

## COLUMN

# Defining NP scope of practice and associated regulations: Focus on acute care

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### Abstract

**Purpose:** Although the nurse practitioner (NP) role has been in existence for over 40 years, there continues to be uncertainty about the essential components that define NP scope of practice. The purpose of this article is to review definitions and concepts related to NP scope of practice with an emphasis on NPs working in acute care.

**Data sources:** A synthesis literature review was conducted on defining NP scope of practice. Simultaneous review of authoritative resources including National Council of State Board of Nursing, individual state board of nursing language, and NP scope and standards of practice documents was conducted.

**Conclusions:** Scope of practice is a legal term used by states to define what activities an individual professional can undertake. The Consensus Model for Advanced Practice Registered Nurse (APRN) Regulation outlines that licensure and scope of practice are based on graduate education within a defined patient population for the APRN role. The APRN Consensus Model further identifies that the services provided by APRNs are not defined or limited by setting but rather by patient care needs. For the acute care NP, this is especially significant, as patient acuity and care requirements can vary across settings. When implemented, the Consensus Model will help to standardize regulation for APRNs as well as ensure congruence between licensure, accreditation, certification, and education.

**Implications for practice:** Providing clarification of the NP scope of practice, especially as it pertains to NPs working in acute care settings, remains needed to support practice based on educational preparation, licensure, certification, and focus of practice.

Nurse practitioners (NPs) represent a growing segment of healthcare professionals who provide care to patients in a variety of settings. Since the role emerged in the mid-1960s, formal educational requirements for entry into practice have increased from an initial certificate to a graduate degree. Moreover, NPs must successfully pass a national certification examination for licensure that is based on the focus of the NP's formal educational program. This focus is either on pri-

mary and/or acute care populations and lays the foundation to define an NP's scope of practice (SOP). However, despite the existence of a number of authoritative documents that outline SOP for NPs, uncertainty continues to exist about the essential components that define NP SOP. Therefore, the purpose of this article is to review definitions and concepts related to NP SOP with an emphasis on nurse practitioners working in acute care.

A synthesis literature review was conducted on defining NP SOP using the U.S. National Library of Medicine (NLM) MEDLINE, PUBMED, and CINAHL searches with “Nurse Practitioner” or “Advanced Practice Nurse” or “Advanced Practice Registered Nurse” and “scope of practice” and “1995/01/01. [PDat] : “2011/06/15”[PDat]) AND (Humans[Mesh]) AND (English[lang]) OR medline[sb] OR pubmed pmc local[sb]) AND (adult[MeSH]). Simultaneous review of authoritative resources including National Council of State Board of Nursing, individual state board of nursing language, and NP scope and standards of practice documents was conducted.

SOP is a set of rules, regulations, and boundaries within which a fully qualified NP may practice (Federation of State Medical Boards, 2005; National Council of State Boards of Nursing [NCSBN], 2009). NP programs adopted uniform core requirements and met nationally vetted educational and accreditation standards. National certification exams were developed to test entry level practice competency (American Association of Colleges of Nursing [AACN], 1996; AACN, 2006). Much of this work was completed in conjunction with nursing regulatory groups that have responsibility to monitor NP practice as a measure of public protection. Even with efforts to provide consistency in NP education, there continues to be much state-to-state variation on NP SOP. NPs do not enjoy the same common SOP and cross-border consistencies that are afforded to registered nurse, physicians, and physician assistants (Christian et al., 2007; Pearson, 2010).

In an effort to mitigate the proliferation of new NP programs, some of which focused on sub-specialty practices with resultant certification that was not uniformly recognized across states, the profession worked together to develop the Consensus Model for Advanced Practice Registered Nurse (APRN) Regulation. This document is the outcome of a national effort to resolve the issues of inconsistent APRN education, issues of certification, and issues of inconsistent licensure requirements across jurisdictions. The document states that the education, accreditation, certification, and licensure (LACE) of APRNs should be aligned in order to ensure patient safety while also expanding patient access to APRN care and promoting a consistent SOP (APRN Consensus Work Group, 2008).

The APRN Consensus Model outlines that licensure and SOP are based on graduate education within a defined patient population within one of four APRN roles—certified NP, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife. The APRN Consensus Model further identifies that the services provided by APRNs are not defined or limited by setting but rather by patient care needs. Thus, SOP

for acute care nurse practitioners (ACNPs) is not based on a practice setting such as a hospital intensive care unit (ICU), but rather on patient healthcare needs such as respiratory assessment and ventilator management that can occur in the hospital or the home setting (Figure 1; APRN Consensus Work Group, 2008)

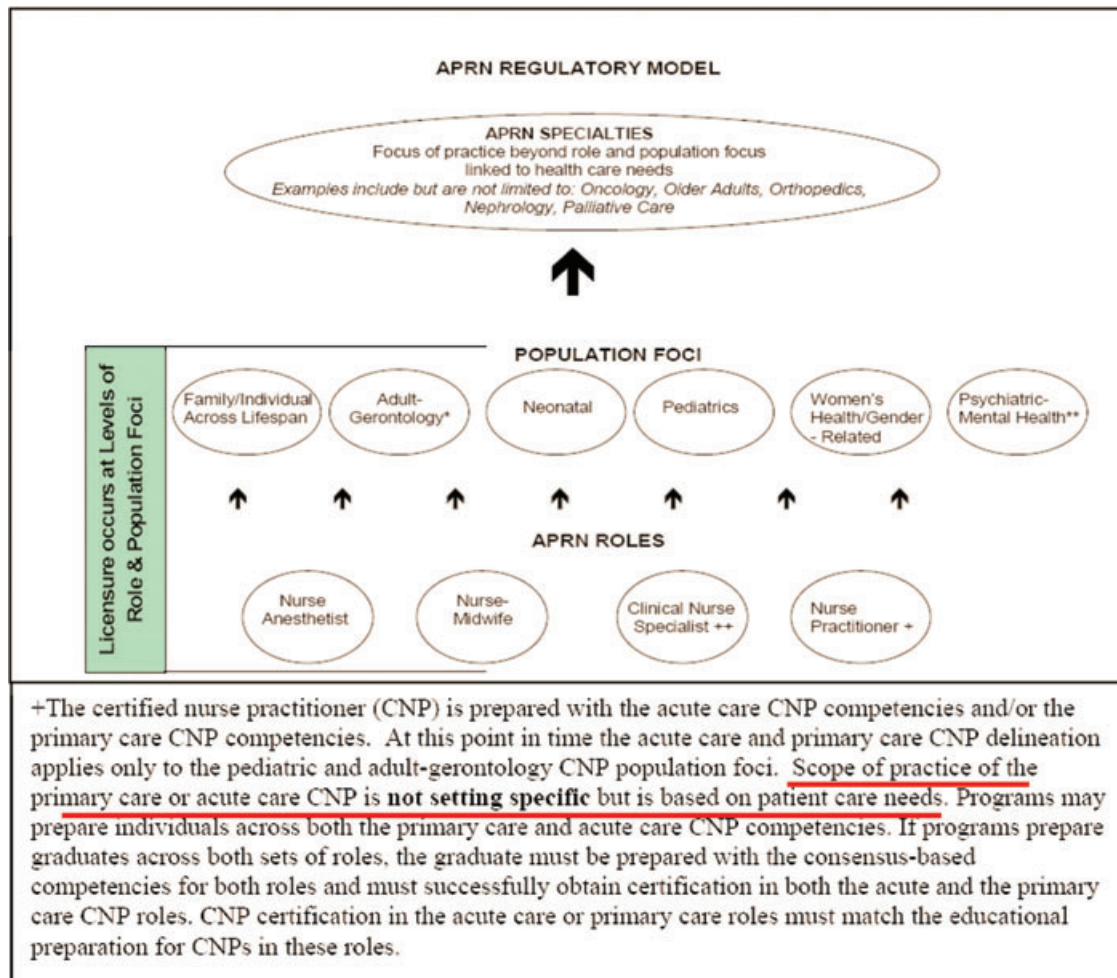
Professional associations and regulators are working together to implement a consistent SOP for NPs throughout all jurisdictions. An implementation date for the Consensus Model of 2015 has been established; thus there is a transition time whereby educational programs are restructuring to meet new accreditation requirements, certification exams are being refined, and stakeholders are seeking to modify nurse practice acts to comply with the 2008 Consensus Document recommendations.

### **Role of professional associations in defining scope of practice for NPs**

Because professional associations that represent specific practitioners are the groups most closely engaged with contemporary practice, they are recognized as the expert source for tracking healthcare trends and making recommendations to update NP SOP. Associations such as the American Academy of Nurse Practitioners (AANP) develop and publish SOP statements for use by regulators, employers, payers, and other stakeholders. The National Panel for Acute Care Nurse Practitioner Competencies (2004) and the American Association of Critical-Care Nurses (2006) specifically address SOP for ACNPs. The American Association of Colleges of Nursing (AACN) recently completed work on the National Adult-Gerontology Acute Care Nurse Practitioner Competencies, which address ACNP care based on the entire spectrum of adults, including young adults, adults, and older adults (AACN, 2011).

The AANP identifies NPs as licensed independent practitioners who practice in ambulatory, acute, and long-term care as primary and/or specialty care providers and who provide nursing and medical services to individuals, families, and groups according to their practice specialty. The AANP identifies that in addition to diagnosing and managing acute episodic and chronic illnesses, NPs emphasize health promotion and disease prevention. NP services are outlined to include, but not limited to, ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, and prescribing of pharmacologic agents and nonpharmacologic therapies. Teaching and counseling individuals, families, and groups are also identified as major parts of NP practice (AANP, 2011).

NP educational programs may prepare individuals across both primary care and acute care competencies. If programs prepare graduates across both sets of



**Figure 1** APRN consensus model highlighting scope of practice is not setting specific but determined by patient care needs.

From APRN Consensus Work Group & National Council of State Boards of Nurses. Consensus model for APRN regulation: licensure, accreditation, certification and education. Retrieved June 10, 2011, from [http://www.ncsbn.org/7\\_23\\_08\\_Consensus\\_APRN\\_Final.pdf](http://www.ncsbn.org/7_23_08_Consensus_APRN_Final.pdf).

competencies, the graduate must successfully obtain national certification in both the acute and the primary care NP roles. NP certification in the acute care or primary care roles must match the educational preparation for NPs in these roles. According to the competencies set forth by the AACN (2011) National Taskforce for ACNP Competencies (2004), the Scope and Standards of Practice for the ACNP (American Association of Critical-Care Nurses, 2006), and the National Association of Pediatric Nurse Practitioners (NAPNAP, 2011), ACNPs are educationally prepared to provide advanced nursing care to patients with complex acute, critical, and complex chronic health conditions, including the delivery of acute care services to those patients found in critical care areas throughout the hospital, outpatient clinics, or in home settings. While SOP of APRNs is not setting specific, the scope and standards of practice for ACNPs identify that most

ACNPs practice in acute care and hospital-based settings (including sub-acute care, emergency care, and intensive care settings), and that the continuum of acute care services spans the geographic settings of home, ambulatory care/clinic/office setting, urgent care, rehabilitative care, and palliative care (American Association of Critical-Care Nurses, 2006).

### **Role of regulation in defining scope of practice for NPs**

SOP is a legal term used by the state to define what activities a profession can undertake. In the United States, SOP is granted to a profession by the people through their elected legislators. Because state legislators cannot monitor every profession, state regulatory boards are established that are composed of members of the

profession who are in good standing and who are charged to define the procedures, actions, and processes that are permitted for the licensed individual (O'Neil & The Pew Health Professions Commission, 1998). The outcome of the work of regulatory boards is to assure the public that individuals recognized to practice in the profession can provide certain services competently and safely, assure the public that there is a mechanism to protect them from incompetent and unethical practitioners, and to offer assurance that mechanisms exist to remove from practice those practitioners who do not meet standards (NCSBN, 2009).

The work of state regulatory boards is approved by legislators in the form of statutes called practice acts. In addition to practice acts that provide broad statements to govern the functions of a profession, rules and regulations are promulgated that support the practice acts. Both the practice act and its associated rules and regulations are used to define NP SOP and require legislative approval to become law. Boards can enact policies and position statements within their own rights that can also impact SOP. Public protection is the primary role of state licensing boards, and these boards hold professionals accountable to meet practice standards, remain current, and to comply with state laws (NCSBN, 2009).

Boards of nursing generally establish NP SOP in one of three ways: (1) they endorse a nationally vetted SOP statement established by a national organization representing NPs, (2) they craft state-specific SOP statements based on stakeholder input, or (3) they use a combination of national statements with state-specific guidelines added to provide further clarity or restriction (Hudspeth, 2009.)

Questions about changes in SOP are inherent in today's healthcare system and are necessarily evolving. These changes are in response to patient demographics, technology, geographic provider distribution, costs, and many other environmental and societal factors. One specific aspect that relates to ACNP education, training, and SOP is the inclusion of gerontology as an area of focus for the ACNP. Until all states have implemented Consensus Model recommendations, state variation in SOP will continue and supplemental resources will be needed to provide clarity to SOP questions.

State boards of nursing (BONs) do not regulate the facility in which an NP practices; rather boards regulate the practice in which an NP engages. For most states, the NP SOP includes the provision of preventive and primary care services and evaluation and promotion of patient wellness within the NP's specialty area of focus, consistent with the nurse's education and certification, and in accordance with the Board's rules. For example, the Arizona BON states "A registered nurse practitioner

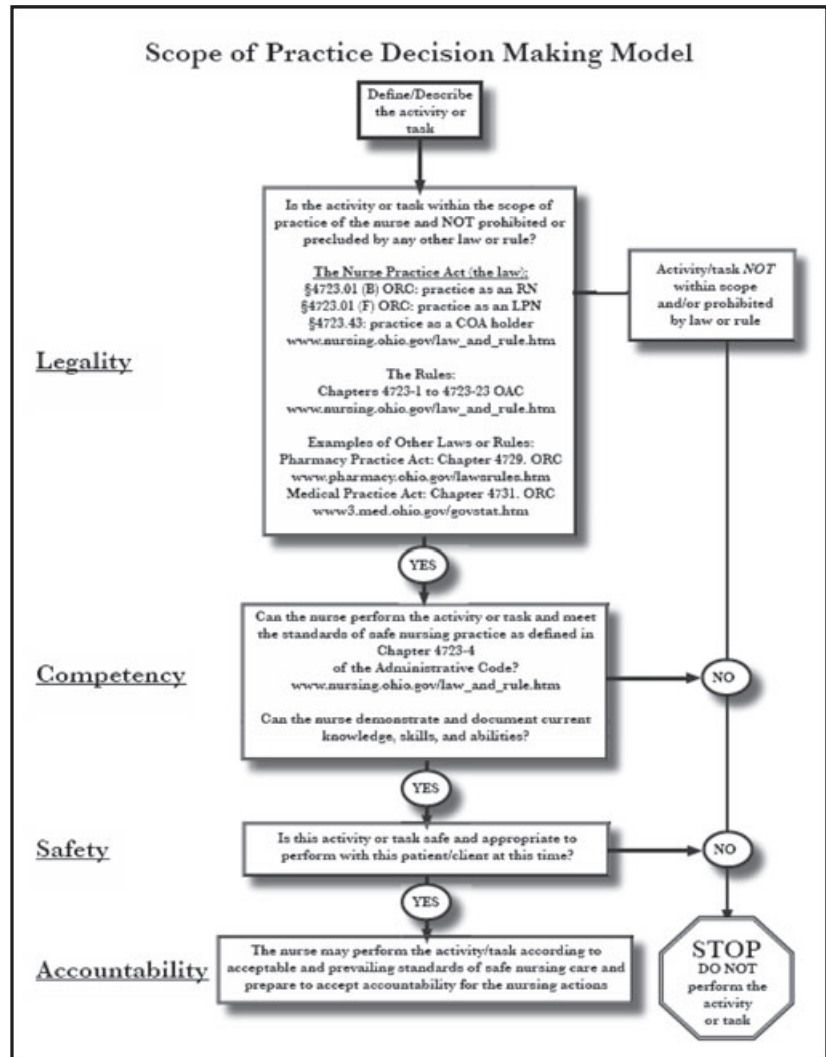
(RNP) shall only provide healthcare services within the nurse practitioner's SOP for which the NP is educationally prepared and for which competency has been established and maintained. Education preparation means academic coursework or continuing education activities that include both theory and supervised clinical practice (AZ Admin Code R4-19-508 C)" (Arizona BON, 2009).

In a white paper published in 2009, the Arizona BON further clarified SOP between primary care NPs and ACNPs. This document addressed NPs in acute care settings and limits caring for complex unstable patients in acute care settings to ACNPs. "A primary care NP may have a role in assisting or directing management of the acute care patient as long as the aspect of care is within the limits of their specialty and role of nurse practitioner certification" (Arizona BON, 2009). Clarification is made that although RN experience may give some familiarity with a particular patient population, experience as an RN does not determine SOP as an NP. For example, an NP prepared as an FNP and who worked as a staff RN in an ICU would not be authorized to practice in the same ICU setting as an NP. This is because her/his education, training, and certification were as an FNP with a primary care focus (Arizona BON, 2009).

Furthermore, in the remaining states that require physician supervision or collaboration to practice, the NP SOP is impacted by the collaborative practice agreement between the NP and physician. The agreement cannot serve to expand the education and certification as an acute care or primary care NP. To assist individual NPs, employers, and the public in understanding state-specific SOP interpretations, BONs have staff or practice consultants who routinely answer questions and provide guidance. Additionally, some state BONs have developed decision trees for use by individuals and agencies when questions arise about whether or not an action is considered within an SOP. The decision trees use a common algorithm but can have state-specific variation (Figure 2; Ohio BON, 2004).

The NCSBN has developed model language for statute and rule promulgation that assists BONs in updating practice acts and aids in the establishment of uniformity between jurisdictions. This document outlines the APRN SOP, defines the mechanisms and qualifications for licensure approval, defines approval standards for APRN educational programs and faculty qualifications, and defines the requirements of prescribing and ordering authority, including the management of sample drugs (NCSBN, 2010).

The APRN Committee of NCSBN also developed tools for states to use in conducting a gap analysis that compares existing state-specific statute language to the



**Figure 2** Ohio Board of Nursing Decision-Making Model. Retrieved from <http://www.nursing.ohio.gov/pdfs/Decmodel.pdf>.

recommendations of the APRN Consensus Document and the model language for statute and rule.

**Role of credentialing and privileging within a healthcare organization**

Institutions that employ NPs can place restrictions on SOP beyond that allowed by the state licensing authority. However, institutions cannot be less restrictive than the state licensing authority (Klein, 2008; McLaughlin & Kleinpell, 2007; NCSBN, 2009).

Hospitals have established mechanisms to review the requests of providers and to allow providers to use the hospital facilities to provide medical and nursing care to people in need within the SOP authorized by the state for a specific profession. The hospital has the responsibility to protect the public interest by ensuring that those seeking to provide care are appropriately educated,

experienced, peer reviewed, and hold unencumbered licenses to practice. Most American hospitals have an approved process that is delegated to and managed by the hospital administration and the elected or appointed representatives of the medical staff (The Joint Commission, 2010).

ACNPs who seek to provide care in these institutions must undergo a credentials review similar to that of physicians and other providers, and must be granted the privilege to practice in the hospital through the authority given to the medical staff by the board of directors.

State statute does not normally specify specific tasks that may or may not be performed by NPs. The dynamic and constant changes in healthcare technology pose issues for formal education programs when it comes to training and competency assessment in using equipment, performing procedures commonly seen within subspecialties, and for documenting education that is beyond

the broad, nationally vetted curriculum. For this reason, mechanisms are established through the institutional privileging process that allows for updated SOP and competency assessments to be performed and authorization given to perform these tasks under varying degrees of supervision, collaboration, or independently. These tasks, however, must be within the SOP of the NP. In this way, patient safety is assured and the SOP for the practitioner can be updated within the institution.

### Contemporary NP and ACNP issues

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

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

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

tients across a spectrum of care areas. It becomes evident that differentiating SOP is an essential aspect of ensuring congruency of NP practice based on licensure, accreditation, education, and certification.

This issue commonly appears before state boards of nursing as they are posed with questions such as, "Can an Adult NP treat a patient with X condition?", or "Is it within the scope of practice of a Family NP to perform Y procedure?" This can also be an issue if an ACNP wishes to practice in a primary care environment for which they are not appropriately trained.

Recently, the National Organization of Nurse Practitioner Faculties (NONPF) issued a statement on acute care and primary care NP practice which reiterates that NP competencies are not setting specific, and that regulation should be based on educational preparation and SOP (NONPF, 2011). They further outline that SOP is based on formal APRN education and not pre-APRN education or on-the-job training.

### Contradictory evidence

Despite the increasing number of references clarifying NP SOP, several recent literature sources have contributed to the confusion related to NP SOP, including the American Medical Association's Scope of Practice Data Series on Nurse Practitioners (American Medical Association, 2009). This compendium, created for state medical associations to provide background information to challenge advocacy campaigns seeking to expand SOP for "nonphysician healthcare providers," called for assessment of the quality of NP training in relation to SOP expansions sought at the state level. While the document identified that a healthcare professional's authority to provide services should be commensurate with their education and training, it questioned whether the NP educational system was currently ensuring that NPs are adequately trained to provide appropriate care for patients and inquired if NPs were being granted SOP for which they are not adequately prepared. Documents such as this that are aimed at limiting the APRN SOP unfortunately only contribute to the continued confusion over NP SOP.

A recently published nursing study of 1216 NPs certified as adult, family, or acute care NPs reported to examine NP practice sites as compared with their certification (Keough, Stevenson, Martinovich, Young, & Tanabe, 2011). "Traditional" practice settings for NPs were identified as either primary or acute care. However, a methodologic flaw in the study categorized ambulatory settings with primary care settings and designated that ambulatory care was a "nontraditional" practice setting for ACNPs. The results designating that 42% of ACNPs were

practicing in nontraditional practice setting can therefore be questioned, as ambulatory settings are indeed a practice site for ACNPs based on the scope and standards of ACNP practice.

A 2011 posting on a college of nursing's website identified the following question and response: *If I become certified as an Adult-Gerontology Primary Care Nurse Practitioner, am I only permitted to work in primary care settings or will I be qualified to work in acute/critical care and hospital settings as well?*

*"You will be able to work in both settings, primary and acute/critical care. Currently, many hospitals employ ANPs and FNPs and do not require a certification as an Acute Care Nurse Practitioner. If you desire to work in an acute/critical care setting, then it will be helpful for you to have RN experience in that setting and/or didactic and clinical acute/critical care experience during your program"* (University of Washington School of Nursing, 2011). Messages such as this provide incorrect information and only adds to the confusion about APRN SOP.

Publications and communication media that provide inaccurate information about SOP of NPs unfortunately continue to exist. Providing clarification of the NP SOP, especially as it pertains to ACNPs, remains needed to support practice based on the educational preparation, licensure, certification, and focus of practice.

## Conclusion

Clarifying the SOP for NPs is a priority area of focus to ensure that NPs are practicing in accordance with their education and training. The practice of any NP should not be regulated by the practice site. There is a role for primary care NPs to practice within institutions and also for ACNPs to practice outside of institutions. It is the professional responsibility of all NPs to self-assess the appropriateness of their individual educational preparation, their demonstrated competency as evidenced by the certification they hold, and their legally authorized SOP granted by their state license and also by the institutional credentialing process, and to match those with the identified patient care need they are seeking to meet.

The Institute of Medicine Report on the Future of Nursing highlighted the important role of NPs as Advanced Practice Registered Nurses and included the recommendation that APRNs should be able to practice to the full extent of their education and training, citing that SOP restrictions currently limit APRN practice (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine, 2011).

Uncertainty about NP SOP continues to exist and misconceptions continue to appear in current literature, as

well as other healthcare professional communication media. For NPs practicing with acute care certification, clarification of SOP issues is crucial in ensuring that ACNPs are recognized as being competent providers, regardless of practice settings (Melander, Kleinpell, & McLaughlin, 2007). Elucidating APRN SOP will enable optimal care to be provided for patients in all types of healthcare settings as well as ensure that NPs are functioning to their fullest capacity. Continued progress in implementing uniform nurse practice acts and standardized SOP for APRNs, including ACNPs, will benefit the overall health of the nation and will greatly assist in meeting the health manpower needs of the future.

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