Week 2: Introduction to NP Practice

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Historical Development of Advanced Practice Nursing

The road to advanced practice for nurses in the United States has required patience, dedication, and advocacy. The historical development of the role dates back to 1965 when nurse Loretta Ford and physician Henry Silver, from the University of Colorado, suggested that a nurse practitioner (NP) could best alleviate the primary care shortage (especially in the area of pediatrics) and developed a pediatric nurse practitioner plan of study. Their efforts were met with much resistance from both the nursing and medical communities (Hain & Fleck, 2014). Nurses thought such a role was "playing doctor," whereas physicians thought such a role was "practicing medicine without a license." However, the early work by Ford and Silva paved the way for advanced practice nursing. Eventually, four advanced practice nursing (APN) roles emerged: Certified Nurse Midwife/CNM, Certified Nurse Practitioner/CNP, Clinical Nurse Specialist/CNS and Certified Nurse Anesthetist/CRNA. ANPs can further specialize within the CNP role to include expertise in mental health, geriatrics, acute care, and palliative care (Hain & Fleck, 2014).

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Initially, many APNs received education through hospital-based certificate programs that prepared them to function as nurse clinicians or nurse anesthetists. As nurse clinician programs grew in popularity, education moved away from hospital-based programs towards university-based education. Specialized education at the graduate level became required in order to obtain advanced practice credentials.

Some important professional organizations that contributed to early role development include the American Association of Nurse Anesthetists (AANA) and the American Association of Nurse Practitioners (AANP), both with a largely clinical focus; the American College of Nurse Practitioners (ACNP), with a largely legislative focus; and the National Organization of Nurse Practitioner Faculty (NONPF), with a largely educative focus.

With the emergence of new APN roles, healthcare delivery by APNs has progressed past simply augmenting care in traditional MD/DO practices. As noted above, APNs now practice a wide variety of ways in diverse settings. Some even own their own practices where the delivery of care is independent of physician oversight. One concern with the expansion of the APN role is that state governance of APN continuing education continues to differ widely with regard to professional preparation requirements, scope and standards of practice, level of autonomy, and individual certification requirements, which has led to confusion among APNs, legislators, payers, other healthcare professionals, and laypersons (IOM, 2011).

Education and Specialization

Advanced practice nursing provides the nurse with the opportunity to make a larger contribution to person, environment, health, and nursing. The advanced practice nurse builds on advanced pathophysiology, pharmacology, and health assessment skills, knowledge, and integrative abilities to intervene on behalf of the person to restore, maintain, and/or promote health at a higher level than the generalist nurse. The advanced practice nurse is a specialist in healthcare delivery.

As noted above, graduate education is now required for entry into APN practice. Graduate education helps students learn to utilize advanced skills, knowledge, and integrative abilities in assessment, planning, diagnosis, implementation, and evaluation of healthc are, which includes preparation for role specialization, and possibly sub-specialization. Initially, the role of the NP was limited to primary care ( Goroll & Mulley, 2014). Role specialization may now include other areas, including acute care, geriatric care, palliative care , and mental health care. The American Association of Colleges of Nursing (2004) has recommended that the practice doctorate (DNP) be the required degree for entry into NP APRN practice.

There are still some challenges related to APN specialization. State definitions of the roles of CNM, CNP, CNS, and CRNA vary, which has let to confusion with regard to role separation, competency, emphasis, approach, and variation. This confusion extends to nurse educators, providers, reimbursement, and even the public. In addition, a lack of clarity regarding initial role preparation versus current certification serves to further frustrate accreditors, consumers, and employers alike. More recent attempts to designate direct care versus indirect care roles have only heightened this frustration.

Credentialing

There are a variety of credentialing methods for health professions regulation. Types of regulation include licensure, registration, certification, recognition, and self-regulation (DeNisco & Barker, 2015) . The APN and public alike continue to suffer from role confusion, partly due to the lack of standardization in credentialing form for APNs. Eunice Cole, past president of the American Nurses Association, recommended that nurses should only list the highest earned degree in a given discipline, followed by licensure, state designations, national board certifications, and concluding with honorary awards . The degrees earned appear first (these are credentials such as MSN or PhD that can never be taken away). Next, licensure information appears (these are credentials such as RN or ARNP that are regulated by the state). Certification credentials follow (these are credentials that aren't necessarily regulated, like APRN, BC from the American Nurses' Credentialing Center [ANCC], which is earned through testing and renewal, or NP-C from the American Academy of Nurse Practitioners [AANP], which is likewise earned through testing and renewal). Finally, come honorary credentials, such as FAANP .