# CHAPTER 21

# APPROVAL:
## NATIONAL COUNCIL OF STATE BOARDS OF NURSING

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The content of this chapter relates to the following major content areas and subconcepts on the Certified Nurse Educator Examination Detailed Test Blueprint:

- **Participate in Curriculum Design and Evaluation of Program Outcomes.** (All the subconcepts of this content area relate, but specifically that of:)
  - Revise the curriculum based on evaluation of program outcomes; learner needs; societal and health care trends; stakeholder feedback
  - Implement curriculum revisions using appropriate change theories and strategies
  - Update course to reflect the philosophical and theoretical framework of the curriculum
  - Implement program assessment models
  - Analyze results of program evaluation and initiate curricular change
  - Critique the program evaluation methods and plan
- **Pursue Continuous Quality Improvement in the Academic Nurse Educator Role**
  - Acquire knowledge of legal and ethical issues relevant to higher education and nursing education
- **Function Effectively Within the Institutional Environment and the Academic Community**
  - Identify how social, economic, political, and institutional forces influence nursing and higher education

### Introduction

*An approval at state boards of nursing*
*Takes a careful review and conversing*
*On the health of a school*
*And meeting each rule.*
*And that's what this chapter's rehearsing!*

Professional regulation in nursing is defined as the process whereby governmental agencies grant legal authority for an individual who has met specified qualifica-

tions and demonstrated a minimum entry-level competence to practice a chosen profession (Sheets, 1996). This definition is used to provide the framework for this chapter. Although this definition implies that regulation is mandated by governments, others assert that professions are also regulated by certification (as opposed to state-issued certification) and accreditation. This chapter, however, makes a distinction between regulation and licensure versus accreditation and certification because the former are governmental mandates.

Nursing is regulated because it is one of the health professions that pose risk of harm to the public if practiced by someone who is unprepared and incompetent. The public may not have sufficient information and experience to identify an unqualified health care provider and is vulnerable to unsafe and incompetent practitioners (NCSBN, 2008d).

Regulation can be on four levels (National Council Position Paper, 1993):

- Designation/recognition
- Registration
- State-issued certification
- Licensure

The least restrictive level is designation/recognition, and regulation at this level does not limit the right of the nurse to practice; neither can the state inquire about incompetence. It merely provides the public with information about nurses with special credentials. Likewise, registration does not involve state inquiry into the scope of practice, or competence; it merely involves providing information to an official roster. These are the most elementary levels of regulation.

The next level is state-issued certification, which allows for the legal authority to practice. A few states issue state certification to advanced practice nurses, though state-issued certification does not include a defined scope of practice. The federal government has used the term *certification* to define credentialing by a nongovernmental agency, and today most of the boards use APRN certification examinations of nursing as one of the requirements for advanced practice licensure (Chornick, 2008). The most restrictive type of regulation is licensure, in which the professional must demonstrate minimal competency to practice and the state has the authority to take disciplinary action should licensees violate the law or rules under which they are regulated (Sheets, 2002).

## Brief History of State Approval of Nursing Schools

The approval of nursing programs is part of the regulatory process carried out by the state boards of nursing in the 50 states, territories, and the District of Columbia, in the United States. See Table 1 for a list of 60 boards of nursing. The approval process can be defined as "official recognition of nursing education programs which meet standards established by the board of nursing" (NCSBN, 2004b). Approval standards are defined by the NCSBN model practice act as: "The board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences, and approve such programs that meet the requirements of the Act and board rules" (NCSBN, 2004a). Some boards of nursing use "accreditation" instead of "approval," but the term "approval" will be used in this chapter to avoid confusion with national nursing accreditation. See Table 2 for definitions of relevant terms for nursing regulation.

| Area I | Area II | Area III | Area IV |
|---|---|---|---|
| Alaska | Illinois | Alabama | Connecticut |
| American Samoa | Indiana | Arkansas | Deleware |
| Arizona | Iowa | Florida | District of Columbia |
| California-PN and California-RN | Kansas | Georgia-PN and Georgia-RN | Maine |
| Colorado | Michigan | Kentucky | Maryland |
| Guam | Minnesota | Louisiana-PN and Louisiana-RN | Massachusetts |
| Hawaii | Missouri | Mississippi | New Hampshire |
| Idaho | Nebraska and Nebraska-APRN | North Carolina | New Jersey |
| Montana | North Dakota | Oklahoma | New York |
| Nevada | Ohio | South Carolina | Pennsylvania |
| New Mexico | South Dakota | Tennessee | Rhode Island |

Table 1. The 60 State Boards of Nursing

| Northern Mariana Islands | West Virginia-PN and West Virginia-RN | Texas | Vermont |
|---|---|---|---|
| Utah | | | |
| Washington | | | |
| Wyoming | | | |

* Please note: California, West Virginia, Georgia, and Louisiana all have separate RN and PN Boards of Nursing; Nebraska has a separate APRN Board of Nursing. As of August, 2008, British Columbia has become NCSBN's first Associate Member.

**Table 1 continued: The 60 State Boards of Nursing**

The early struggle for nursing regulation began in England with what has been termed the Thirty Years War. The debate was one of self-regulation versus legal regulation. Some nurses, such as Ethel Bedford Fenwick, also known as Ethel Gordon Fenwick (Griffin, 1995), one of the founders of the British Nurses' Association, viewed legal regulation as an opportunity to establish uniform qualifications, thus safeguarding the profession and the public. However, others, including Florence Nightingale, believed the focus should be on social and moral standards of the nurse. Nightingale thought Fenwick's plan for regulation would exclude working-class nurses, and she objected to a written examination on the grounds that it could not test moral and personal character, as well as the application of knowledge to the patients on the wards. While Nightingale did not rule out some system of registration in the future, based on certifying them individually on an apprenticeship model, she thought for the time (late 1800s), nursing needed to continue its progress without interference from the regulators (Bostridge, 2008).

Further, the physicians and hospital administrators feared that legal registration would lessen their control over nurses and grant nurses "undeserved" professional status (International Council of Nurses, 1985; Weisenbeck & Calico, 1991). While this debate was raging, other nations enacted the first registration laws. The first registration law was enacted in Cape Town, South Africa in 1891, and another in New Zealand in 1901, but England did not pass registration laws until 1919 (Dorsey & Schowalter, 2008).

**Accreditation** – a voluntary process by private agencies which is an external quality review by peers to assure that an educational program meets established standards for structure, function, and performance (Sheets, 2002).
**Approval** – official recognition of nursing education programs which meet standards established by the board of nursing (NCSBN, 2004b).
**Approval Standards** – the board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences, and approve such programs that meet the requirements of the Act and board rules. (NCSBN, 2004a).
**APRN** – advanced practice registered nurses, including certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners (NPs) (NCSBN, 2002b).
**Boards of Nursing** – serve to protect the public through 4 major domains: (1) approving and enforcing educational standards, (2) licensing on the basis of psychometrically and legally defensible testing, (3) monitoring and decision making related to practice issues, and (4) using the disciplinary process to remove from practice those nurses who fail to maintain standards (Hudspeth, 2008).
**Certification** – either state-issued or voluntary; if state issued, it allows for the legal authority to practice; if voluntary, it is a professional credential that recognizes that a practitioner has passed a professional certification exam given by a private agency, and it does not grant a legally defined scope of practice (Sheets, 2002).
**Designation/Recognition** – provides the public with information about nurses with special credentials. It is the least restrictive type of regulation, and it does not limit the right of the nurse to practice, nor can the state inquire about incompetence (NCSBN, 1993).
**Licensure** – the most restrictive form of professional regulation where regulated activities are complex, requiring specialized knowledge and skill and independent decision-making. In the licensure process, predetermination of qualifications is made (for example, passing the NCLEX® in nursing), monitoring of qualifications is often ongoing, and licensure provides authority to take disciplinary action if the law or rules are not followed (Sheets, 2002).
**Nurse Practice Act** – the statutes that authorize the board of nursing to promulgate rules that are necessary for the implementation of the nurse practice act (Weisenbeck & Calico, 1991).
**Registration** – does not involve state inquiry into the scope of practice or competence; it merely involves providing information to an official roster (NCSBN, 1993).

Table 2. Definition of Regulatory Terms

**Regulation** – the process whereby governmental agencies grant legal authority for an individual who has met specified qualifications and demonstrated a minimum entry-level competence to practice a chosen profession (Sheets, 1996).
**Rules** – regulations that are consistent with the nurse practice act. The rules cannot go beyond the law, and once enacted, they have the force of the law. Some states refer to these as the regulations, though this chapter will refer to them as the rules.

**Table 2 continued: Definition of Regulatory Terms**

The first reference to the employment of nurses in the United States was in 1777. Sophia Palmer, the editor of the *American Journal of Nursing*, called for regulation of nursing at the New York State Federation of Women's Clubs in 1899. However, it was not until 1903 that North Carolina enacted the first registration law for nursing, followed by New York, New Jersey, and Virginia (Dorsey & Schowalter, 2008; Flanagan, 1976; Weisenbeck & Calico, 1991). Soon thereafter, boards of nursing began to emerge for the purpose of regulating nurses. By 1906, inspectors of schools or hospitals with nurse training programs began making program visits for approval. Annie Damer, of New York, was a member of the first Board of Nurse Examiners, where they inspected nursing programs, and she later became its president (American Nurses Association, 2008).

The early regulation of nurses protected the title of those who met a minimum set of criteria for registration. Those requirements included:

- Completion of an educational program that met standards set by the board of nursing
- Successful completion of a written and performance examination
- Evaluation of moral and character fitness (Weisenbeck & Calico, 1991)

While the early laws made provisions for the above, absent from these laws was a definition of practice. New York (in 1938) became the first state to define the scope of practice and to adopt a mandatory licensure law. While it took several years for the law to be fully implemented because of World War II and other societal changes, it was a landmark law that all boards of nursing subsequently followed. This new law also delineated two classes of licenses, the professional nurse and the practical nurse, and it listed specific violations whereby a license could be suspended or revoked for just cause (Dorsey & Schowalter, 2008).

Resistance to mandatory licensure came from hospital administrators who realized there would be an economic effect from adopting a compulsory law. Therefore, it was not until the mid-1960s that all states had adopted definitions of nursing, delineating the scope of practice along with mandatory licensure.

Safriet (2002) asserted that nursing was "relegated to a scope of practice that was by definition 'carved out' of medicine's universal domain" (p. 308). Because physicians were the first to secure licensure, Safriet stated, the rest of the healthcare fields had to defer to physicians, whose scope of practice is extremely pervasive. According to Safriet a physician could practice gynecology, oncology, orthopedics, pediatrics, retinal surgery, or psychiatry using outdated treatment modalities – all with the same license that the physician obtained years ago. Realistically, physicians do not do this, though Safriet contended that it is not the law that constrains them. Safriet reminded nurses that only three decades ago, nurses needed orders for taking a blood pressure. Until the 1970s, only physicians had the authority to pierce ears.

The mission of boards of nursing includes developing rules and approving nursing education programs for the purpose of protecting the health, safety, and welfare of the public. Boards also have the legal authority to license nurses and to discipline nurses for unsafe practice. Although approval is mandated by the boards of nursing for the purpose of protecting the health, safety, and welfare of the public, accreditation is a voluntary, nongovernmental, peer-review process to assure that programs are meeting standards of structure, function, and performance. The first nursing accreditation program began in 1916, and currently, two private agencies accredit nursing programs. The National League for Nursing Accrediting Commission (NLNAC) accredits practical, associate degree, diploma, baccalaureate, master's, and clinical doctorate nursing programs (NLNAC, 2008), while the Commission on Collegiate Nursing Education (CCNE) accredits baccalaureate, master's, and doctor of nursing practice (DNP) programs. In 2008 CCNE finalized standards for accrediting post-baccalaureate residency programs (CCNE, 2008).

Historically, most professions have had only one accrediting agency. The competitive model is a new concept to nursing and bears watching. Boards of nursing approve practical, associate degree, diploma, and baccalaureate programs, and some boards approve RN to BSN programs and advanced practice nursing programs. Although there is some redundancy in the process, boards of nursing and accrediting agencies are working together to make the process more seamless for schools of nursing.

In 2004 NCSBN published a white paper on the state of the art of approval processes in boards of nursing (NCSBN, 2004b), which was approved by the 2004 NCSBN Board of Directors. This document presented the 5 templates that Boards of Nursing use to approve the nursing programs in their jurisdictions, along with

the advantages and disadvantages of each. See Table 3 for a summary of the approval templates used by boards of nursing.

| | |
|---|---|
| I | Boards of nursing act independently to approve/accredit nursing programs. |
| II | Boards of nursing collaborate with national nursing accreditors, on-site visits or with the program reports, when approving programs. |
| III | Boards of nursing deem national nursing accreditation as meeting state approvals. |
| IV | Boards of nursing deem accreditation as meeting approvals, though they require further documentation. |
| V | Boards of nursing require national nursing accreditation. |
| VI | Boards of nursing are not involved with the approval system at all. In these two states, while the nursing programs are not approved by the board of nursing, they are approved by the Board of Higher Education and that is done by PhD educated nurses. |

**Table 3: Approval Templates Used by Boards of Nursing**

The following are some major differences between approval and accreditation (Gloor, 2001):

- Boards of nursing approve nursing programs for minimal standards of practice and from the point of view of public protection. Because of this, the criteria from boards of nursing must be met, rather than being met at different levels, as is the case with accreditation.
- Boards of nursing monitor and sanction nursing programs through statutory authority. The professional accreditation process, however, focuses on the quality and integrity of nursing programs (CCNE, 2008; NLNAC, 2008).
- With the accrediting process, schools can lose their accreditation status, but they cannot be shut down. The boards of nursing, through legal authority, can close programs that do not meet their criteria, after the programs have been given a reasonable opportunity to comply with the standards. Typi-

cally boards of nursing collaborate closely with programs that do not meet their standards.

- Nursing accreditation is voluntary, while approval is mandatory.
- By law, the boards of nursing monitor the licensure exams so they align with current practice. To do this, comprehensive studies and job analyses are conducted. Although private accreditors often conduct their own research, the law does not mandate they do so.
- Boards of nursing may make emergency visits to the nursing program if problems are reported to them.
- Boards of nursing are in the unique position of being able to demonstrate great awareness of statewide nursing education needs, but accreditation is a national process.
- Boards of nursing do all of this at little cost to nursing programs, but private accreditation can be quite costly.

In addition to approval and accreditation, nursing programs must also meet standards of other agencies. For example, they must meet the standards of the Occupational Safety and Health Administration (OSHA), as well as be in compliance with the Americans with Disabilities Act (ADA). The parent institutions may be required to meet standards set by various state or regional agencies, such as, North Central Association of Colleges and Schools in the Midwest or the Southern Association of Colleges and Schools (SACS) in the South. Practice settings also must follow regulations set by federal and state agencies, and many of them seek voluntary accreditation, such as accreditation awarded to hospitals by the Joint Commission.

## Rationale and Evidence for Regulation of Nursing Education Programs

Boards of nursing exist to protect the public health, safety, and welfare of individuals. Approval of nursing programs ensures that nursing is practiced by minimally competent licensed nurses within an authorized scope of practice. There is worldwide agreement by nurse leaders that there is a direct relationship between safe patient care and the quality of nursing programs (Gloor, 2001; ICN, 1997). This is particularly important for boards of nursing since their mission is to protect the public. Furthermore, the release of the Institute of Medicine's report on medical errors (Kohn, Corrigan, & Donaldson, 1999), followed by other national reports on safety in health care, has created national attention on patient safety. However, nurse researchers need to conduct more studies that describe the relationship between education programs and teaching strategies with patient outcomes.

Additionally, it is important for educators to remember that licensure of new nurses is a two-pronged process, involving the faculty members and the regulators. While each new nurse must pass the NCLEX® before being licensed, the new nurse must first graduate (the legislative language varies with jurisdictions) from an approved nursing program before the student is eligible to take the NCLEX®. Therefore, while regulators have the responsibility for approving nursing programs, educators have the responsibility for deciding whether the student should graduate, thereby affirming that the student is safe and competent enough to take the NCLEX®. This decision by faculty members should not be taken lightly.

Effective communication among many stakeholders in regulation, such as nursing programs, nurse educators, practice partners, accrediting agencies, nursing organizations, and the community are necessary for an effective approval process. Approval can also present unique opportunities to nursing because it can provide databases and information sharing to individual boards as well as to the nursing education community and nursing organizations (Gloor, 2001).

The approval process is carried out somewhat differently by each of the 60 boards of nursing because nursing regulation is state-based, with the underlying assumption being there are many ways to effectively regulate nursing education. Creative and visionary ways for regulating nursing programs are shared among the various boards of nursing. The NCSBN facilitates this communication by hosting monthly education conference calls, holding education meetings at NCSBN's annual Delegate Assembly, and developing electronic means of communication, such as use of Wikis and Web surveys. An NCSBN committee found that most of the 60 boards of nursing share the following roles (Gloor, 2001):

- Granting approval to basic nursing education programs
- Monitoring and sanctioning programs at risk, according to statutes
- Demonstrating awareness of state nursing education needs
- Participating in setting standards for nursing programs

This same committee identified some of the quality indicators that nurse regulators look for in nursing education programs. See Table. 4

1. Consistency of program outcomes with state laws and administrative rules
2. Consistency of program outcomes with general standards of practice
3. Consistency of program outcomes with needs and expectations of consumers
4. Consistency of program outcomes with a comprehensive systematic evaluation plan that incorporates continuous quality improvement
5. Evidence of faculty and student participation in program planning
6. Consistency of program outcomes with a curriculum that provides diverse learning experiences
7. Fiscal, human, physical, and learning resources that support program outcomes and quality improvement
8. Program administrator who is a professionally and academically qualified registered nurse with institutional authority and administrative responsibility
9. Professionally and academically qualified nurse faculty sufficient in number and expertise to accomplish program outcomes and quality improvement
10. Evidence that information communicated by the nursing program is fair, accurate, inclusive and consistent

**Table 4. Quality Indicators of Nursing Education Programs: Regulatory Perspective**

The boards of nursing use the available evidence to support their administrative education rules. To assist with evidence-based nursing regulation, NCSBN, though its research and committee work, provides data to the boards of nursing. In 2005 NCSBN released an evidence-based position paper (NCSBN, 2005) on the necessity of clinical experiences, at the level of licensure, in prelicensure nursing programs. This paper has been frequently used by the boards of nursing to support their regulations related to prelicensure clinical practice experiences. While most boards of nursing don't set specific numbers of clinical hours (Table 5) in their education administrative rules, the boards of nursing do require sufficient clinical experiences, under the guidance of qualified faculty, to meet the program's outcomes. Furthermore, this position paper, which was adopted by the NCSBN membership, explicitly calls for students to directly care for patients in their prelicensure programs. While the use of simulation and laboratory experiences in nursing education are excellent teaching methodologies, they cannot replace actual experiences with patients.