



**National
Association of
Neonatal
Nurses**

**National Association of
Neonatal Nurse Practitioners**



A division of NANN

Advanced Practice Registered Nurse: Role, Preparation, and Scope of Practice

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In recent years, the National Association of Neonatal Nurses (NANN) and the National Association of Neonatal Nurse Practitioners (NANNP) have developed several policy statements on neonatal advanced practice registered nurse (APRN) workforce, education, competency, fatigue, safety, and scope of practice. This position paper is a synthesis of previous efforts and discusses the role, preparation, and scope of practice of the neonatal APRN.

Association Position

Graduation from a graduate-level, accredited neonatal APRN program and national certification as a neonatal nurse practitioner (NNP) or neonatal clinical nurse specialist (NCNS) are the standards for advanced nursing practice in the neonatal population.

An APRN is a nurse who has (National Council of State Boards of Nursing [NCSBN], 2008):

- completed an accredited graduate-level education program preparing him or her for one of four recognized APRN roles within the six population foci (neonatal, pediatrics, family, psych-mental health, adult-gerontology, and gender specific [women's health])
- passed a national certification examination that measures APRN, role, and population-focused competencies and who maintains competence through recertification in the role and population through the national certification program
- acquired advanced clinical knowledge and skills preparing him or her to provide direct care to patients, as well as a component of indirect care; whose practice builds on the competencies of registered nurses (RNs) and who are educationally prepared to assume responsibility and accountability for health promotion and maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and nonpharmacologic interventions
- obtained clinical experience of sufficient depth and breadth to reflect the intended license and has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

The neonatal population is served by two neonatal APRN roles—the neonatal nurse practitioner (NNP) and the neonatal clinical nurse specialist (NCNS). Nurse practitioners and clinical nurse specialists who practice in neonatal intensive care units (NICUs) but are not formally educated in the neonatal population are practicing outside their scope of practice.

Background and Significance

Neonatal Nurse Practitioner

CNPs are members of the health delivery system, practicing autonomously in diverse areas along the wellness-illness continuum in which direct primary and acute care is provided across settings. CNPs diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. CNPs provide initial, ongoing, and comprehensive care, including taking complete histories; providing physical examinations and other health assessment and screening activities; and diagnosing, treating, and managing patients with acute

and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases (NANN, 2000; APRN Consensus Model Work Group, 2008).

NNPs are CNPs who are prepared to practice across the continuum, providing primary, acute, chronic, and critical care to neonates, infants, and toddlers through age 2. In addition, NNPs select and perform clinically indicated advanced diagnostic and therapeutic invasive procedures.

Neonatal Clinical Nurse Specialist

The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, and system. The three spheres are overlapping and interrelated, but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision making, and respond to diversity.

The NCNS is prepared to autonomously improve the quality of neonatal health care through the processes of change, collaboration, consultation, education, modeling of expert care, leadership, case management, care coordination, and research utilization across the neonatal population continuum for neonates, infants, and toddlers through age 2. The NCNS's collaboration with interprofessional healthcare teams and families ensures that the healthcare system is safe and promotes positive outcomes for this population (National Association of Clinical Nurse Specialists [NACNS], 2013).

Historical Background

The first modern day NICU opened in 1960 at Yale-New Haven Hospital under the auspices of Louis Gluck, a pioneer in the emerging pediatric specialty, neonatology (Honeyfield, 2009; Johnson, 2002). Dr. Gluck's NICU concept demonstrated improved outcomes of sick and preterm infants and led to the emergence of NICUs across the country by the late 1960s (Johnson, 2002). Most NICUs were located in large, university settings with patient management provided by medical interns and residents supervised by a neonatologist. To meet the needs of this vulnerable population, nursing roles expanded to include tasks previously relegated to physicians, such as initiating intravenous access and phlebotomy (Honeyfield, 2009).

In 1965, the first nurse practitioner program in the United States was developed at the University of Colorado to prepare pediatric nurse practitioners for primary care (Trotter & Danaher, 1994). The CNS role, which was the first master's-prepared APRN, was advocated by the National League of Nursing in 1948 when the need for nurses with specialized knowledge and skill became apparent (Anderson, Baltz, & Lankford, 2010). By the late 1960s there was an increase in the number of educational programs available for the expansion of the role to specialties such as community health and acute care settings in hospitals, including the newly developed NICUs (Anderson et al., 2010; Hartjes & Dreifruet, n.d.).

By the 1970s, neonatal intensive care was an integrated medical service in many large teaching hospitals across the country, providing successful management of the preterm and sick newborn and reducing the neonatal mortality rate (Honeyfield, 2009; Johnson, 2002). Neonatal transport services were established to move newborns from their birth facility to the nearest NICU, enabling expansion of the NICU nursing role as nurses filled these new positions. Guidelines published by the American Nurses Association (ANA) in 1975 set the NNP program standards until NANN published *Education Standards and Guidelines for NNP Programs* in 2002 (Honeyfield, 2009; Johnson, 2002; ANA, 1975; NANN, 2002). These ANA standards led to the proliferation of hospital-based, certificate programs to train nurses as NNPs.

In 1982, the American Academy of Pediatrics issued a statement in support of the NNP role, recognizing that the scope of advanced neonatal nursing practice encompassed a knowledge base and set of technical skills that were traditionally considered the province of the physician (Harper, Little, & Sia, 1982; Reynolds, 2007). National certification for NNPs began in 1983 by the NAACOG Certification Corporation, now the National Certification Corporation (NCC) for Obstetrics, Gynecologic and Neonatal Nursing Specialties (NCC) (Honeyfield, 2009). NANN was established in 1984, providing support to foster the neonatal advanced practice nursing movement (Johnson, 2002). During the 1980s, research studies began to report the success of the NNP role, and the trend toward master's-degree preparation for all nurse practitioners began.

In the 1990s, states began requiring national certification or master's degree as entry into practice for the NNP (Johnson, 2002). The NCNS role began to change from the traditional role of expert knowledge for quality care to include the dissemination of research, leadership in evidence-based practice efforts, and case management of complex patients and effective system change management (Hartjes & Dreifruet, n.d.; NACNS, 2004; Cukr, 1996). In the early 2000s, nurse practitioners lobbied for prescribing privileges to make their provider status fully operational. In 2007, NANNP, a division of NANN, was founded as the only national association dedicated solely to NNPs (NANNP, 2007).

Today, neonatal APRNs are recognized as professional providers, and they have become an integral part of the neonatal health team at all levels of care (Johnson, 2002; Nagle & Perlmutter, 2000). According to the NCC, there are presently approximately 5,200 NNPs with national certification (NCC, 2013). Fifty-two states and jurisdictions already require advanced certification for APRNs (NCSBN, 2013). Presently, only Kansas and New York have no requirement for advanced certification for APRNs with Alaska, California, Indiana, Mississippi, New Hampshire, Pennsylvania, and Washington are missing the requirement for at least one of the APRN roles. This is not the case for the NCNS. The number of CNSs in the United States is estimated at around 67,000 (NACNS, 2004). Although there are more than 5,200 certified NNPs, only 47 are certified neonatal CNSs (American Association of Critical Care Nurses [AACCN], 2013). One reason for the paucity of certified NCNSs is that certification in a specialty is not required by many organizations and states. In addition, until 1999, there was no neonatal specific certification exam available for the CNS.

Education

Although CNS educational programs have always been offered at the master's level, early NNP programs were developed independently by institutions to provide didactic and clinical training to nurses in their hospitals. Most times, the education of these nurse clinicians was undertaken by neonatologists, pediatric subspecialists, and the neonatal APRN that worked alongside the nurses. As a result, the initial NNP program training was only acknowledged by a certificate of completion. This mindset led to a delay of acceptance and integration of the neonatal APRN role into graduate nursing programs.

The NCC has been integral in setting the standards for the educational preparation of the NNP and acknowledges the graduate degree as the minimum entry-level degree that must be obtained prior to sitting for the certification exam. As the roles of the neonatal APRN became more widely accepted, individuals in practice saw the value of obtaining the same educational preparation as their other advanced practice colleagues (e.g., CNS, CRNA, family nurse practitioners) and endorsed the master's degree in nursing as the entry-level degree for NNPs. This has become the standard accepted both by the certification institution as well as by most state boards of nursing.

The Institute of Medicine (IOM) report, *To err is human: building a safer health system*, renewed recognition of the importance of the CNS role in achieving optimal patient outcomes and helped reverse the loss of CNS education programs (IOM, 1999). According to the NACNS website, there are 218 CNS master's and DNP programs in the United States (NACNS, 2003). Of those programs, six are specifically for the neonatal population, four have a perinatal focus, and one specializes in the high-risk mother and baby.

Although neonatal nurses were initially only recognized by their institutions as having received advanced training in the care of the high-risk neonate, they now are acknowledged as graduate-prepared neonatal APRNs who deliver high-quality, cost-effective care. It was through the persistent belief in the value of this role by the first generation of neonatal nurses and physicians that neonatal APRNs now sit as equal partners with other advanced practice nursing colleagues and have the opportunity to forge ahead with the new challenges in APRN education.

Most recently, practice demands associated with an increasingly complex healthcare system created a mandate to reassess the foundational education for clinical practice for all nursing professionals. To this end, the American Association of Colleges of Nursing (AACN) convened a task force to investigate the feasibility of a practice doctorate in nursing. The task force proposed doctoral-level education as the entry-level preparation for APRNs. This recommendation was approved by the AACN membership in its document, *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006). This publication illustrates the "curricular expectations that will guide and shape doctor in nursing practice (DNP) education." The document outlines the "curricular elements and competencies that must be present in programs conferring the doctor of nursing practice degree and addresses the foundational competencies that are core to all advanced nursing practice roles" (AACN, 2006). It is not yet clear when doctoral-level education will become the entry-level degree for all roles of APRN practice.

Scope of Practice

Scope of practice can be defined as the activities healthcare practitioners are permitted to perform within their profession. This helps determine for which patients a provider can provide care and under what circumstances this care is given. To determine scope of practice for APRNs, consideration must be given to advanced practice education in a role and population foci, scope of practice standards published by the national specialty organization or APRN associations, and the state's nurse practice act and board of nursing rules and regulations.

For most boards of nursing, the scope of practice for the APRN is based upon his or her advanced educational preparation (NCSBN, 2012). The patient population, advanced educational program content, and competencies obtained in the advanced practice nursing educational program always serve as the foundation for advanced nursing practice. Previous RN experience does not expand one's scope of practice as an APRN (Missouri Nursing Association, n.d.; Arizona Board of Nursing, 2009; NANNP, 2010). Scope of practice also determines the minimum standard of competency and is governed by requirements for continuing education and professional accountability (Klein, 2005).

The scope of the neonatal APRN is expected to evolve through experience, education (formal and informal), evidence-based practice, developing

technology, and changes in the healthcare delivery system. The neonatal APRN's practice may be extended through continued advanced practice experience congruent with the accepted scope of practice (National Organization of Nurse Practitioner Faculties, 2013). There are finite limits, however, to the expansion of scope of practice without completing additional formal education. An APRN licensed in one role and population cannot practice in another APRN role or population without additional formal education, certification, and board of nursing recognition in the second role and/or population. APRNs are expected to seek and document appropriate education and competencies when expanding their scope of practice.

The neonatal population has traditionally been thought of as those patients in the NICU. In 2010, the Competencies and Orientation Toolkit for NNPs confirmed that the population was not just those infants physically housed in the NICU, but also those who suffered from chronic conditions as a result of complications of prematurity and neonatal pathophysiology (NANNP, 2010). NNPs have specific competency standards encompassing wellness through critical care in the population of neonates, infants, and toddlers through 2 years of age. NNP education standards of practice have evolved beyond acute and chronic care to include primary care across the continuum (NANN, 2009; NANN, 2013). The NCNS scope of practice involves collecting data relevant to the three spheres of influence. The NCNS, while not providing direct patient care the majority of the time will ensure the highest quality of care is provided to all patients and families, in conjunction with his or her NNP and physician colleagues (AACCN, 2002).

Recommendations

1. Educational preparation for a neonatal APRN should be from an accredited graduate-level, neonatal population-specific program.
2. National certification and recertification serves as the basis for neonatal APRN scope of practice and continuing competency validation.
3. APRNs who (a) have not sought graduate-level neonatal population specific education or cannot provide evidence of neonatal-specific content and supervised clinical experiences in their formal education programs and (b) are practicing in an NNP or CNS role in the NICU, are practicing outside their scope of practice.

Conclusions

The role of the neonatal APRN has a long and rich legacy. The neonatal population is defined as neonates, infants and toddlers through age 2. Neonatal APRN scope is determined by advanced practice educational preparation of the APRN, board certification as an NNP (through the NCC) or neonatal clinical nurse specialist (through AACN-CC), and state regulations and authorization by the boards of nursing in each respective state. Scope of practice is in alignment with NANNP's NNP competencies and the National Association of Clinical Nurse Specialists' core competencies with the neonatal population focus (NANNP, 2010; AACCN, 2002, NACNS, 2006). NANN and NANNP encourage nursing

executive and administrative staff and physician colleagues to look beyond NICU staffing needs to appropriate and safe mechanisms of providing care. The solution to the workforce shortage of neonatal APRNs is not the substitution of practitioners whose expertise lies in other specialty areas, but the preparation of more neonatal APRNs (Cavaliere & Sansoucie, 2001, NANNP 2009).

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