nursing students should be aware of the nurse practice act in the state in which they are enrolled as a student. 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, boundaries 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 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 vocational/practical nurses (LVN/LPNs) and 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 state board—all are state employees. 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 LVN/LPNs), but also are responsible for monitoring nursing education (RN and LPN) programs in the state. The 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 individual 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 if 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 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

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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 he or she has 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 4 U.S. territories (American Samoa, Guam, Northern Mariana Islands, and Virgin Islands). Through this organization, all state 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 registered nurse licensing examinations. 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, 2013):

- 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 (individual state boards of nursing).
- 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 based on state law; however, all states 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, which is obtained through endorsement, 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. Examples of initial licensure

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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 but no further testing required for renewals or change of license from one state to another)
- For renewal, **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; also asked if any felonies when renewing license or getting a license in a different state may require background check)
- For renewal or new state, active employment for a specific number of hours within a specified time period (varies from state to state)
- For renewal or new 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, and conduct evaluation of care as part of an accreditation process.

National Council Licensure Examination

The NCLEX is the national nursing exam that is developed and administered through the NCSBN (2017a). 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 (or LPN/LVN). RN 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 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 a variety of types of questions such as multiple-response, fill-in-the-blank, and hot spot items using a picture or graphic.

If a candidate does not pass the NCLEX, he or she may retake the exam. Most schools of nursing provide some type of preparation (for example, 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. In reality, exam preparation takes place every day in nursing programs—in courses and clinical experiences as students learn and practice receiving faculty feedback.

Students are asked by their school to complete an application for NCLEX in the final semester before

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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.

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. On the scheduled date, the student goes to the designated testing site to take the computerized exam. Candidates are fingerprinted and photographed to ensure security for the exam and are provided an orientation and a brief practice session prior to taking the exam. An exam session lasts several hours, but because of the computerized adaptive test method, the amount of time that an individual candidate takes on the exam varies; that time is not an indicator of passing or failing.

Passing scores are the same for every state and are set by the NCSBN; they can vary from year to year. 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 are 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. Schools of nursing can be put on probation by their state boards of nursing if pass rates are a problem. This leads to further evaluation of the program and monitoring of outcomes. The state boards of nursing protect students and potential students in ensuring that the education provided will prepare them at the level expected.

Critical Current and Future Regulation Issues

Nursing regulation covers many issues related to legal requirements about nursing practice. Most of the focus and responsibility for nursing regulation falls on the state boards of nursing and their respective legislative bodies; however, the National Council for State Boards of Nursing offers advise to state boards of nursing. Nursing professional organizations also offer their advice but cannot formally regulate practice. There have been some regulatory efforts at the federal level, though this is not common but if done more routinely would lead to more consistency across states.

Nurse Licensure Compact

There has been a growing need to design 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 with care provided via technology in more than one state. To address these types of issues, the NCSBN created a new model for license portability called mutual recognition or **nurse licensure compact** (NLC) (Wallis, 2015). Each state in a mutual recognition compact must enact legislation or regulation authorizing the NLC and also adopting administrative rules and regulations to implement the compact. Each compact state must also appoint an NLC administrator to facilitate the exchange of information between the states that relates to compact nurse licensure and regulation. Twenty-five states have adopted this model (NCSBN, 2017a). 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 the NCSBN website. There have been suggestions that what is needed is national licensure, but it is not likely to occur at this time (Wallis, 2015).

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The same type of licensure questions applies to APRNs. In 2002, the NCSBN Delegate Assembly approved the adoption of model 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. Many states are now working on 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.

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. Some state boards of nursing 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 staff 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 has been 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. Other work areas and professions have examined this problem and taken steps to reduce hours, for example, the aviation industry has cut back the number of hours that flight crews can work without sleep; 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, 2017). **Nurse migration** is a complex area—affecting the country of origin, which may then experience a shortage and the need to effectively integrate foreign nurses in the United States who may not have had a the type of nursing education we expect (Jacobson, 2015). The International Centre for Nurse Migration provides resources for nurses who are moving from one country to another and information about this critical topic to increase the profession's understanding of this issue.

The NCSBN notes that each state board of nursing is responsible for RN licensure for its state. States may vary in requirements, but all internationally educated nurses must pass the NCLEX exam; 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 (NCSBN, 2017b).

What do these nurses have to do to meet practice requirements in the United States? The Commission on Graduates of Foreign Nursing Schools (2017) 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

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to ensure that their English language ability is at an acceptable level. This requirement also applies to students who want to enter U.S. nursing education 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 is required in the educational program. Licensure is not required to enter a pre-licensure program (BSN) in nursing, but it is required for a graduate nursing program.

Global Health Regulatory Issues

With the development of the Internet, telehealth and global migration have forced nursing to confront the need to examine changes related to interstate nursing practice and possible responses. 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, 2017) is a nursing organization that focuses on getting nurse educators from around the world to work together to develop and facilitate nursing education and professional development for nurses worldwide in order to improve care globally. These efforts recognize the need for international standards in nursing education. Nursing has moved from a focus on individual hospitals, to the state level, to the national level, and now to a global level.

Stop and Consider #8

Regulation protects patients.

CHAPTER HIGHLIGHTS

1. The evolution of nursing education influences how nursing is taught.
2. Nursing has multiple types of programs and degrees: diploma, associate degree, baccalaureate, master's, and doctoral levels.
3. Nursing organizations, such as AACN and NLN, guide nursing education, provide resources, and accreditation.
4. There is a need to improve nursing education to better meet patient care needs—for example, use of standards, competencies, recognition of excellence, and accreditation.
5. Licensure and regulation of nursing practice set standards and rules for nursing education. Different levels of nursing pre-licensure education have different competencies and expectations, yet nurses at all levels take the same licensure examination.
6. Nursing education is undergoing changes to improve and meet needs.
7. Interprofessional education is now an important consideration in nursing education.
8. Examples of critical concerns related to education, regulation, and practice are compact licensure, mandatory overtime, and global migration of nurses.

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ENGAGING IN THE CONTENT

Discussion Questions

1. Why do you think it is important that nursing now emphasize education over training? Consider Donahue's definitions for education and training found in the chapter. How has apprenticeship been adapted to current nursing education needs?
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 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 NLC? Visit https://www.ncsbn.org/158.htm to find out. Why might this be important to you if you choose to be licensed in your state after graduation?

CRITICAL THINKING ACTIVITIES

1. Conduct a debate in class with another 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 another 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.
3. Consider your nursing education program. What aspects do you think are effective for you as a student, and why? What are problems you identify, and what ideas do you have for solutions?

ELECTRONIC REFLECTION JOURNAL

Assess your current nursing program—you may not be in the program long, but consider your admission process, orientation, any courses you have taken (non-nursing and nursing), communication with faculty, relationships with other students and the culture of the school, and any clinical or lab experiences you have had. How might you use your reflection to improve your nursing education experiences?

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CASE STUDIES

Case 1

The executive committee of your school's Student Nurses' Association chapter 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?

Case 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, authors such as Kutney-Lee, Sloane, and Aiken have conducted studies that have concluded the BSN should be the entry-level degree (2013). Cynthia Maskey, PhD, RN, CNE, in the March 2013 issue of *Health Affairs*, responded to this study. Dr. Maskey is an OADN board member. Review the study and Dr. Maskey's response:

- Article: Kutney-Lee, A., Sloane, D., & Aiken, L. (2013). An increase in the number of nurses with baccalaureate degrees is linked to lower rates of postsurgery mortality. *Health Affairs, 32*, 3579–3586.
- At the link for this study see response by C. Maskey, The study focuses on problems, not solutions. Retrieved from http://content.healthaffairs.org/content/32/3/579 /reply#healthaff_el_476350

Case Questions

After reading this article and visiting the website with Maskey's response, consider the following questions.

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

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CASE STUDIES (CONTINUED)

Working Backward to Develop a Case

Write a brief paragraph that describes a case related to the following questions.

1. What is the purpose of nursing education accreditation?
2. Why do we as students need to be involved?
3. What do we want to share about our school?

REFERENCES

Aiken, L., Clarke, S., Cheung, R., Sloane, D., & Silber, J. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association*, *290*, 1617–1623.

Aiken, L. et al. for the RN4CAST consortium. (2014, February 15). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *Lancet*. doi: 10.1016/S0140-6736(13)62631-8

American Association of Colleges of Nursing. (2005a, May 6). *AACN applauds decision of the AONE board to move registered nurse education to the baccalaureate level* (press release). Washington, DC: Author.

American Association of Colleges of Nursing. (2005b). *Alliance for Nursing Accreditation statement on distance education policies*. Retrieved from http://www.aacn.nche.edu/education/disstate.htm

American Association of Colleges of Nursing. (2005c). *Fact sheet: Articulation agreements among nursing education programs*. Washington, DC: Author.

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Washington, DC: Author. Retrieved from http://www.aacn.nche.edu/dnp/Essentials.pdf

American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC: Author. Retrieved from http://www.aacn.nche.edu/Education/pdf/BaccEssentials98.pdf

American Association of Colleges of Nursing. (2011). *The Essentials of masters education for nursing*. Washington, DC: Author. Retrieved from http://www.aacn.nche.edu/education-resources/MasEssentials96.pdf

American Association of Colleges of Nursing. (2013). *Competencies and curricular expectations for clinical nurse leader education and practice*. Washington, DC: Author.

American Association of Colleges of Nursing. (2015a). *New AACN data confirm enrollment surge in schools of nursing*. Retrieved from http://www.aacn.nche.edu/news/articles/2015/enrollment

American Association of Colleges of Nursing. (2015b). *The doctor of nursing practice: Current issues and clarifying recommendations*. Retrieved from http://www.aacn.nche.edu/aacn-publications/white-papers/DNP-Implementation-TF-Report-8-15.pdf

American Association of Colleges of Nursing. (2016a). *DNP fact sheet*. Retrieved from http://www.aacn.nche.edu/media-relations/fact-sheets/dnp

American Association of Colleges of Nursing. (2016b). *About AACN*. Retrieved from http://www.aacn.nche.edu/about-aacn

American Association of Colleges of Nursing. (2017). *AACN strategic plan 2017–2019*. Retrieved from http://www.aacn.nche.edu/about-aacn/strategic-plan

American Association of Colleges of Nursing, American Organization of Nurse Executives, & National Organization for Associate Degree Nursing. (1995). *A model for differentiated nursing practice*. Washington, DC: Author.

American Nurses Association. (1965). Education for nursing. *American Journal of Nursing*, *65*(12), 107–108.

American Nurses Association. (2011). *ANA fact sheet*. Retrieved from http://nursingworld.org/NursingbytheNumbersFactSheet.aspx

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American Nurses Association. (2015). *Nursing scope and standards of practice*. Silver Spring, MD: Author.

American Organization of Nurse Executives. (1990). *Current issues and perspectives of differentiated practice.* Chicago, IL: American Hospital Association.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.

Brown, E. (1948). *Nursing for the future: A report prepared for the National Nursing Council*. New York, NY: Russell Sage Foundation.

Commission on Collegiate Nursing Education. (2013). *Standards for accreditation of baccalaureate and graduate nursing programs*. Retrieved from http://www.aacn.nche.edu/ccne-accreditation/Standards-Amended-2013.pdf

Commission on Graduates of Foreign Nursing Schools. (2017). *CGFNS website*. Retrieved from http://www.cgfns.org/about/

Council on Accreditation. (2017, January). *Transition nurse anesthesia programs to doctoral degree*. Retrieved from http://home.coa.us.com/Pages/default.aspx

Cronenwett, L., Dracup, K., Grey, M., McDauley, L., Meleis, A., & Salmon, M. (2011). The doctor of nursing practice: A national workforce perspective. *Nursing Outlook*, *59*(1), 9–17.

Damgaard, G., VanderWoude, D., & Hegge, M. (1999). Perspectives from the prairie: The relationship between nursing regulation and South Dakota nursing workforce development. *Journal of Nursing Administration*, *29*(11), 7–9, 14.

Donahue, M. (1983). Isabel Maitland Stewart's philosophy of education. *Nursing Research*, *32*, 140–146.

Estabrooks, C., Midodzi, W., Cummings, G., Ricker, K., & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research*, *54*(2), 74–84.

Fernandez, R., & Hebert, G. (2004). Global licensure. New modalities of treatment and care require the development of new structures and systems to access care. *Nursing Administration Quarterly*, *28*, 129–132.

Girard, N. J. (2003). Lack of sleep another safety risk factor (editorial—medical errors). *AORN Journal*, *78*, 553–556.

Global Alliance for Leadership in Nursing Education. (2017). *GANES about*. Retrieved from http://ganes.info/About.php

Godfrey, N., & Martin, D. (2016). Breakthrough thinking in nursing education. The Baccalaureate big 5. *Journal of Nursing Administration, 46*(7/8), 393–399.

Goldmark, J. (1923). *Nursing and nursing education in the United States*. New York, NY: Macmillan.

Hayden, J., Smiley, R., Alexander, M., Kardong-Edgen, S., & Jeffries, P. (2014). Supplement: The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. *Journal of Nursing Regulation, 5*(2), C1–S64.

Hutchins, G. (1994). Differentiated interdisciplinary practice. *Journal of Nursing Administration*, *24*(6), 52–58.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press.

International Centre on Nurse Migration. (2017). *ICNM website*. Retrieved from http://www.intlnursemigration.org/

Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborative practice: 2016 update.* Washington, DC: Author. Retrieved from https://ipecollaborative.org/uploads/IPEC-2016-Updated-Core-Competencies-Report__final_release_.PDF

Jacobson, J. (2015). The complexities of nurse migration. *AJN,* 115(12), pp. 22–23.

Knowles, M. (1975). *Self-directed learning: A guide for learners and teachers*. Chicago, IL: Follett.

Knowles, M. (1984). *Andragogy in action*. San Francisco, CA: Jossey-Bass.

Kutney-Lee, A., Sloane, D., & Aiken, L. (2013). An increase in the number of nurses with baccalaureate degrees is linking to lower rates to post surgery mortality. *Health Affairs 30*(3), 579–586.

Leighow, S. (1996). Backrubs vs. Bach: Nursing and the entry-into-practice debate: 1946–1986. *Nursing History Review*, *4*, 3–17.

Lopreiato, J. (2016, October). *Healthcare simulation dictionary.* Rockville, MD: Agency for Healthcare Research and Quality, AHRQ Publication No. 16(17)-0043.

Loquist, R. (2002). State boards of nursing respond to the nurse shortage. *Nursing Administration Quarterly*, *26*(4), 33–39.

Lundy, K. (2005). A history of health care and nursing. In K. Masters (Ed.), *Role development in professional nursing practice* (Ch. 1). Burlington, MA: Jones & Bartlett Learning.

Manatt Health Project Team. (2016). *Advancing healthcare transformation. A new era for academic nursing*. Washington, DC: American Association of Colleges of Nursing. Retrieved from http://www.aacn.nche.edu/AACN-Manatt-Report.pdf

Manfredini, R., Boari, B., & Manfredini, F. (2006). Adverse events secondary to mistakes, excessive work hours,

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and sleep deprivation. *Archives of Internal Medicine*, *166*, 1422–1433.
Masters, K. (2005). *Role development in professional nursing practice*. Burlington, MA: Jones & Bartlett Learning.
McHugh, M., & Lake, E. (2010). Nurse education, experience, and the hospital context. *Research in Nursing & Health*, *33*, 276–287.
Montag, M. (1959). *Community college education for nursing: An experiment in technical education for nursing*. New York, NY: McGraw-Hill.
Montgomery, V. (2007). Effect of fatigue, workload, and environment on patient safety in the pediatric intensive care unit. *Pediatric Critical Care Medicine*, *8*(suppl. 2), S11–S16.
National Academy of Medicine. (2015). *Assessing progress on the Institute of Medicine report The Future of Nursing*. Washington, DC: The National Academies Press.
National Council of State Boards of Nursing. (1996). *Why regulation paper: Public protection or professional self-preservation?* Retrieved from https://www.ncsbn.org/why_regulation_paper.pdf
National Council of State Boards of Nursing. (2005). *Position paper: Clinical instruction in pre-licensure nursing programs*. Retrieved from http://www.ncsbn.org/pdfs/Final_Clinical_Instr_Pre_Nsg_programs.pdf
National Council of State Boards of Nursing. (2007). *Guiding principles of nursing regulation*. Retrieved from https://www.ncsbn.org/Guiding_Principles.pdf
National Council of State Boards of Nursing. (2013). *About NCSBN*. Retrieved from https://www .ncsbn.org/about.htm
National Council of State Boards of Nursing. (2017a). *Nurse license compact*. Retrieved from https://www.ncsbn.org/nurse-licensure-compact.htm
National Council of State Boards of Nursing. (2017b). *U.S. nursing licensure for internationally educated nurses*. Retrieved from https://www.ncsbn.org/171.htm
National League for Nursing. (2014). *NLN Biannual survey of schools of nursing, 2014*. Retrieved from http://www.nln.org/docs/default-source/newsroom/nursing-education-statistics/number-of-basic-rn-programs-total-and-by-program-type-2005-to-2014.pdf?sfvrsn=0
National League for Nursing. (2015). *A vision for teaching with simulation*. Retrieved from http://www.nln.org/docs/default-source/about/nln-vision-series-(position-statements)/vision-statement-a-vision-for-teaching-with-simulation.pdf?sfvrsn=2
National League for Nursing. (2016, February). Commission for Nursing Education Accreditation. *Accreditation standards for nursing education programs*. Retrieved from http://www.nln.org/docs/default-source/accreditation-services/cnea-standards-final-february-201613f2bf5c78366c709642ff00005f0421.pdf?sfvrsn=4
National League for Nursing. (2017a). *Mission and goals*. Retrieved from http://www.nln.org/about/mission-goals
National League for Nursing. (2017b). *National league for nursing commission for nursing education accreditation (CNEA)*. Retrieved from http://www.nln.org/accreditation-services/overview
National League for Nursing. (2017c). *Hallmarks of excellence*. Retrieved from http://www.nln.org/professional-development-programs/teaching-resources/hallmarks-of-excellence
National League for Nursing. (2017d). *Academy of nursing education*. Retrieved from http://www.nln.org/recognition-programs/academy-of-nursing-education
National League for Nursing. (2017e). *Eligibility criteria*. Academy of Nursing Education. Retrieved from http://www.nln.org/recognition-programs/academy-of-nursing-education/eligibility-requirements
Organization for Associate Degree Nursing , & American Nurses Association. (2015). *Organization for Associate Degree Nursing and the American Nurses Association joint position statement on academic progression to meet the needs of the registered nurse, the healthcare consumer, and the U.S. health care system*. Retrieved from http://www.nursing world.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANA PositionStatements/Position-Statements-Alphabetically/Academic-Progression-to-Meet-Needs-of-RN.html
Organization for Associate Degree Nursing. (2017). *About OADN*. Retrieved from https://www.oadn.org/about-us/about-oadn
O'Shea, E. (2003). Self-directed learning in nurse education: A review of the literature. *Journal of Advanced Nursing*, *43*(1), 62–70.
Quality and Safety Education for Nurses. (2017). *QSEN*. Retrieved from http://qsen.org/
Reinert, B., & Fryback, P. (1997). Distance learning and nursing education. *Journal of Nursing Education*, *36*(9), 421.
Robert Wood Johnson Foundation. (2015, September 9). *In historic shift, more nurses graduate with bachelor's degrees*. Retrieved from http://www.rwjf.org/en/library/articles-and-news/2015/09/more-nurses-with-bachelors-degrees.html
Robert Wood Johnson Foundation. (2016, January). Changing face of nursing: Creating a workforce for an increasingly diverse nation. *Charting Nursing's Future, 27*, p. 1. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf425988

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Schaefer, B. (1990). International credentials review: Crucial and complex. *Nursing Healthcare*, *11*, 431–432.

Sigurdson, K., & Ayas, N.T. (2007). The public health and safety consequences of sleep disorders. *Canadian Journal of Physiology and Pharmacology*, *85*, 179–183.

Tri-Council for Nursing. (2010). *Tri-Council for Nursing issues new consensus policy statement on the educational advancement of registered nurses*. Retrieved from http://www.tricouncilfornursing.org/

Wallis, L. (2015). The case for license portability. *AJN*, *115*(9), 18–19.

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Geneva, Switzerland. Retrieved from http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf

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