



National Association of Neonatal Nurses
A D V A N C E D P R A C T I C E
A division of NANN

Advanced Practice Registered Nurses Practicing Within the Neonatal Population: Role, Preparation, and Scope of Practice

Position Statement #3059

NANN-AP Council
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As the professional voice of neonatal APRNs, the National Association of Neonatal Nurses—Advanced Practice (NANN-AP) has developed several policy statements on neonatal advanced practice registered nurse (APRN) workforce, education, competency, fatigue, quality and safety, and scope of practice. This position paper is an updated synthesis of previous and current efforts and discusses the role, preparation, and scope of practice of the neonatal APRN and those caring for patients in the neonatal population. NANN-AP believes that all providers who practice in the NICU should have completed a neonatal population-specific educational program and achieved neonatal population-specific national certification.

Council Position

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

The neonatal population foci as defined in the APRN Consensus Model and by the national specialty associations is birth to age 2 years and is served by two 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 have not graduated from a neonatal-specific graduate program (or postgraduate certificate program) are practicing outside their scope of practice.

Background and Significance

Since the APRN Consensus Model was adopted in 2009 as the regulatory model for advanced practice nursing in the United States, APRNs have been defined using the following criteria (APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, 2008):

- graduation from an accredited graduate-level (master of science in nursing [MSN] or doctor of nursing practice [DNP]) education program or a postgraduate certificate program
- education and training for one of four recognized APRN roles (certified registered nurse anesthetist [CRNA], certified nurse midwife [CNM], nurse practitioner [NP], clinical nurse specialist [CNS]) and within the six population foci:
 - neonatal
 - pediatrics (primary or acute care)
 - family
 - psych-mental health
 - adult-gerontology (primary or acute care)
 - gender specific (women's health).

For licensure in all but three states (National Council of State Boards of Nursing, 2022), neonatal APRNs must pass a national certification examination that measures APRN, role, and population-focused competencies. APRNs also must demonstrate continued competence through maintenance of certification programs for continued licensure.

Neonatal Nurse Practitioner

NPs are members of the healthcare system, practicing autonomously in diverse areas in which direct primary and acute care are provided across settings. Certified NPs diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. 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 (APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, 2008; National Association of Neonatal Nurses, 2000).

Neonatal nurse practitioners (NNPs) are certified NPs who are prepared to practice across the continuum, providing primary, acute, chronic, and critical care to neonates, infants, and toddlers to age 2 years (National Association of Neonatal Nurse Practitioners, 2017, 2022). This includes obtaining perinatal history, performing antenatal consultations, and directing the resuscitation and stabilization of neonates in the delivery room. In addition, NNPs select and perform clinically indicated advanced diagnostic and therapeutic invasive procedures. The scope and environment within which the NNP practices has evolved to meet the complex needs of neonatal patients within the healthcare system and to deliver care for complex infants with primary, acute, and chronic conditions in various settings, including telehealth (National Association of Neonatal Nurse Practitioners, 2022).

Neonatal Clinical Nurse Specialist

The CNS, as defined by the National Association of Clinical Nurse Specialists (NACNS), is a certified advanced practice registered nurse who has clinical expertise and advanced

knowledge that allows them to function independently and achieve high-quality patient outcomes through collaboration with other members of the healthcare team (National Association of Clinical Nurse Specialists, 2019). The role of the CNS is to foster the delivery of high-quality, evidence-based, patient-centered care, while influencing three spheres of impact: patient, nurse, and system. Through the three spheres, the primary goal is continuous improvement of patient outcomes and nursing care through mentoring and system change (Fulton et al., 2020).

The neonatal CNS (NCNS) is prepared to 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. The NCNS's collaboration with interprofessional healthcare teams and families improves the safety of the healthcare system and promotes positive outcomes for the neonatal population (NACNS, 2019).

Historical Background

The first NICU in the United States opened in 1960 at Yale-New Haven Hospital under the auspices of Louis Gluck, a pioneer in the emerging pediatric specialty, neonatology (Honeyfield, 2009). The NICU concept demonstrated improved outcomes for sick and preterm infants and led to the emergence of NICUs across the country by the late 1960s (Johnson, 2002). Most NICUs were affiliated with large, academic medical training programs. Patient management was provided by interns and residents supervised by a pediatrician who had a special interest in the emerging field of neonatology. 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).

The clinical expert in nursing practice role—the CNS—began in the 1940s owing to *The Study of Nursing and Nursing Education in the United States* report, written almost two decades earlier. This report led to greater significance being placed on the academic curricula and quality of education for nurses. From this increased focus on the education content of nursing came Esther Lucile Brown's *Nursing for the Future* (1948), which called for a collegiate level of nursing education.

The CNS, which was the first master's prepared APRN role, was supported by the National League of Nursing in 1948 in recognition of the need for nurses with specialized knowledge and skill (Anderson et al., 2010). Hospital-based nursing education lacked curriculum standards, pedagogical knowledge of faculty, and the application of science and theory to practice (Fulton et al., 2020). Nursing theorist and psychiatric nurse Hildegard Peplau, EdD RN, created the first clinical nurse specialist graduate program in 1954 at Rutgers University School of Nursing, in the field of psychiatric/mental health nursing (Rust, 2004). Dr. Peplau is often considered the mother of the CNS role because she created the first dedicated graduate program for the CNS. And, 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.

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 (Johnson, 2002). Neonatal transport services were established to move newborns from their birth facility to the nearest NICU. The need for transport personnel, along with progressively restrictive time and service commitments of residents in the NICU, became the stimulus for the evolution of the neonatal nurse clinician role, the precursor to the NNP (Johnson, 2002).

Guidelines published by the American Nurses Association (ANA) in 1975 set NNP program standards and remained the NNP training program standards for nearly two decades (Johnson, 2002). These ANA standards led to the proliferation of hospital-based certificate programs to train nurses as NNPs. In these initial guidelines, the first advanced practice neonatal nurses were given the title of neonatal nurse clinician (NNC) to differentiate the educational preparation of the NNC from that of the CNS. Early programs were 4–9 months in length, and most were hospital based, like the physician assistant (PA) programs at that time. Registered nurses with 1–2 years of experience in the NICU or special care nurseries met the basic criteria for admission. Many nurses were hospital-sponsored candidates, often advancing into positions within the program's affiliated hospitals (Johnson, 2002). Concurrently, in 1982, the American Academy of Pediatrics (AAP) issued a statement in support of the NNP role, recognizing that the scope of advanced neonatal nursing practice encompassed a population-specific knowledge base and set of technical skills traditionally considered only within the scope of a physician (Harper et al., 1982). The next year, in 1983, national certification of NNPs began by the NAACOG Certification Corporation, now known as the National Certification Corporation for Obstetrics, Gynecologic and Neonatal Nursing Specialties (NCC; Honeyfield, 2009). By the end of the 1980s, hospital-based NNP certificate programs began to close, with more and more programs moving to university-based education. It was during this time that research studies reported the cost-effectiveness of university-based programs, and the trend toward master's-degree preparation began. Neonatal content was integrated into graduate program curriculum, although there was no consensus on clinical performance expectations (Johnson, 2002).

In the 1990s, states began requiring national certification and/or a master's degree for entry into practice for APRNs (Johnson, 2002). Then, in 1992, a working group of NNP educators developed a monograph, *Neonatal Nurse Practitioners: Standards of Education and Practice*, and in 1994 the National Association of Neonatal Nurses (NANN) published *Program Guidelines for Neonatal Nurse Practitioner Education Preparation*. From the initial NNP standards and competencies in 1994 through the most recent iteration, the scope of practice remains across the continuum of care, encompassing both acute and primary healthcare service provision for this specialty population (Etten et al., 2022). From the 1990s into the 2000s, the NCNS role began to expand from the traditional role of expert in knowledge of 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.

In the early 2000s, neonatal APRNs lobbied for prescribing privileges to make their provider status fully operational. The National Association of Neonatal Nurses—Advanced Practice (NANN-AP) was founded in 2007 as the National Association of Neonatal Nurse Practitioners

(NANNP), a division of NANN and the only national association dedicated solely to NNPs. In 2008, NANN was invited to be part of the APRN Consensus Work Group and began to advocate for the neonatal population to be separate and distinct from pediatrics for NP and CNS roles. In 2009, when the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education was adopted by the National Council of State Boards of Nursing (NCSBN), the neonatal population was one of six for NP and CNS preparation (APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, 2008). After five decades of overcoming interprofessional isolation, variable educational preparation, underutilization, and title ambiguity, neonatal APRNs are recognized as professional providers and are an integral part of the neonatal health team at all levels of care (Johnson, 2002; Nagle & Perlmutter, 2000; Stark et al, 2023).

Certification

National certification validates the special knowledge and experience required for safe and competent practice in a specialty or defined subspecialty area of practice. Core population-specific national certification for the NNP (NNP-BC®) or NCNS (ACCNS-N® or legacy CCNS-N) validates readiness to provide core knowledge-based care to critically ill neonates. Maintenance of specialty certification (MOC) demonstrates ongoing competency and validates specialty expertise (National Certification Corporation, n.d.a; retrieved February 25, 2024).

According to NCC, 7,360 NNPs hold national certification, an increase of almost 25% in the past decade (National Certification Corporation, n.d.b; retrieved February 25, 2024). This is not the case for the NCNS. Although there are more than 7,360 certified NNPs, there are only 57 APRNs certified as neonatal CNSs (up from 47 in 2013), with an additional 43 holding the legacy certification credential CCNS-N, which is no longer available (American Association of Critical-Care Nurses, n.d.; retrieved February 25, 2024). In the past, many states and organizations did not require certification for CNS practice, and until 1999, there was not a population-specific certification exam for NCNSs. NNPs are required to be certified to practice in 48 of 50 states (New York and Indiana do not require certification for practice). NCNSs require certification in 47 states, with California, Indiana, and New York not requiring certification (National Council of State Boards of Nursing, 2023).

Education

The master's degree is recognized as the standard entry-level degree accepted by certifying institutions and state boards of nursing for the NNP and NCNS. In 2004, the American Association of Colleges of Nursing (AACN) issued a position statement calling for the DNP to become the required degree for entry level into advanced practice by 2015 (AACN, 2004). In 2018, the National Organization of Nurse Practitioner Faculties (NONPF) endorsed the DNP as the entry-level degree, with a goal of implementation by 2025 (NONPF, 2018). The DNP degree has been embraced by NPs and CNSs as an appropriate alternative to the PhD as a terminal degree for experts in practice, but, as of 2023, there is no evidence to support the move to require a DNP for entry into practice.

As the experts on NNP practice, NANN-AP and the NANN Board of Directors fully endorse the DNP as a terminal, practice-focused degree but not as a mandatory requirement for entry into advanced practice (NANNP, 2018). NANN-AP and NANN recommend that the DNP degree be

supported as one option for NNP education and be recommended as a practice-focused doctorate for advanced nursing expertise representing the highest level of clinical competence. Both master's and DNP programs should be endorsed as providing proper preparation for entry into advanced nursing practice. The requirement of the DNP degree for entry into NNP practice should be a future goal with the timeline determined when substantive evidence exists to support the requirement (NANNP, 2018).

NANN-AP believes it is imperative that neonatal content experts define competencies and the systems of education and training required to obtain them. NANN and NANN-AP collaborate with several regulatory, licensing, education, and credentialing agencies to produce the most current education and curriculum standards (NANNP, 2023). The competencies align with and reflect AACN's *The Essentials: Core Competencies for Professional Nursing Education* (AACN, 2021), NONPF's *Nurse Practitioner Role Core Competencies* (NONPF, 2022), and the National Task Force on Quality Nurse Practitioner Education (NTF) *2022 Standards for Quality Nurse Practitioner Education (6th edition)*; National Task Force on Quality Nurse Practitioner Education, 2022). Key components of quality NNP education include input from community stakeholders, competency-based education, increased direct-care clinical hours, neonatal program directors and educators who have ongoing clinical practice and current knowledge, the continued recommendation for a minimum of 2 years of relevant Level III/IV NICU RN experience for students before entry into clinical courses, and a focus on evidence-based practices and self-care as part of NP professional identity and responsibility (NANNP, 2023).

Scope of Practice

In 2021, the National Academies of Sciences, Engineering, and Medicine released their report *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity*. This publication, sponsored by the Robert Wood Johnson Foundation, builds upon the 2011 Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health*. The 2021 report recommends removing barriers to APRN full practice authority and calls for the nationwide adoption of the nurse licensure compact and for the use of federal authority to supersede restrictive state laws related to scope of practice (National Academies of Sciences, Engineering, and Medicine, 2021).

Scope of practice includes specific activities, interventions, or roles permitted under the APRN's level of education, training, and competence while meeting the standards established by the Nurse/Nursing Practice Act and the rules and regulations of each state or jurisdiction (National Council of State Boards of Nursing, n.d.). Most boards of nursing consider the APRN scope of practice to include graduate education in a role and population foci, national certification standards, scope of practice standards published by the national organizations or APRN associations, and the state's Nurse/Nursing Practice Act and board of nursing rules and regulations. The APRN's scope of practice is not expanded by previous RN experience or postgraduate fellowship training (APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, 2008; APRN LACE Network, 2021; Arizona State Board of Nursing, 2009; Missouri Nurses Association, 2014; NANNP, 2014). Scope of practice also determines the minimum standard of competency and is governed by requirements for continuing education through MOC processes and professional accountability (Klein, 2005).

The scope of the neonatal APRN evolves through experience, education (formal and informal), advances in evidence-based practice, developing technology, and changes in the healthcare delivery system. The APRN's practice may be extended through continued advanced practice experience congruent with the accepted scope of practice (APRN LACE Network, 2021; NONPF Population-Focused Competencies Task Force, 2013). There are limits, however, to the expansion of scope of practice without completion of additional formal education. An APRN licensed in one role and population cannot practice in another APRN role, population, or care provision (acute vs. primary care) 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 (APRN LACE Network, 2021).

Traditionally, the neonatal population was thought of as the patients in the NICU. In 2010, the first edition of the *Competencies and Orientation Toolkit for NNPs* included competencies for infants physically cared for in the NICU and those who suffer from chronic conditions as a result of complications of prematurity and fetal/neonatal pathophysiology, up to the age of 2 years (NANNP, 2010). The second edition, published in 2014, affirmed this patient population and delineated specific primary care competencies (NANNP, 2014). NNPs have specific competency standards encompassing wellness through critical care in the population of neonates, infants, and toddlers to 2 years of age. Since 2009, NNP educational program standards also have evolved to include content and clinical experiences for students across the continuum of care and the neonatal patient population (NANNP, 2023).

NNPs are unique providers; along with their physician counterparts, they are the only providers who obtain an education specific to the fetal/neonatal population. Other providers—such as physician assistants, pediatricians, and nurse practitioners educated in other population foci—have a generalist education, which impacts the provision of high-quality, safe, and cost-effective neonatal care (Keels et al., 2019; NANNP, 2017, 2022).

The NCNS scope of practice involves optimization of resources and improving outcomes based on data relevant to the three spheres of impact (patient, organization, and nurse), implementing evidence-based practices through quality improvement initiatives or evidence-based practice changes at the different levels within an organization, mentoring and supporting nursing staff, providing consultations, and participating in multidisciplinary activities. Though not providing direct patient care much of the time, the NCNS ensures the highest quality of care is provided to all patients and families through the lens of patient- and family-centered care—in conjunction with nurse, NNP, and physician colleagues—through clinical inquiry and systems thinking (AACN, 2022). Currently, there are no published neonatal-specific CNS program standards or competency standards for the role.

Workforce Regulation/Influences

NANN-AP is committed to expert care for all neonates across all levels of care as described by the AAP (Stark et al., 2023). In the current competitive healthcare market, inpatient neonatal units frequently encounter shortages of all types of providers: physicians, APRNs, and PAs, across all levels of care (Keels et al., 2019). As a result, those in positions to recruit and fill employment vacancies make decisions without a clear understanding of which type of provider

is the best fit to fill a particular position, considering education and training, licensure, national certification, and scope of practice.

Lack of understanding regarding these tenets of practice and regulation may lead to hiring an advanced practice provider (APP) into a role that includes duties outside their academic preparation, national certification, and scope of practice. Though motivated by the desire to fill vacant provider positions, this practice jeopardizes patient safety and outcomes and increases the risk of malpractice litigation for providers and institutions.

Providing safe and cost-effective care for neonates can involve several types of providers working within their respective scopes of practice. There is well-recognized overlap in population foci within APRN/NP nursing education programs. It is important to understand the education, training, and national certification criteria for each type of provider, so that hiring decisions are based on patient care needs that align with the APP's scope of practice.

Table 1: APP Educational Curriculum, Competency, and Certification Criteria

Type of APP	Program Curriculum Related to Neonatal Population	Missing Educational Content/ Competencies to Meet Neonatal Population Specifics	Types of Neonates Within Scope of Practice
Family Nurse Practitioner (FNP)	<ul style="list-style-type: none"> • Emphasis is on primary care of well, late-preterm neonates through the elderly population • Health promotion, disease prevention, and management and treatment of non-urgent illnesses for infants down to a gestational age of 36 weeks (NONPF, 2013) 	<ul style="list-style-type: none"> • Content related to neonates <36 weeks gestational age • Fetal/neonatal pathophysiology or acute care management and treatment • Ventilator management • TPN administration and nutritional management • Delivery room resuscitation and management of emergencies (Keels et al., 2019; NONPF, 2013) 	Stable “growing preemies” or other infants requiring Level I care (Keels et al., 2019; NONPF, 2013; Stark et al., 2023)
Pediatric Nurse Practitioner–Primary Care (PNP-PC)	<ul style="list-style-type: none"> • Educational content includes health promotion, disease prevention, and management/treatment of non-urgent illnesses for patients from gestational age of 36 weeks through young adulthood (NONPF, 2013; Pediatric Nursing Certification Board, n.d.-a) 	<ul style="list-style-type: none"> • Content related to neonates <36 weeks gestational age, • Fetal/neonatal pathophysiology or acute care management and treatment • Ventilator/respiratory management • TPN administration and nutritional management • Delivery room resuscitation and management of emergencies (Keels et al., 2019; NONPF, 2013; Pediatric Nursing Certification Board, n.d.-a) 	Stable “growing preemies” or other infants requiring Level I care (Keels et al., 2019; Stark et al., 2023)

<p>Pediatric Nurse Practitioner–Acute Care (PNP-AC)</p>	<ul style="list-style-type: none"> • Educational content includes management and treatment of acute urgent illnesses for patients from 36 weeks gestational age through young adulthood • Management of acutely ill late-preterm infants and older infants (NONPF, 2013; Pediatric Nursing Certification Board, n.d.-a) 	<ul style="list-style-type: none"> • Delivery room resuscitation and management of emergencies • Fetal/prematurity pathophysiology or management and treatment for conditions arising from such • TPN administration and nutritional management for infants <36 weeks gestational age • Ventilator and respiratory management strategies for infants <36 weeks gestational age (NONPF, 2013; Pediatric Nursing Certification Board, n.d.-b) 	<p>Acute management of infants greater than 36 weeks gestational age requiring Level II–IV care (AAP, 2023; Keels et al., 2019; Pediatric Nursing Certification Board, n.d.-b)</p>
<p>Neonatal Nurse Practitioner (NNP)</p>	<ul style="list-style-type: none"> • All primary and acute neonatal care areas • Diagnosis and management of critically ill infants along all gestational ages, ranging from the edge of viability to 2 years of age (Keels et al., 2019; NANNP, 2023; NONPF, 2013) 		<p>All neonates (regardless of gestational age), infants, and toddlers to age 2 (NANNP, 2023; NONPF, 2013; Stark et al., 2023)</p>

<p>Physician Assistant (PA)</p>	<ul style="list-style-type: none"> • “Educated in general medicine,” grounded first in primary care or generalist practice (American Academy of Physician Associates, 2022; Keels et al., 2019) • Curriculum includes instruction in the provision of medical care across the life span (including prenatal, infants, children, adolescents, adults, and elderly) and care of infants as part of general pediatrics rotation (American Academy of Physician Associates, 2022) 	<ul style="list-style-type: none"> • Critical/acute care management/treatment for preterm, term, and surgical neonates • Delivery room management and resuscitation • Fetal/prematurity pathophysiology or management and treatment for conditions arising from such • TPN administration and nutritional management for critically ill neonates and young infants • Acute respiratory and ventilator management strategies for critically ill neonates and young infants (Accreditation Review Commission on Education for the Physician Assistant, Inc, 2023; American Academy of Physician Associates, 2022) 	<p>Infants requiring Level I care (based on the 2021 PA Competencies document, PAs do not have population-specific competencies for pediatrics or neonatology) (American Academy of Physician Associates, 2021); specialty population competencies are not measured through specialty board examinations, unlike physicians and APRNs (American Academy of Physician Associates, 2023)</p>
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Council Position

1. Educational preparation for the neonatal APRN should be from an accredited graduate-level, neonatal population–specific program.
2. National certification and recertification in the neonatal population serves as the basis for initial validation of knowledge competence, scope of practice, and continuing competence for advanced practice providers working within the neonatal population.
3. NPs and CNSs who have education, training, and certification for small subsets of the neonatal population (birth to age 2) must only care for infants within their scope of practice; see Table 1.
 - a. Other APRNs and providers who are practicing in an advanced provider role in the NICU and (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) do not hold national neonatal population certification are practicing outside their scope of practice.

Conclusions

The role of the neonatal APRN has a long and rich legacy, validated as safe and cost effective. The neonatal population is defined as neonates, infants, and toddlers to age 2. Neonatal APRN scope is determined by advanced practice educational preparation of the APRN, board certification as an NNP or NCNS, and state regulations and authorization by the boards of nursing in each state. Scope of practice is in alignment with NANN-AP's Education Standards: Curriculum Guidelines and Education Competencies for Neonatal Nurse Practitioner Programs and the NACNS's core competencies with the neonatal population focus (AACN, 2022; Fulton et al., 2020; NACNS, 2019; NANNP, 2022, 2023).

NANN and NANN-AP encourage nursing executives, 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 populations but in establishing innovative partnerships with academic programs to increase the neonatal APRN workforce pipeline (Cavaliere & Sansoucie, 2001; NANNP, 2022).

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