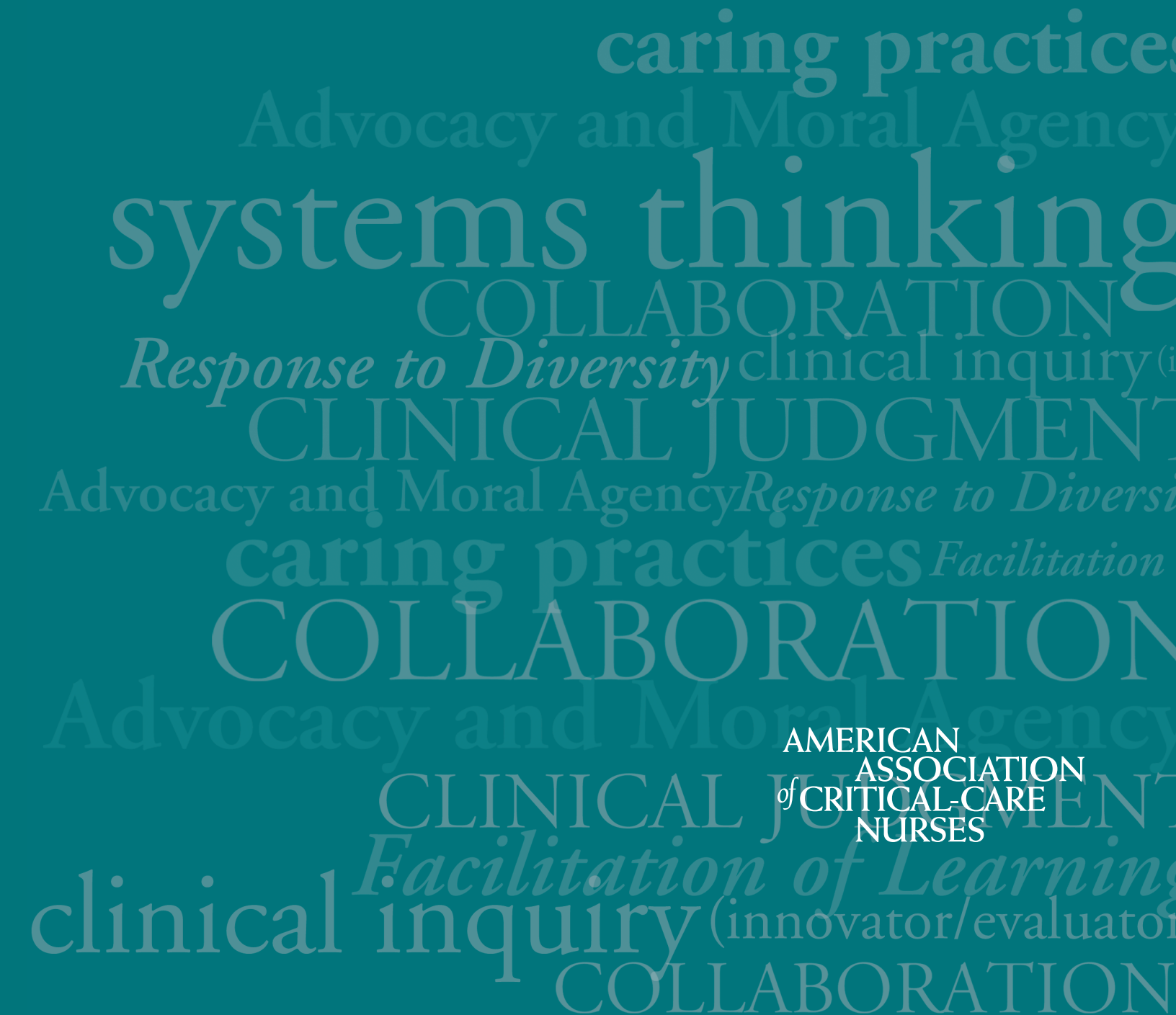
AACN Scope and Standards for Adult-Gerontology and Pediatric Acute Care Nurse Practitioners 2021



AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

AACN Mission
Patients and their families rely on nurses at the most vulnerable times of their lives. Acute and critical care nurses rely on AACN for expert knowledge and the influence to fulfill their promise to patients and their families. AACN drives excellence because nothing less is acceptable.

AACN Vision
AACN is dedicated to creating a healthcare system driven by the needs of patients and families where acute and critical care nurses make their optimal contribution.

AACN Core Values
As AACN works to promote its mission and vision, it is guided by values that are rooted in, and arise from, the Association's history, traditions, and culture. AACN, its members, volunteers, and staff will honor the following:

- **Ethical accountability and integrity** in relationships, organizational decisions, and stewardship of resources
- **Leadership to enable individuals to make their optimal contribution** through lifelong learning, critical thinking, and inquiry
- **Excellence and innovation** at every level of the organization to advance the profession
- **Collaboration** to ensure patient- and family-focused care

AACN Scope and Standards for Adult-Gerontology and Pediatric Acute Care Nurse Practioners 2021

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

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We are also indebted to the ACNP students, faculty, and practitioners who provided thoughtful review and comment for this document throughout the period of public comment.

AACN Scope and Standards for Adult-Gerontology and Pediatric Acute Nurse Practitioners 2021

Introduction

context for this update

The past year has seen unprecedented numbers of admissions to acute and intensive care units across the United States and around the world, due to the COVID-19 pandemic. Inherent in caring for the high volume of patients is the need for practitioners with the qualifications and expertise to collaborate in the medical management of these patients. The ongoing crisis-management conditions that have occurred in waves across the United States, combined with the high death rates, have contributed to exhaustion and burnout at all levels of health care. In addition, the number of older adults continues to increase, the number of uninsured persists, and social determinants of health along with disparities in health care availability have continued to strain a system overwhelmed by the pandemic.

There is an increasing mismatch between historical provider characteristics and patient needs. What has emerged is a need for a provider with unique knowledge, skills, and abilities to manage a patient's care across the continuum of acuity and care services. Pediatric and adult-gerontology–focused acute care nurse practitioners (ACNPs) are uniquely prepared to meet this need and collaborate with their primary care and other colleagues across disciplines to achieve continuity for safe, effective, and quality patient- and family-centered care.

purpose of this document

The purpose of this scope- and- standards document is to describe the practice of the ACNP who is educated and certified to care for acute care pediatric or acute care adult-gerontology populations. The **Scope of Practice, Standards of Clinical Practice, and Standards of Professional Performance** are delineated. Although neonatal nurse practitioners (NPs) are recognized as ACNPs, they are not included in this document, because their educational preparation and scope of practice have been defined elsewhere.[1,2]

This document is intended for use by all those involved in the professional life of the ACNP, including students, faculty, pediatric and adult-gerontology ACNPs in practice, members of the interprofessional team, and other nursing colleagues. In addition, administrators, medical staff professionals, boards of nursing, policy makers, and insurers will benefit from the description of the role and accountabilities of the ACNP.

The authors of and contributors to this update of the ACNP scope and standards have worked to appropriately describe the most current functions of the role in a manner consistent with the education, certification, and licensure of the pediatric and adult-gerontology ACNP. It is recognized that the role will evolve as the needs of patients, families, the health care system, and society dictate. This has never been more evident than in the current environment.

definition and role of scope

Scope of practice defines the boundaries of the practice of the practitioner; that is, the procedures, actions, and processes contained within the role for which the practitioner has received the education, certification, and licensure to practice. Documents describing scope of practice should describe who, what, where, when, why, and how the practitioner functions within a defined role.[3]

However, the boundaries of nursing practice (ie, the what, when, why, and how) should not be confined to a historical definition. Expanding definitions allows for exchange, expansion, and flexibility of the profes-

sion to meet the evolving needs of patients, organizations, and society at large.[4] In the recent update *The Future of Nursing 2020-2030,*[5] the National Academy of Medicine Committee on the Future of Nursing 2020-2030 recommended that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality and value."[5(p.2)] The committee cited 2 examples that demonstrate the effectiveness of this recommendation: the emergency action by 8 states during the pandemic to allow NPs to practice at the full extent of their education and training to meet health care gaps; and the federal waiver in 2017 that allowed NPs to prescribe buprenorphine in the treatment of the opioid crisis, which increased access to care.[5]

It is important to remember that state boards of nursing do not define the "where" of practice; the education, certification, licensure, and competencies of the practitioners and the needs of the patients do.[6] With the evolving nature of advanced nursing practice roles, as well as the increasingly complex patients with multiple comorbidities, whether pediatric or adult-gerontology, a scope-of-practice document cannot describe all possible use cases or combinations of patient, their family, or caregiver, and the appropriate NP. Therefore, it is imperative that the practitioner continue to assess their own education and competencies in meeting any given patient's needs and, when appropriate, transition the patient's care to an alternative provider.

There may be situations where the environment and skill sets of the ACNP and the primary care NP may overlap in both the pediatric and adult-gerontology populations (both the *where* and the *who*). For example, as pediatric patients with chronic health care conditions such as congenital heart disease or cystic fibrosis continue to live longer, determining the best appropriate provider can be confusing. An additional example during trauma activation or the current pandemic conditions, is the pregnant person admitted to the intensive care unit for management of their traumatic injuries or progression of their infection with COVID-19 and who requires the skills of both the intensivist/ACNP team and the additional expertise of the trauma or obstetrical team to manage the needs of the parent and fetus. **"The patient's condition and acuity level are the primary factors in determining the most appropriate certified nurse practitioner (CNP) to manage the patient's health care needs, not the setting of care. Neither a primary care CNP nor an acute care CNP is restricted to providing care in any particular setting."**[7]

definition and role of standards

Standards are the statements describing the level of care or performance common to the profession of nursing. They provide a yardstick for measuring the quality of nursing practice.[8] This edition of the ACNP standards is written to establish an example of the roles and responsibilities that can be expected of the pediatric or adult-gerontology ACNP by the profession and society at large. The standards of clinical practice describe a competent level of advanced nursing practice, whereas the standards of professional performance speak to the professional accountabilities expected of the advanced nursing practitioner.

All the standards reflect the competencies and behavior expected of the ACNP based on their education and training, certification, and licensure. The standards also include statements that are key indicators of competent nursing practice, building on the American Nurses Association *Nursing: Scope and Standards of Practice, 4th edition,*[8] *and the AACN Scope and Standards for Progressive and Critical Care Nursing Practice.*[9]

The standards describing clinical practice and professional performance are expected to remain stable over time. However, both the language and the competency statements will continue to be evaluated and revised to incorporate changes as the number, use, and practice of ACNPs evolve. Competency expectations must keep up with the development of new scientific knowledge, terminology, and technology to meet patient, family, organizational, and societal needs.

frameworks for this document

Scientific or Nursing Process

This is the systematic process used to organize professional nursing practice using critical thinking and diagnostic reasoning skills. In this edition of the American Association of Critical-Care Nurses (AACN) Scope and Standards, the nursing process has been adapted to encompass the advanced knowledge, skills, and abilities expected of the pediatric and adult-gerontology ACNP. These include advanced assessment, differential diagnosis, outcome identification, planning and managing care, implementation of interventions, and evaluation of patient progress. Each step is predicated on the accuracy of the previous step; however, the process is dynamic and circular, rather than linear. Ongoing assessment of patients, families and caregivers; their responses to interventions prescribed and implemented in the plan; critical review and evaluation of patient progress; and a reformulation of diagnoses along with interventions and outcomes occur along a continuum. Communication and collaboration between and among interprofessional team members, patients, families, and caregivers are critical to achieving desired outcomes.

The AACN Synergy Model for Patient Care

The fundamental premise of the AACN Synergy Model for Patient Care is that when patient characteristics drive nurse competencies, optimal outcomes occur for patients, families, and caregivers. Patients differ in their capacity for health and their vulnerability to illness on the basis of core characteristics. The skills and level of competency required of the nurse and advanced practice nurse are driven by the patient's needs along the continuum of these core characteristics. This is equally important for all levels of professional nursing practice.

The model focuses on knowing the patient and understanding the perspectives of the patient, family, and caregiver. The model integrates all dimensions of a patient's health status, including physical, social, psychological, and spiritual dimensions, and reflects patient-driven and patient- and family-centered care that requires building relationships to achieve the synergy required to create a healing environment.[10]

AACN Standards for Establishing and Sustaining Healthy Work Environments, A Journey to Excellence, Second Edition

AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence, Second Edition,[11] provides the rationale and criteria for the optimal environment in which ACNPs provide care. The creation of healthy work environments is imperative to ensure patient safety, enhance staff recruitment and retention at every level, and maintain an organization's financial viability.

The Healthy Work Environments document puts forward 6 essential standards: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership. These systematic behaviors are often discounted despite growing evidence that an unhealthy work environment contributes to creating unsafe conditions for staff, patients, families, and caregivers, and obstructs the ability of individuals and organizations to achieve excellence. These standards are applicable to all environments and levels of professional nursing practice.

Consensus Model for Advanced Practice Registered Nurse Regulation

The *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education*[12] reflects the need to align education, licensure, and certification for the 4 clinically based advanced practice nursing roles: (1) the certified registered nurse anesthetist, (2) the certified nurse midwife, (3) the clinical nurse specialist, and (4) the CNP. The model has clarified that the education must be provided by an accredited organization and be consistent with the role and population being served, and that certification assesses the competencies of the role core education.

Licensure grants authority for a NP to practice in the advanced role in the population(s) for which the applicant has been educated and certified. One goal of consensus model development is to ensure consistent licensure and regulatory requirements to achieve practice authority to the full scope of education and training in all states and settings.[12]

Pediatric and Adult-Gerontology ACNP Competencies

Several documents from the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties have been used to clarify both the education and competency development for the ACNP. These documents helped the task force view the complexity of the ACNP role and its obligations to the patient, family, caregivers, the interprofessional team, and society as a whole for both the pediatric and adult-gerontology patient populations.

In 2021, the AACN published *The Essentials: Core Competencies for Professional Nursing Education,*[13] in which the foundation for advanced nursing practice education is described. That document delineates the domains and competencies with the intent of creating consistency in graduate-level educational outcomes. By focusing on competencies rather than academic degree, the hope is that employers will be able to clearly see what can be expected of nursing graduates.[13]

The National Organization of Nurse Practitioner Faculties has created a suggested curriculum to meet NP core competency content.[14] Because the NP student focuses on specific populations, additional competency statements have been developed. *Adult-Gerontology Acute Care and Primary Care NP Competencies*[15] was published in 2016; the pediatric ACNP competencies are delineated in the *Population-Focused Acute Care Nurse Practitioner Competencies*[16] document.

Additional Documents Contributing to Framework

Two additional documents describing focused areas of professional practice were consulted in developing the content for the present scope and standards: the *Core Competencies for Interprofessional Collaborative Practice: 2016 Update*[17] and the *Graduate-Level QSEN Competencies: Knowledge, Skills, and Attitudes.*[18] The first document stresses the need for practitioners to function collaboratively within the interprofessional team. The second advocates for the use of evidence to ensure the delivery of high-quality, safe, and effective patient- and family-centered care. It also calls for training in the use of appropriate tools for measuring patient outcomes.

As with all scope-and-standards documents, the *Code of Ethics for Nurses With Interpretive Statements*[19] provides the foundation for consistency with the high level of ethical practice expected of all nurses. The additional focus on equity, diversity, and inclusion was based on the AACN statement "Our Commitment to Anti-Racism, Equity, Diversity and Inclusion"[20] and was used to assure that the national organizational stance was included.

Nevertheless, "we recognize that the sacred space between nurses and their patients holds the power to create a human-to-human connection that can help heal the wounds of mistrust and inequity. Nurses know the physical body is important, but the essence of personhood lies in a place that can only be accessed through compassion, understanding, and caring. This is an uncharted journey toward improvement because we are all imperfect in our ability to fully understand the suffering of another. It will take courage, patience and persistence to reach the goal of equitable, diverse, and inclusive healthcare" (Melissa Jones, PhD, Managing Editor, AACN Strategic Advocacy. Personal communication, August 2021).

conclusion

The changing turbulent health care environment has accentuated the fragmentation that accompanies the delivery of episodic, specialized care across the continuum of emergent, acute, and long-term, or chronic care services for both the pediatric and adult-gerontology populations. Limited access to care, aging of the population, chronicity, and dependence on medical technology across the life span contribute to the number of vulnerable persons. Management of stable and progressive chronic illness in an acute care setting, where episodic care is provided, often results in lack of continuity and increasing patient vulnerability.

Patient needs are also unmet when care is limited to specialty treatment of an acute illness, and less attention is paid to comorbidities and chronic health conditions or the recognition and minimization of physiological, psychological, and iatrogenic risks. Significant resources are expended for specialty-focused care, both inpatient and outpatient, which, again, affects continuity of care. The result is an environment of uncoordinated, high resource use, and poorly defined holistic patient- and family-centered quality outcomes.

Pediatric and adult-gerontology ACNPs have the knowledge and expertise to medically treat these patient populations with acute, critical, and/or complex chronic illnesses or injury. Their nursing expertise contributes to the coordination of care to meet the patient, family, and caregiver goals as the patient transitions across the continuum. Their unique combination of skills brings the best of both worlds to the patient's bedside at a time when additional providers are needed to address health care needs.

In their recent study, Aiken et al reported, "Patients and nurses in the hospitals [in this study] with higher [NP-to-bed] ratios were significantly more likely to report better care quality and safety, and nurses reported lower burnout, higher job satisfaction, greater intentions of staying in their jobs."[21] Aiken et al concluded that "having more NPs in hospitals has favorable effects on patients, staff nurse satisfaction, and efficiency. NPs add value to existing labor resources."[21]

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Introduction

The historical conceptualization of nursing delineates clinical practice dimensions according to the practitioner's role, the clinical setting, a patient's diagnosis, and a patient's physiologic and psychosocial systems. Today's changing health care calls for the complexities and needs of patients to drive the competencies of nursing and advanced nursing practice. These required competencies reflect the integration of knowledge, skills, and attitudes needed to meet the patients' needs.[1]

- Throughout this document, the term *patient* refers to the individual, family, caregiver, group, or community.
- *Family* refers to the family of origin or significant others, including surrogate decision-makers, and recognizes family as defined by the patient.
- *Caregiver* is defined as family, custodian, or legal guardian.
- The term *acute care nurse practitioner* (ACNP) is used throughout to delineate both the pediatric and adult-gerontology ACNP.

Special attention is currently focused on the use of advanced practice registered nurses (APRNs), such as the ACNP, when the patient's needs are increasingly complex and of higher acuity. "Advanced nursing practice builds on the competencies of the registered nurse and is characterized by the integration and application of a broad range of theoretical and evidence-based knowledge that occurs as part of graduate nursing education."[2(pg 18)] As a result of this advanced preparation and successful completion of certification, ACNPs have great range, breadth, and depth of knowledge and competencies, which result in a broad repertoire of effective solutions for patient needs, patient populations, and systems. This expansion makes the ACNP optimally suited for managing the more complex, uncertain, and resource-exhausting situations characteristic of high-acuity patients and settings

scope of practice

Definition of the ACNP

The ACNP is an APRN who has completed an accredited, graduate-level ACNP educational program with supervised clinical practice to acquire advanced knowledge, skills, and abilities. This formal educational preparation qualifies them to **independently**

- perform comprehensive health assessments
- order and interpret the full spectrum of diagnostic tests and procedures
- formulate a differential diagnosis to reach a diagnosis
- plan and direct care
- order, provide, and evaluate the outcomes of interventions

The ACNP provides comprehensive advanced nursing care across the continuum of health care services to meet the individualized needs of patients with acute, critical, and/or complex chronic health conditions or injury.[3] The practice of the ACNP is not defined by the setting; rather, it is determined by the acuity of patient needs. The ACNP practices in any setting in which patient care requirements include complex monitoring and therapies, high-intensity nursing intervention, or continuous nursing vigilance within the range of high-acuity care. Although ACNPs may traditionally practice in acute care and hospital-based settings, including subacute care, emergency care, and intensive care, the continuum of acute care services for their patient population spans the geographic settings of home, ambulatory care, urgent care, and rehabilitative care.

The ACNP autonomously provides patient-centered care and consults and/or collaborates with other members of the interprofessional team as appropriate. ACNPs **do not** require physician supervision or oversight as may be defined in collaborative practice arrangements to fulfill their role. Designation as a licensed independent practitioner may vary among states or between facilities.

Role of the ACNP

The core body of knowledge and competencies for ACNP preparation and practice are derived from the full spectrum of needs and goals of high-acuity patient care along the wellness-to-illness continuum and includes conversations about palliative care and care at end of life. The ACNP assesses patients with acute, critical, and/or complex chronic illnesses or injury through their health history, physical and mental status examinations, and health risk appraisals. Diagnostic reasoning, development of the plan of care, advanced therapeutic interventions, and referral to and collaboration with other members of the interprofessional team are intrinsic to this role.

The ACNP acknowledges and incorporates the dynamic nature of each patient's response to acute, critical, and/or complex chronic illnesses or injury in the provision of care. The ACNP individualizes care with respect to diversity, fostering equity and inclusivity. The focus of the ACNP is the provision of restorative, curative, rehabilitative, palliative, and/or supportive end-of-life care as determined by patient needs. Goals include patient stabilization for acute and life-threatening conditions, minimizing or preventing complications, attending to comorbidities, and promoting physical and psychological well-being. Additional goals include the restoration of maximum health potential or providing for palliative, supportive, and end-of-life care, as well as an evaluation of risk factors in achieving these outcomes.

Key components of the ACNP role are as follows:

- Performing comprehensive histories, physical examinations, and screening activities
- Diagnosing and treating patients with acute, critical, and/or complex chronic illnesses and injuries
- Ordering, performing, supervising, and interpreting diagnostic studies
- Prescribing medications, durable medical equipment, and advanced therapeutic interventions
- Using specialized skills in the performance of procedures
- Providing health promotion, disease prevention, health education, and counseling
- Collaborating and communicating with members of the interprofessional team
- Assessing, educating, and providing referrals for the patient, family, and caregiver
- Facilitating transitions in the levels of care across the continuum

The ACNP uses invasive and noninvasive technologies, interventions, and procedures to assess, diagnose, monitor, and promote physiologic stability and perform a variety of procedures and skills in providing care (see Appendix C - Adult-Gerontology or Appendix D - Pediatric). The skill set depends on the specific patient-population focus and specialty area of practice.

Practice Population

The population focus for the ACNP is either pediatric, late adolescent, or adult-gerontology patients with acute, critical, and/ or complex chronic illnesses or injury who may be physiologically unstable, technologically dependent, and highly vulnerable for complications. The population served is determined by the educational preparation of the ACNP in a population focus. The ACNP is prepared to "diagnose and treat patients with undifferentiated symptoms to determine a differential diagnosis, as well as those with established diagnoses."[3] The patient may be experiencing an episodic acute or critical illness, stable chronic illness, acute exacerbation of chronic illness, acute injury, or may require palliative and end-of-life care. These patient populations may need complex monitoring and therapies, high-intensity interventions, or continuous vigilance within the range of high-acuity care.

Practice Environment

"The services or care provided by APRNs is not defined or limited by setting but rather by patient care needs."[3] The ACNP practices in any environment in which patients with acute, chronic, and/or complex chronic illnesses or injury may be found. Examples include acute and critical care environments, emergency care for trauma stabilization, and procedural and interventional settings. In addition, the continuum of acute care services spans the geographic settings of home, ambulatory care, urgent care, long-term acute care, rehabilitative care, and palliative care and/or hospice care. The practice environment also extends into the mobile environment, including advanced air and ground ambulances, virtual locations, such as tele-intensive care units and areas using telehealth. The ACNP has the vital role of serving as the communicator, facilitator, and collaborator to enhance the safe transition of care across all these environments.

Educational Preparation

The education of the ACNP who is focused on the pediatric or adult-gerontology population is at the masters, post-masters, or doctoral preparation in nursing. The curriculum is composed of, but not limited to, content to "ensure attainment of the APRN core, role core, and population core competencies."[3] These competencies are delineated by the American Association of Colleges of Nursing documents *The Essentials of Master's Education in Nursing*[4] and *The Essentials of Doctoral Education for Advanced Nursing Practice.*[5] At the conclusion of the educational program, the graduate ACNP must meet the essentials of the degree obtained (eg, master's, postgraduate, doctor of nursing practice), including the clinical hours required by the certifying body, to practice as an ACNP. The educational program must also ensure that graduates are eligible to apply and sit for a national certification examination that is consistent with the role and the population focus of the program and state licensure.[3]

The preceptored clinical practicum is an essential component of the ACNP educational program. The ACNP program will provide appropriate supervised clinical experiences to prepare the graduate to provide care consistent with public safety, as demonstrated by certification, and to promote the performance of ACNP competencies at the entry level after graduation.

Regulation

Regulation of the ACNP is accomplished through scope and standards of practice, specialty certification, nurse practice acts with rules and regulations, institutional policies and procedures, and self evaluation and determination.

Nursing Scope of Practice, Standards of Practice, and Specialty Certification

Scope and standards of practice are set by professional nursing organizations. The American Nurses Association *Nursing: Scope and Standards of Practice,* 4th edition,[6] provides the foundation for specialty organizations to define practice within the specialty and population. The *AACN Scope and Standards for Progressive and Critical Care Nursing Practice*[7] provides an additional definition of foundational practice for clinicians caring for acutely and critically ill patients.

Consistent with the APRN Consensus Model[3], certified ACNPs are those best suited to provide care for patients with acute, critical, and/or complex chronic illnesses or injury. Certification of ACNPs is a formal recognition of knowledge competence in a population focus. Certification eligibility requires the successful completion of the accredited program of study, appropriate course content, and specified amount of supervised clinical practice. An additional component of certification is knowledge assessment, which is determined by passing an initial examination for the selected area of advanced practice.[8] Ongoing maintenance of competency, proficiency, and certification ensures ACNP practice meets established standards of quality and patient safety.

Nursing Practice Act and Rules and Regulation

ACNP practice is externally regulated through licensure or recognition at the state level. Regulation in the state nurse practice acts is informed by the APRN Consensus Model[3] and is administered under the authority of state governments to ensure public safety. Currently, state requirements for the recognition and practice of the ACNP vary despite assertions by many professional organizations that APRNs be allowed to practice to the full extent of their preparation. ACNPs have a responsibility to understand their state's nurse practice act and be aware of ongoing changes in regulations. Practices regulated by the federal government may have alternative regulation arrangements (eg, Veterans Health Administration).

Institutional Policies and Procedures

Institutional policies, procedures, and medical staff bylaws define practice within institutions. Institutional policy regarding APRN credentialing and privileging must be congruent with the educational preparation of the NP and the APRN Consensus Model[3]. To maximize the impact of patient outcomes, the ACNP participates in peer review and regular external performance evaluations consistent with credentialing and privileging. It is essential that ACNPs participate in developing criteria used to establish and measure outcomes of their practice. The information gained in internal, peer, and external reviews will guide the ACNP's efforts to enhance performance and to achieve optimal patient outcomes.

Self Evaluation and Determination

All nurses exercise autonomy within their scope of practice. This autonomy is based on expert knowledge and the willingness to commit to self-regulation, self-evaluation, and accountability for practice. Such self-regulation includes the APRN performing an internal review of their own practice to ensure function consistent with educational preparation, certification, and competencies. Boards of nursing have additional resources to help NPs understand their scope of practice[9] (eg, Ohio Board of Nursing, ACNP competencies, decision-making algorithms [see Appendix F]). Collaborative practice is the hallmark of the ACNP. Additional education may be required to expand the competencies of the ACNP in their role.

Ethical Issues

ACNPs promote ethical practice and base their decisions and actions on behalf of patients, families, and caregivers, consistent with the American Nurses Association *Code of Ethics for Nurses with Interpretive Statements.*[10] They acknowledge the dignity, autonomy, cultural beliefs, diversity, social determinants of health, and privacy of patients and their families. The ACNP advocates for the patient and family in care decisions up to and including the initiation of palliative and end-of-life care, and limitation and/or withdrawal of treatment when appropriate. As an advocate, the ACNP is obligated to demonstrate nonjudgmental and nondiscriminatory attitudes and behaviors toward patients, families, and other members of the health care team. The ACNP acknowledges diversity and fosters equity and inclusion. Inclusion encompasses empowerment and provision of a voice to all patients and their families.[11]

Leadership in the promotion of an ethical, healthy work environment is within the scope of the ACNP practice. Ethical practice is also demonstrated by honesty, appropriate use of technology for documentation of patient care, ensurance of the confidentiality of records and patient information, and ensurance of appropriate informed consent for research studies. Documentation should use standardized language and recognized terminology to ensure effective communication among health care providers and for appropriate billing practices.

conclusion

This scope and standards document reflects the ACNP's education, role, and responsibility to meet the needs of patients and families. An emphasis is also placed on the ACNP's focus on the continuum of care to achieve optimal outcomes, including palliative and end-of-life care. This statement of scope of practice for the ACNP contributes to the evolution of advanced nursing practice in acute health care.

In the original *The Future of Nursing: Leading Change, Advancing Health* publication[12] the Institute of Medicine advocated not only that nurses be allowed to practice to the full extent of their education and training but also that federal and state action is needed to remove the current restrictions to make full use of APRNs in meeting health care needs. In the updated document, published in 2021, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity,*[13] the authors note that progress has been made toward this goal. However, the authors recognized that as the document's writing, 27 states still do not have legislation allowing for full practice authority. However, the ACNP's role will continue to evolve with advances science and systems, and the needs of patients and families will remain the dominant focus and driver of care.

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Introduction

The Standards of Clinical Practice are not intended to stand alone but must be used in conjunction with the other sections of this entire document: the *ACNP Scope of Practice and the Standards of Professional Performance.* The Standards of Clinical Practice apply to the care that the acute care nurse practitioner (ACNP) provides to all patients within the population on the basis of their educational preparation and defines how the quality of care may be evaluated. The Standards of Clinical Practice for the ACNP are built on the generalist standards defined by the American Nurses Association in its publication *Nursing: Scope and Standards of Practice,* 4th edition,[1] and by the American Association of Critical-Care Nurses (AACN) in its publication *AACN Scope and Standards for Progressive and Critical Care Nursing Practice.*[2]

The framework for the ACNP Standards of Clinical Practice continues to be the scientific or nursing process and considers the role competencies as identified by the National Organization of Nurse Practitioner Faculties and AACN. In this edition, the process has been adapted to encompass the advanced knowledge, skills, and abilities expected of the ACNP. These include advanced assessment, differential diagnosis, outcome identification, care planning and management, implementation of treatment, and evaluation. The clinical practice of the ACNP is characterized by the application of relevant theories, research, and collaborative evidence-based guidelines and other best evidence. These provide a basis for advanced nursing practice, therapeutic intervention, and evaluation of patient- and family-oriented outcomes. The focus of ACNP practice is to restore, cure, rehabilitate, maintain, or palliate on the basis of identified patient needs.

standard 1 ADVANCED ASSESSMENT

The ACNP elicits relevant data and information about patients with acute, critical, and/or complex chronic illnesses or injury.

Competencies

The ACNP:

1. Obtains a comprehensive or problem-focused health history, as appropriate.
2. Performs a pertinent, developmentally appropriate, comprehensive, or problem-focused physical examination, as appropriate.
3. Prioritizes data collection, including advanced diagnostic information or procedures according to the patient's immediate needs.
4. Collects data using a continuous process in recognition of the dynamic nature of the patient's needs and any comorbidities.
5. Determines appropriate assessment techniques, supporting diagnostic information, and diagnostic procedures.
6. Interprets physiologically and technologically derived data to determine the patient's needs.
7. Distinguishes between normal and abnormal developmental and age-related physiologic and behavioral changes.
8. Assesses for adverse, contraindicated, and synergistic effects of multiple pharmacologic and non pharmacologic interventions.

9. Assesses for risks to health including but not limited to the following:

    a. Physiologic: genetics, medication adverse effects, immobility, frailty, impaired nutrition, pain, immunocompetence, metabolic imbalance, and iatrogenic effects of therapeutic and diagnostic interventions

    b. Psychological: delirium, cognitive disorders, impaired sleep, impaired communication, substance use and abuse, a threat to life, self-image, independence, and ability to participate in social engagement, play, and recreational activities

    c. Family and social determinants of health: impaired safety, inadequate social support and financial resources, lack of access to health information, and altered family dynamics

    d. Health care environment: polypharmacy, complex therapeutic regimens, inadequate access to care, discoordination, and transitions of care

10. Assesses health literacy and decision-making capacity.

11. Assesses the patient's and family's preferences and cultural and spiritual needs in the context of their care needs, illness, or injury.

12. Determines the need for a transition to a different level of care or care environment on the basis of the patient's acuity, frailty, vulnerability, stability, resources, need for assistance, supervision, or monitoring.

13. Documents patient information using standardized language and recognized terminology.

standard 2 DIFFERENTIAL DIAGNOSIS

The ACNP analyzes and synthesizes the assessment data when determining differential diagnoses for patients with acute, critical, and/or complex chronic illnesses or injury.

Competencies

The ACNP:

1. Formulates the differential and working diagnoses using clinical judgment and diagnostic reasoning.

2. Diagnoses rapid deterioration or life-threatening instability.

3. Anticipates disease progression.

4. Recognizes comorbidities and iatrogenic conditions.

5. Diagnoses behavioral and mental health conditions.

6. Prioritizes differential diagnoses on the basis of the complexity and severity of the patient's needs.

7. Collaborates with the interprofessional team as indicated.

8. Reformulates a diagnosis on the basis of additional data and the patient's dynamic clinical status.

standard 3 OUTCOMES IDENTIFICATION

The ACNP identifies individualized goals and outcomes for patients with acute, critical, and/or complex chronic illness or injury.

Competencies

The ACNP:

1. Derives goals and outcomes from assessment and diagnoses

2. Develops goal and outcomes using shared decision-making with the patient, family, caregivers, and interprofessional team members, as appropriate.

3. Establishes desired restorative, curative, rehabilitative, maintenance, and/or palliative and end-of-life care outcomes.

4. Develops expected outcomes to facilitate coordination and transitions of care.

5. Identifies health risks, benefits, costs, and/or expected trajectory of patient needs, using clinical expertise and current evidence-based practice.

6. Establishes goals and outcomes that consider equity, diversity, inclusion and the preferences of the patient, family, or caregiver.

7. Incorporates benefits, risks, safety, quality, options for alternative therapies, and cost-effectiveness during the decision-making process.

8. Follows incremental trend indicators of progress in achieving goals and outcomes.

9. Modifies goals and outcomes on the basis of changes in the patient's condition and preferences.

10. Establishes alternative goals incorporating social determinants of health, including but not limited to socioeconomic, environmental, and community factors.

11. Develops appropriate and attainable goals for patient disposition informed by shared decision-mak ing with the patient and family when appropriate.

12. Facilitates optimal outcomes by minimizing risk as well as promoting and protecting the health of patients.

13. Documents expected outcomes as measurable goals using standardized language and recognized terminology.

standard 4 CARE PLANNING AND MANAGEMENT

The ACNP develops an outcomes-focused plan of care for patients with acute, critical, and/or complex chronic illnesses or injury.

Competencies

The ACNP:

1. Formulates an individualized, dynamic plan of care that addresses the identified needs and can be applied across the continuum of care.

2. Collaborates with the patient, family, caregiver, and interprofessional team in establishing a plan of care.

3. Modifies the plan of care on the basis of the patient's response and treatment goals, including but not limited to rapid deterioration and/or life-threatening instability.

4. Prescribes diagnostic strategies and therapeutic interventions.

5. Interprets diagnostic tests and procedures.

6. Initiates referrals and consultations with the appropriate interprofessional team member.

7. Incorporates health promotion, protection, and injury prevention measures into the plan of care.

8. Facilitates the patient's safe transition across levels of care including admission, transfer, and discharge.

9. Informs the patient, family, and caregivers about the intended effects and potential adverse effects of proposed therapies.

10. Documents the plan of care in the patient's health record using standardized language and recog nized terminology.

standard 5 IMPLEMENTATION

The ACNP implements the plan of care for patients with acute, critical, and/or complex chronic illness or injury based on best evidence available.

Competencies

The ACNP:

1. Prescribes evidence-based interventions and therapies that are consistent with the established inter professional plan of care.

2. Performs diagnostic and therapeutic (pharmacologic and nonpharmacologic) interventions on the basis of the patient's condition and the established plan of care, which is consistent with the ACNP's education, practice, organizational, and state regulatory requirements.

3. Collaborates with the interprofessional team members to implement the plan of care, including con sultations and referrals.

4. Supervises the interprofessional team members in performing diagnostic and therapeutic procedures.

5. Initiates interventions to monitor, sustain, restore, and support the patient with a rapidly deteriorat ing condition.

6. Certifies eligibility requirements, including but not limited to home care, worker's compensation, the Family and Medical Leave Act, independent education plans, and disability consistent with state and federal regulations, for patients with acute, critical, and/or complex chronic illness or injuries.

7. Implements educational interventions appropriate to the needs of patients (including families or caregivers) congruent with the needs, preferences, and cognitive and developmental levels of the patient, family, and caregiver.

8. Performs consultations on the basis of the ACNP's knowledge, education, and expertise.

9. Implements health promotion, health maintenance, health protection, and disease prevention initia tives individualized for the patient.

10. Uses technology, including telehealth, in implementing the plan of care.

11. Communicates the progression of the plan of care to the patient, caregivers, and interprofessional team, including elements necessary for safe transition of care.

12. Documents the provision of professional services, medical decision-making, and patient responses in the patient's health record using standardized language and recognizable terminology.

standard 6 EVALUATION

The ACNP evaluates the patient's progress toward the achievement of goals and outcomes.

Competencies

The ACNP:

1. Performs a systematic and ongoing evaluation of dynamic changes in patient status, needs, and re sponses to therapeutic interventions.

2. Uses input from the interprofessional team members and multiple data sources as part of ongoing evaluation.

3. Evaluates the safety and efficacy of therapeutic interventions, including recognition of adverse and unanticipated treatment outcomes.

4. Uses scientific evidence, quality indicators, risk-versus-benefit analysis, and clinical judgment when evaluating the patient's progress toward goals and outcomes.

5. Consults as indicated on the basis of the evaluation of the patient's progress.

6. Evaluates the effectiveness and adequacy of the patient's and/or caregivers' support systems.

7. Modifies the plan of care as indicated on the basis of the evaluation of progress toward goals and outcomes, to include risk, benefits, and alternative treatments.

8. Communicates the effectiveness of the plan of care to the patient, caregivers, and interprofessional team.

9. Confirms the goals of the plan of care remain aligned with the desires of the patient.

10. Documents the evaluation of the patient's response, the effectiveness of the plan of care, and medical decision-making in the patient's health record using standardized language and recognizable terminology.

Introduction

The Standards of Professional Performance are not intended to stand alone but must be used in conjunction with the other sections of this full document: the *ACNP Scope of Practice and the Standards of Clinical Practice.* The Standards of Professional Performance continue to follow the format defined by the American Nurses Association in its publication *Nursing: Scope and Standards of Practice,* 4th edition,[1] and by the American Association of Critical Care Nurses (AACN) in its publication *AACN Scope and Standards for Progressive and Critical Care Nursing Practice.*[2]

The Standards of Professional Performance describe a competent level of behavior in the professional role, including activities related to professional practice, education, collaboration, ethics, advocacy, systems and organizational thinking, resource utilization, leadership, collegiality, quality- and evidence-based practice, and clinical and practice inquiry. Some activities included are not unique to the ACNP; rather, they cross all roles of the advanced practice nurse and describe the responsibilities of advanced nursing practice. ACNPs should be self-directed and purposeful in seeking the necessary knowledge, skills, and abilities to demonstrate lifelong learning and continued professional development.

standard 1 PROFESSIONAL PRACTICE

The ACNP evaluates their clinical practice in relation to institutional guidelines, professional practice standards, and relevant statutes and regulations.

Competencies

The ACNP:

1. Maintains professional certification as an ACNP.
2. Holds self accountable for safe, effective, and competent care delivery.
3. Analyzes data regarding the performance and delivery of care within the context of practice.
4. Evaluates patient outcome measures as a component of individual performance appraisal.
5. Participates in peer review as available to foster a culture of clinical and professional excellence.
6. Identifies their own role in the interprofessional plan for emergency and disaster response.
7. Communicates care provided in accordance with institutional documentation policies.

standard 2 EDUCATION

The ACNP maintains current knowledge according to best available evidence.

Competencies

The ACNP:

1. Engages in lifelong learning in formal and informal educational activities related to professional and clinical practice.

2. Assimilates knowledge to improve patient outcomes and professional performance.
3. Maintains personal professional records to provide evidence of competence.

standard 3 COLLABORATION

The ACNP collaborates with the patient, family, and members of the interprofessional team across the continuum of care.

Competencies

The ACNP:

1. Uses skilled communication to build relationships with the patient, family, and members of the interprofessional team.

2. Performs consultations to facilitate optimal care.

3. Advances best practices by teaching, supervising, coaching, and mentoring members of the interprofessional team.

4. Coordinates services across the continuum of care.

5. Collaborates with other disciplines in technological skill development, research, and other professional activities.

standard 4 ETHICS

The ACNP integrates ethical considerations into all areas of practice congruent with the ANA Code of Ethics and patient and family needs.

Competencies

The ACNP:

1. Accepts accountability for their own actions.

2. Monitors practice to ensure the delivery of ethical care.

3. Promotes respect for the autonomy of persons, helping them or their surrogate participate in their care and clinical decisions.

4. Protects information in a confidential manner.

5. Delivers care in an equitable, inclusive, and culturally congruent manner.

6. Contributes to the establishment of an ethical environment that supports the rights of patients and members of the interprofessional team.

7. Reports unethical and illegal practices.

8. Leads in achieving resolution of ethical issues, including leveraging ethics consultation.

9. Collaborates in interprofessional teams in addressing ethical risks, benefits, and outcomes as indicated.

10. Uses principles of ethics when supervising, delegating, and directing interprofessional services.

standard 5 ADVOCACY

The ACNP functions as an advocate for patients, families, and the health care team.

Competencies

The ACNP:

1. Advocates for the patient's and family's access to available health care resources within systems and communities.

2. Values and honors the spectrum of human experiences, perspectives, and identities.

3. Promotes equity in health and health care delivery.

4. Champions efforts to overcome organizational system barriers to achieve optimal patient care.

5. Participates in professional organizations at the local, state, and national levels.

6. Encourages policy and legislation at the system, local, state, and national levels to promote health and improve care delivery models across the health care system.

standard 6 SYSTEMS/ORGANIZATIONAL THINKING

The ACNP engages in organizational systems and processes to promote optimal outcomes.

Competencies

The ACNP:

1. Applies knowledge of organizational theories and systems to provide evidence-based, safe, high-quality, and cost-effective care.

2. Analyzes the organizational system and its effect on patient care delivery and coordination.

3. Addresses challenges to optimal care created by the competing priorities of patients, payers, and suppliers.

4. Leads in the design and development of care programs and initiatives across the continuum of care.

5. Implements the integration of evidence-based and best practice standards into systems of health care delivery.

6. Collaborates in the leadership role with the development of institutional and organizational planning for emergency and disaster response

7. Applies knowledge of governmental and regulatory constraints or opportunities that affect the delivery of care.

standard 7 RESOURCE UTILIZATION

The ACNP incorporates best available evidence regarding diagnostic strategies, therapies, and complementary health alternatives to achieve optimal outcomes.

Competencies

The ACNP:

1. Assists patients, families, and caregivers to access appropriate health care services.

2. Develops innovative solutions addressing patient care that efficiently uses resources while maintaining or improving quality and patient safety.

3. Guides interprofessional team members, patients, families, and caregivers in selecting therapies that integrate perspectives of benefit, risks, safety, quality, and fiscally responsible decisions.

4. Serves as an expert resource and advocate to influence the formation of organizational and health care policies.

standard 8 LEADERSHIP

The ACNP leads in the profession and practice setting.

Competencies

The ACNP:

1. Continually strives to improve interpersonal skills.

2. Educates the interprofessional team and the public about the ACNP role.

3. Promotes dissemination of knowledge and advances the profession through scholarly activities.

4. Demonstrates leadership through teaching, coaching, and mentoring.

5. Develops innovations to effect change in practice and to improve outcomes.

6. Leads organizational committees, councils, or administrative teams.

7. Promotes the nursing profession and other disciplines through educational programs and staff development.

8. Promotes advancement of the profession through leadership positions in community, professional, policy, and/or regulatory organizations.

9. Provides leadership in the implementation of the advanced practice registered nurse (APRN) Consensus Model at the system, local, state, or national level.

standard 9 COLLEGIALITY

The ACNP promotes respect for colleagues and the interprofessional team.

Competencies

The ACNP:

1. Contributes to a healthy work environment by encouraging and facilitating open communication.

2. Seeks opportunities to teach, coach, and mentor.

3. Shares skills, knowledge, and strategies for patient care and system or organizational improvement.

4. romotes a respectful environment that enables the interprofessional team to make optimal contributions for systems and organizations to function effectively.

5. Exhibits professionalism in interactions with patients, family, colleagues, interprofessional team members, and other stakeholders.

6. Celebrates contributions of diverse interprofessional team members in patient care and system improvements.

standard 10 QUALITY- AND EVIDENCE-BASED PRACTICE

The ACNP ensures the quality, safety, and effectiveness of care across the continuum of acute care.

Competencies

The ACNP:

1. Collaborates with patients, families, caregivers, colleagues, and the interprofessional team to achieve quality patient outcomes.

2. Engages in self-reflection, performance appraisal, and peer review to improve the quality of care provided.

3. Uses scientific evidence and principles of implementation science to ensure safe, quality patient outcomes.

4. Conducts evaluation and improvement efforts to enhance the quality, safety, and effectiveness of care.

5. Contributes to the design, implementation, and evaluation of evidence-based, age-appropriate professional standards and guidelines for care.

6. Uses practice-based data to improve quality and outcomes.

7. Participates in resource allocation efforts to achieve high-quality, cost-effective care.

8. Improves the quality of practice of the ACNP through dissemination of evidence-based data to influence and advocate for initiatives at the system, local, state, or national level.

9. Disseminates data, information, and knowledge about the delivery of health care services.

standard 11 CLINICAL/PRACTICE INQUIRY

The ACNP enhances knowledge, attitudes, and skills through participation in research, translation of scientific evidence, and promotion of evidence-based practice.

Competencies

The ACNP:

1. Evaluates existing practice and makes changes related to current evidence-based recommendations, guidelines, and benchmarking.

2. Provides equitable and inclusive care through the integration of research knowledge and application of evidence-based practice to reduce disparities in health and health care outcomes.

3. Applies clinical inquiry skills for process improvement and patient safety.

4. Disseminates best practices to colleagues at the system, local, state, national, or international level through, but not limited to, activities such as formal presentations, publications, consultations, and journal clubs.

5. Translates quality improvement and research findings to influence health care policies that promote improved health outcomes.

6. Innovates health care delivery through improvement science using best available evidence.

exemplar 1

Susan is a new adult geriatric acute care nurse practitioner (AG-ACNP) who has been hired to work with a group of interventional pulmonologists in a university hospital system. The group covers a large consulting service population including an intensive care unit ICU and stepdown unit. Their daily staffing pattern includes 1 pulmonologist and 2 AG-ACNPs. Today, the census of the consulting service is 15 and includes 2 bronchoscopies and 3 pulmonary stent placements, which will be performed by the pulmonologist. These procedures will occupy many hours of the pulmonologist's time, so the AG-ACNPs will need to see the remaining 10 patients and there are several possible admissions in the Emergency Department that will need to be evaluated (*Standard 7 Resource Utilization; Standard 3 Collaboration*). Susan assesses 7 of the service patients on the floor and sets a plan. She writes a detailed, highest-level subsequent hospital-visit note about each of these patients and ensures that her plan of care is completed (*Standard 4 Care Planning and Management*). When the pulmonologist has completed all his interventional procedures, he discusses the patients whom Susan has evaluated. He tells her he wants to see her patients and to write a note so he can charge 100% for the visit vs 85% for her nurse practitioner (NP) care. This is a common use of the "shared visit" concept that is allowed by Centers for Medicare & Medicaid Services as long as he actually assesses the patient and writes a note with the proper components. He is aware of all the reimbursement rules and completes the requirements so there is no concern for fraud. However, Susan's care for the patient will now be "invisible" because she will not be able to charge for her services. What can she do?

This is a difficult situation that NPs face in today's competitive reimbursement environment. Susan decides to speak to her colleagues (*Standard 3 Collaboration; Standard 8 Leadership*) to see if she has any recourse regarding this type of situation. The group agrees that having their work be invisible is a major concern for the justification of their role. They decide to (*Standard 5 Advocacy*):

1. Track their visits and collect reimbursement data on how much their work can add to the financial viability of the service (*Standard 1 Professional Practice*).

2. They will also track the financial interventional reimbursement data of the service and list the reimbursement for each type of procedure.

3. They will discuss the data with the leadership of the service and then plan to present these data to the pulmonologist group (*Standard 6 Systems/Organizational Thinking*).

4. They hope to persuade the pulmonologists that the NP role will provide excellent care for their patients with good patient outcomes while the pulmonologists can become more involved in interventional procedures, which will also add to the financial security of the group. Therefore, "shared visits" will not be needed to increase reimbursement revenue of the group (*Standard 10 Quality/Evidence-Based Practice*).

5. This plan will secure the AG-ACNP role as an efficient and effective method of providing excellent patient care while benefiting the financial security of the pulmonologist group (*Standard 9 Collegiality*).

exemplar 2

An ACNP working in a 32-bed medical ICU (MICU) in a 780-bed tertiary care community hospital noticed an increasing rate of central line-associated bloodstream infections (CLABSI) and slow progress reducing CLABSIs over 2 years. The ACNP performed care audits in the MICU and noted significant variation in central- line access and maintenance practices (*Standard 10 Quality/Evidence-Based Practice*). The ACNP led a multidisciplinary team of key stakeholders (ie, executive leadership, physicians, advanced practice providers,

unit nursing leadership, and bedside nurses) (*Standard 3 Collaboration*) to reduce the CLABSI rate (*Standard 8 Leadership*). The ACNP queried nursing and medical literature (*Standard 2 Education*) and developed a quality improvement project that included:

1. developing a checklist for central venous catheter (CVC) insertion criteria,

2. nurse verification of preprocedure hand washing and maintenance of sterility throughout the procedure,

3. nursing education for "scrub the hub" and CVC maintenance practices,

4. identified unit-based CVC quality improvement champions who performed

    a. direct observation of scrub the hub practices with positive reinforcement awards for compliance, and

    b. identification of CVC dressing-change champions who performed all CVC dressing changes on preselected days of the week (eg, every Tuesday) for all CVCs on the unit.

The ACNP oversaw the project implementation over several plan-do-study-act cycles (*Standard 11 Clinical/Practice Inquiry*). One year after project implementation, the ACNP evaluated the project's effectiveness: the CLABSI rate was reduced to zero! (*Standard 10 Quality/Evidence-based Practice*). The unit has now gone more than 2 years without a CLABSI. The ACNP led the dissemination of the results by producing a poster presented at a regional nursing conference (*Standard 8 Leadership*). The ACNP consulted with management teams of other hospital units (cardiac care unit, neurology ICU, and bone marrow transplantation) to implement the program on these units.

exemplar 3

The ACNP who works in a cardiovascular surgical ICU notes a lack of care coordination for patients in the cardiovascular surgical ICU. The ACNP notes that the cardiovascular surgery team rounds on patients at 6 AM, the intensivist physician and ACNP round at 9 AM, a pharmacist reviews the electronic medical record sometime after 1 PM, and a registered dietitian evaluates patients 3 days a week. The ACNP makes a note of frustration from the bedside nurses that they "do not know the plan of care" and that orders to implement the care plan frequently come many hours after seeing a provider. The pharmacy team notes that duplicative and contradictory medication orders occur with some frequency. The ACNP identifies no formal time for multidisciplinary communication among the many groups caring for these critically ill patients. The ACNP established an interdisciplinary workgroup (*Standard 3 Collaboration*), evaluated the literature (*Standard 11 Clinical/Practice Inquiry*), and developed a plan for structured, nurse-led, multidisciplinary daily rounds in the cardiovascular surgical ICU using a formal rounding sheet (*Standard 8 Leadership*). The rounding team includes the intensivist physician, ACNPs from the intensivist and cardiovascular surgery teams, the ICU charge nurse, the bedside nurse, the critical care pharmacist, the registered dietitian, and the unit's respiratory therapist. The rounding flow sheet includes data reporting from each discipline, concluding with a summary of the daily plan of care by the intensivist physician. Orders are entered and verified during rounds (*Standard 6 Systems/Organizational Thinking*). Barriers to implementing this project included adjusting the established workflow for rounding participants and empowering the nurses to lead the multidisciplinary rounds. After 6 months of project implementation, nurses report increased satisfaction with understanding the plan of care, the pharmacy reports a significant decrease in duplicative medication orders, and the ICU length of stay decreased secondarily to increased postoperative bundle compliance (eg, time to extubation, weaning of vasopressors) (*Standard 7 Resource Utilization*).

exemplar 4

The ACNP team in the MICU at a large referral center is responsible for accepting and coordinating patient transfers from referring facilities. The MICU at this referral facility accepts patients with many diagnoses, but recently initiated a veno-venous extracorporeal membrane oxygenation (ECMO) program. After initiation of the ECMO program, the ACNPs began screening transfer calls for patients being sent for evaluation of advanced respiratory therapies, including ECMO. As the ECMO referral volume increased, the ACNPs noted that ECMO referral calls became quite lengthy and burdensome to workflow, because each ACNP wanted different data from referring providers, patients being referred for ECMO evaluation were inappropriate, and accepted patients often arrived *in extremis* as a result of unsafe transfer practices and protocols. The ACNP team developed a multifaceted approach to improve the transfer process of patients to receive ECMO (*Standard 3 Collaboration; Standard 6 Systems/Organizational Thinking*). First, a referral-screening checklist was developed to aid the transfer center in determining inappropriate patients for a referral. Second, a conversation guide was developed that prompted the ACNP team with regard to data collection during the referral call. Third, the team developed a transfer protocol that is sent to the referring facilities and emergency medical services and transfer personnel that details practices for the safe transfer of patients with refractory respiratory failure (*Standard 7: Resource Utilization*). Once put in place, these practices resulted in fewer declined transfer requests, shorter referral phone calls, and improved patient stability on arrival to the MICU (*Standard 8 Advocacy*).

exemplar 5

A 73-year-old patient with a history of hypertension, hyperlipidemia, diabetes, and chronic kidney disease presented to the neurosurgery clinic with progressive low back pain associated with bilateral lower extremity pain and paresthesia. The symptoms worsened with sitting and were slightly improved by constant movement, heat packs, stretching, and pain medication. Magnetic resonance imaging of the lumbar spine without contrast revealed multilevel degenerative disk disease and a narrowing spinal canal with herniated disks at L2-3, L3-4, and less so at L4-5, L5-S1. On examination, the patient had decreased somatic sensation to touch to both lower extremities (*Standard 1: Advanced Assessment*). Despite conservative measures (physical therapy, epidural steroid injection, and medications [naproxen and gabapentin]) (*Standard 4 Care Planning and Management; Standard 5 Implementation*), the patient's low back pain worsened and was accompanied by persistent bilateral lower extremity pain, paresthesia, and weakness. Given the result of the neuroimaging, worsening back pain, and exhaustion of all conservative therapies to relieve the back pain, surgery was scheduled. The patient underwent an elective L2-5 posterior decompressive laminectomy, medial facetectomy, and foraminotomy (*Standard 5 Implementation*). Postoperative daily assessments and rounding were performed to monitor for any acute complications. This included performing advanced neurosurgical assessments (*Standard 1 Advanced Assessment*); consulting the hospitalist team to assist with the management of the patient's medical comorbidities (*Standard 3 Collaboration*); monitoring daily outcomes of the patient's recovery in the hospital (*Standard 6 Evaluation*); developing expected outcomes to facilitate coordination and transition of care with the interprofessional team members such as the physician therapy, occupational therapy, case manager, and pharmacist; and implementing educational interventions to the patient and family regarding the patient's postoperative state (*Standard 4: Care Planning and Management; Standard 3 Collaboration*).

The dynamic nature of health care requires clinicians to systematically review and refine the framework under which care is provided. The ACNP scope and standards were due to be reviewed in 2020, which also was recognized as the International Year of the Nurse and Midwife in honor of Florence Nightingale's 200th birthday. Early in the midst of this yearlong celebration, we were thrown into the international coronavirus pandemic. The call to action to combat this pandemic brought nurses to the forefront, spotlighting our vital role and contribution to the health and wellness of the world. ACNPs were instrumental in providing direct patient care, adopting and revising protocols, guidelines, therapeutics, and techniques to combat COVID-19 as our acute care population was inundated by overwhelming numbers of the most critically ill patients encountered in recent history. We witnessed removal or suspension or waivers of collaborative agreements and restrictions; adoption of compacts; and federal and state waivers for provisions of telehealth, which allowed NPs to practice to their full extent without restrictions or barriers. Positive strides have already been made in the acceptance and visibility of the ACNP role. Since the inception of the role in the early 1990s, challenges have persisted, but the pandemic accelerated opportunities for ACNPs to demonstrate their full value as providers, educators, and leaders.

To promote a cohesive APRN framework for practice and to promote uniform recommendations to state licensing, the Consensus Model for APRN Regulation was developed.[3] The Consensus Model provided a structure for APRN education, certification, accreditation, and licensure (LACE). Essential to this model was the shift to population-based foci of care: family and individuals across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related, and psychiatric-mental health. The adult-gerontology and pediatrics populations were further distinguished by either an acute care or a primary care focus. ACNPs have long provided care consistent with the population-based paradigm rather than by location or geography.[4] Care is provided to acute, critical, and/or complex chronically ill or injured patients throughout the health care environment.

According to 2019 data APRNs, and more specifically certified nurse practitioners, are the fastest growing sector of nursing professionals. That number is expected to increase 45% by 2029, adding more than 117,000 APRNs to the profession to the currently more than 263,000 within that 10-year span.

In 2010, the Institute of Medicine, now the National Academy of Medicine, recommended the removal of scope-of-practice barriers for APRNs to "practice to the full extent of their education and training."[5] The Institute of Medicine report recommended reforming scope-of-practice regulations at the state level to conform to the National Council of State Boards of Nursing Model Act and Model Rules. The National Council of State Boards of Nursing Model Act describes APRNs as "independent practitioners within standards established or recognized by the [Board of Nursing]."[6] Although APRNs are independent practitioners, the National Council of State Boards of Nursing Model Act stresses that each APRN is accountable to patients, the nursing profession, and the state board of nursing for providing quality advanced nursing care, recognizing their limits of knowledge and experience, planning for management of situations beyond the APRN's expertise; and consulting with colleagues or referring patients, as appropriate.

This full practice authority allows APRNs to practice to the full extent of their education and training under the exclusive licensure authority of the state board of nursing. Full practice authority has been adopted in close to half of the states, with several states on the cusp of reducing or removing barriers to practice in their 2021 legislative sessions.[7] As of January 2017, the Department of Veterans Affairs amended its medical regulations to permits full practice authority to NPs, clinical nurse specialists, and certified nurse midwives when acting within the scope of their VA employment.[8] This change improved access to care while maintaining "patient-centered, safe, high-quality care"[8] and should be adopted nationally.

Despite the positive strides toward full practice authority in some states and within the VA, continued resistance remains, most notably from the American Medical Association, which has continued to oppose "legislation that would allow for the independent practice of advanced practice registered nurses."[9] The American Medical Association opposition appears to be in conflict with studies showing APRN quality is comparable to or better than physician comparisons.[10]

ACNPs must be cognizant of their scope of practice and continue to educate their physician colleagues, administrators, the public, and legislators on the quality and value offered. This will be an ongoing conversation that references the ACNP Scope and Standards document, as well as the relevant state and national regulations and guidelines. The conversation will be enriched by research demonstrating the effectiveness of care and the uniqueness of the ACNP practice model, which will only be enhanced by additional research and data collected during the COVID-19 pandemic. The ACNP should maintain a keen understanding of health care financing and reimbursement issues to participate in the ongoing dialog. Regardless of the future, change is inevitable.

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Glossary

AACN Synergy Model for Patient Care: the core concept of the conceptual model of certified acute and critical care nursing and advanced nursing practice. This model specifies that the needs or characteristics of patients and families drive the characteristics or competencies of the nurse from novice through advanced practice.

Acute care nurse practitioner (ACNP): An ACNP is an advanced practice registered nurse who has completed graduate education and supervised clinical practice to acquire advanced competencies that qualify him or her to perform comprehensive health assessments, order and interpret the full spectrum of diagnostic tests and procedures, use differential diagnosis to reach a medical diagnosis, and order, provide, and evaluate the outcomes of medical interventions for patients who are physiologically unstable, technologically dependent, and highly vulnerable for complications within his or her population foci.

Acute critical illness: condition of a patient who is at high risk for life-threatening health problems. The more critically ill the patient, the more likely he or she is to be highly vulnerable, unstable, and complex.

Advocacy: the act or process of supporting a cause or proposal; the act or process of advocating something[1]

Assessment: systematic, dynamic process by which the ACNP, through interaction with the patient or family nursing personnel, and interprofessional team, collects and analyzes data. Data may include the following dimensions: physical, psychological, social, environmental, cultural, spiritual, cognitive, functional, organizational, developmental, and economic factors. Data may also be collected to meet regulatory requirements or external demands.

Autonomous practice: the ability to provide patient care services without supervision or by mandated collaboration with other health professionals[2]

Caregiver: a person who provides direct care for children, elderly people, or the chronically ill[3]

Chronically critically ill: adult patients who survive the life-threatening phase of critical illness but continue to require extensive critical care support services.[4] An additional definition recently has been described for the Centers for Medicare & Medicaid Services as 1 of 5 clinical conditions plus at least 8 days in an intensive care unit during an acute care hospitalization. The 5 conditions are (1) prolonged acute mechanical ventilatory support (ie, mechanical ventilatory support for at least 96 hours in a single episode), (2) tracheotomy, (3) sepsis and other severe infections, (4) severe wounds, and (5) multiple organ failure, ischemic stroke, intracerebral hemorrhage, or traumatic brain injury.[5]

Collaboration: working with individuals of other professions to maintain a climate of mutual respect and shared values to improve coordination, communication, and the quality and safety of patient care. The term describes joint practice, consultation, or referral in the care of patients. This does not require mandated agreements between the professions to provide care.[2,6]

Competency: integration of knowledge, attitudes, and skills necessary to function in a specific role and work setting[7]

Complementary health: a non-mainstream practice used together with conventional medicine. This may be the use of natural products or mind and body practices.[8]

Comprehensive health history: a full account of past and present illness, injury, and treatment obtained by asking questions of a patient or family member[9]

Comprehensive physical examination: the highest level of physical examination; indicates that 9 of 10 physiologic systems were assessed, with at least 2 characteristics in each system documented

Consensus Model for APRN Regulation: model developed to align the licensure, education, accreditation, and certification requirements for the 4 APRN roles: certified registered nurse anesthetist, certified nurse practitioner, clinical nurse specialist, and certified nurse midwife[10]

Continuity of care: interprofessional process that includes patients and families or significant others in the development of a coordinated plan; a process that facilitates the patient's transition between settings, based on changing needs and available resources

Continuum of care: conceptual model that describes a person's movement from wellness through desired quality of life to a dignified death. A person's place on the continuum is individually determined.

Credentialing: refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, certification, relevant training and experience, and current competence and health status

Diagnosis: a clinical judgment about the patient's response to actual and potential health conditions or needs; may be medical or nursing diagnosis; provides the basis for determining an interprofessional plan of care to achieve expected outcomes

Differential diagnosis: part of the systematic process of developing a medical diagnosis whereby the practitioner makes a list of potential diagnoses, including any pathological causes that may demonstrate the patient's signs and symptoms[11]

Diversity: variation that occurs among a set of similar items. With respect to patients, the factors that vary include, but are not limited to, race, culture, spirituality, ethnicity, socioeconomic status, age, lifestyle, and values.

End-of-life care: includes referrals, pain management, palliative care. End-of-life care is the support and medical care given during the time surrounding death.[12]

Equity: justice according to natural law or right, freedom from bias or favoritism[13]

Evaluation: process of determining the patient's progress toward the attainment of expected outcomes

Evidence-based practice (EBP): a systematic process of inquiry and a method of providing optimal patient care in complex health care environments. EBP integrates the best available evidence and the clinical expertise of the interprofessional team together with patient and family preferences to facilitate decision-making and optimize outcomes.[14]

Family: family of origin or significant others and/or surrogate decision-makers as identified by the patient

Geriatrics: the comprehensive health care of older adults

Gerontology: study of aging processes and individuals as they grow from middle age through later life

Guidelines: broad practice recommendations based on scientific theory, research, and/or expert opinion

Healing environment: an organizational philosophy and commitment to structuring resources to support and focus on integrating science and spirituality. A healing environment provides conditions that stimulate and

support the inherent healing capacities of patients and families.[15]

Health care literacy: the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions[16]

Health equity: providing a fair and just opportunity to be as healthy as possible; removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care[17]

Health promotion and disease prevention: identifying and mitigating factors that create a risk for injury or illness in an individual or group of individuals

Health protection: includes risk and safety; defending a state of wellness from potential sources of injury or illness

Healthy work environment: a work environment that supports the standards of skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership[18]

Hospitalist: a practitioner who is engaged in clinical care, teaching, research, and/or leadership in the field of hospital medicine. Practitioners of hospital medicine include physicians, nurse practitioners, and physician assistants.[19]

Illness: poor health resulting from disease of body or mind; sickness[20]

Implementation: the process of carrying out the interdisciplinary plan of care that may include implementing, delegating, and/or coordinating interventions; the patient and/or family or health care providers may be designated to implement interventions within the plan

Improvement science: an applied science that emphasizes innovation, rapid-cycle testing in the field, and spread in order to generate learning about what changes, in which contexts, produce improvements. It is characterized by the combination of expert subject knowledge with improvement methods and tools.[21]

Inclusion: the act or practice of including and accommodating people who have historically been excluded (eg, because of their race, sex or gender, sexuality, or ability)[22]

Innovation: to develop new or improved health policies, systems, products and technologies, and services and delivery methods that improve people's health, with a special focus on the needs of vulnerable populations[23]

Injury: form of hurt, damage, or loss; damage or harm done to or suffered by a person or thing[24]

Intensivist: a provider who specializes in the care and treatment of patients in intensive care[25]

Interprofessional: working with individuals of other professions; as a team, individuals of different disciplines working, collaborating, and communicating to accomplish goals

Intraprofessional: individuals from the same discipline; as a team, working, collaborating, and communicating to accomplish goals

Judgment: forming a conclusion that encompasses critical thinking, problem solving, ethical reasoning, and decision-making

Knowledge: encompasses thinking, an understanding of science and humanities, professional standards of practice, and insights gained from practical experiences, personal capabilities, and leadership performance

Licensed independent practitioner (LIP): an individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision. An LIP operates within the scope of his or her license, consistent with individually granted privileges.[26]

Nocturnist: a hospital-based provider who only works overnight[27]

Nonpharmacologic: referring to therapy that does not involve drugs[28]

Nurse: an individual who is licensed by a state agency to practice as a registered nurse

Nurse characteristics: as defined by the AACN Synergy Model for Patient Care. Reflect an integration of knowledge, skills, experience, and attitudes needed to meet the needs of patients and families; continuums of nurse characteristics are derived from patient needs. These characteristics, according to the model, are clinical judgment, advocacy and moral agency, caring practices, collaboration, systems thinking, facilitation of learning, response to diversity, and clinical inquiry.

Nursing: the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, communities, and populations[29]

Nursing process: also known as the scientific process. A dynamic, systematic method of caring for patients from a nursing perspective. The steps of the nursing process include assessment, diagnosis, planning, implementation, and evaluation. The dynamic and circular nature of the nursing process is apparent in the ACNP's continuous collection (recollection) and assessment (reassessment) of data, the patient's response to care, formulation (reformulation) of the outcomes to be expected, and provision of interventions based on these data. This assumes that the ACNP includes the patient, the family, and the interprofessional team in the formulation of the plan.

Outcomes: measurable, expected goals. Expected outcomes describe the results that are anticipated or expected as a result of the interventions of the ACNP.

Palliation/palliative care: specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.[30]

Patient: recipient of nursing care. The term refers to the individual, family, caregiver, group, or community.

Patient characteristics: as defined by the AACN Synergy Model for Patient Care. Patient characteristics span the continuum of health and illness and include resilience, vulnerability, stability, complexity, resource availability, participation in care, participation in decision-making, and predictability.

Peer review: the process by which professionals with similar knowledge, skills, and abilities judge the processes and/or outcomes of care

Pharmacologic: pertaining to pharmacology or to the properties and reactions of drugs[31]

Plan of care: an interprofessional outline of care based on individualized expected outcomes for the patient. The patient, family, and health care providers participate in carrying out the plan for the implementation or delivery of care.

Population foci: the 6 categories of patient populations as defined by the *Consensus Model for APRN Regulation:*

Licensure, Accreditation, Certification & Education[8]: (1) family or individual across the life span, (2) adult/gerontology, (3) neonatal, (4) pediatric, (5) women's health/gender-related, and (6) psychiatric/mental health.

Privileging: the process by which a practitioner who is licensed for independent practice is permitted by law and the facility to practice independently and to provide specific medical or other patient care services within the scope of the individual's license. Peer references, professional experience, health status, education, training, and licensure contribute to this determination of the clinical competence of the practitioner. Clinical privileges must be specific to both the facility and the provider.

Problem-focused physical examination: only a signal problem is investigated and other systems unrelated to that problem are not checked[32]

Quality of care: cooperative and collaborative process that combines the goals of professional standards of care with the defined expectations of the patient and family

Reflective learning: recurrent, thoughtful, personal self-assessment, analysis, and synthesis of strengths and opportunities for improvement

Skill: ability that includes psychomotor, communication, interpersonal, and diagnostic components

Standard: authoritative statement articulated and supported by the profession that describes a level of care or performance by which the quality of practice, service, or education can be measured or judged

Standards of practice: authoritative statements that describe a level of care or performance common to the profession of nursing and by which the quality of practice can be judged. These standards describe a competent level of clinical practice demonstrated through assessment, diagnosis, outcome identification, planning, implementation, and evaluation. The associated competency statements identify ways in which the standard can be met.

Standards of professional performance: authoritative statements that describe a competent level of behavior in the professional role, including activities related to professional practice, education, collaboration, ethics, systems thinking, resource utilization, leadership, collegiality, quality of practice, and clinical inquiry. The associated competency statements identify ways in which the standard can be met

Social determinants of health: conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks[33]

Supervision/supervising: action, process, or occupation of supervising, a critical watching and directing activities or a course of action[34]

System: organization of groups of people, resources, and institutions that provide health services to meet the needs of patients

Telehealth: a variety of technologies and tactics to deliver virtual health care, public health, and health.[35]

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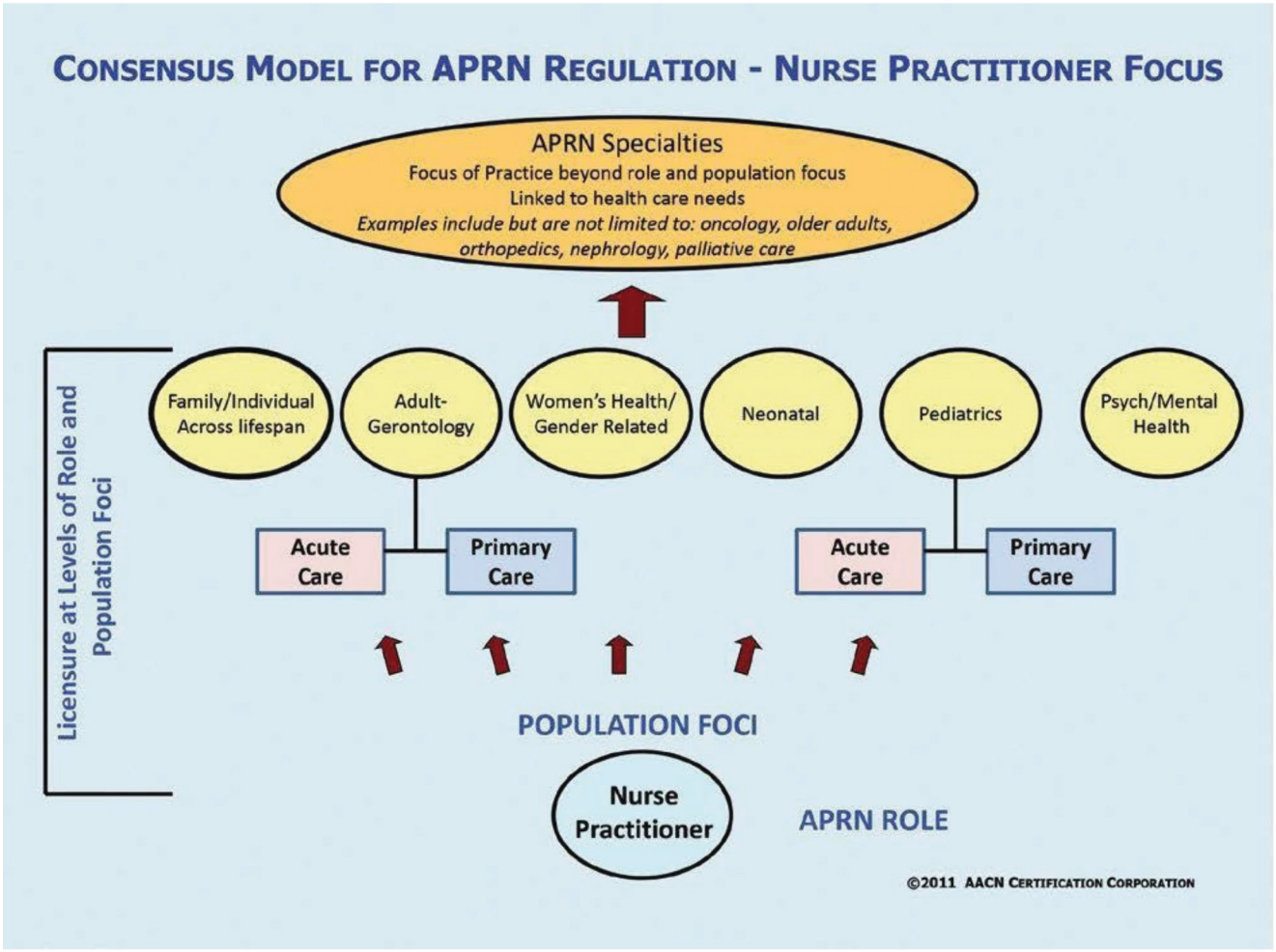
Appendix A

CONSENSUS MODEL for APRN REGULATIONS



Appendix B

ADDITIONAL FOUNDATIONAL RESOURCES

The National Organization of Nurse Practitioner Faculties (NONPF) identifies competencies for nurse practitioners (NPs) for entry into practice. These documents are accessible as noted below:

• National Organization of Nurse Practitioner Faculties. Nurse Practitioner Core Competencies Content. 2017 https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/2017_NPCoreComps_with_Curric.pdf

• National Organization of Nurse Practitioner Faculties. Adult Gerontology Acute Care and Primary Care NP Competencies. https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/files/np_competencies_2.pdf

• National Organization of Nurse Practitioner Faculties. Population-Focused Nurse Practitioner Competencies: Family/Across the Lifespan, Neonatal, Pediatric Acute Care, Pediatric Primary Care, Psychi-atric-Mental Health, Women's Health/Gender-Related, 2013.
https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/populationfocusnpcomps2013.pdf.

Nurse practitioner organizations and state boards of nursing have made statements about the roles of the Acute Care vs. Primary Care Nurse Practitioner practice. Here are some resources that can help discussion in your institution:

• National Organization of Nurse Practitioner Faculties. Primary Care and Acute Care Certified Nurse Practitioners. https://www.pncb.org/sites/default/files/2017-02/NONPF_AC_PC_Statement.pdf.

• American Association of Nurse Practitioners. Nurse Practitioner State Practice Environment. 2021.
https://www.aanp.org/images/documents/state-leg-reg/stateregulatorymap.pdf.

• Ohio Board of Nursing. Certified nurse practitioner (CNPs) in primary care or acute care.
http://nursing.ohio.gov/wp-content/uploads/2019/10/10.4.19-cnp.pdf

• Ohio Board of Nursing APRN Decision Making Model
http://nursing.ohio.gov/wp-content/uploads/2019/10/10.2019-APRN-Decision-Model-2019-1.pdf

Additional resources that may be helpful:

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Appendix C

Adult-Gerontology Acute Care Nurse Practitioner Skills and Procedures:

In addition to classifying items according to the patient care problems specified, and identifying related underlying competencies, items may also require an understanding of skills and procedures pertinent to the Adult-Gerontology Nurse Practitioner. The study of practice sought to determine whether selected skills and procedures are performed and important to the Adult-Gerontology Nurse Practitioner. The following lists skills and procedures that may be incorporated within items. This list is not intended to be all encompassing, that is, other well-established skills and procedures may also be included in the examination content.

A. Cardiovascular
1. Insert/remove arterial access devices
2. Insert/remove central venous access devices
3. Insert/remove midline catheters/PICCs
4. Interpret electrocardiograms
5. Interpret cardiac rhythms
6. Interpret echocardiograms
7. Interpret hemodynamic values
8. Lead cardiopulmonary resuscitation team
9. Manage temporary pacemakers
10. Manage cardiac implantable electronic devices
11. Perform cardioversion
12. Manage mechanical circulatory support devices

B. Respiratory
1. Initiate mechanical ventilation
2. Manage mechanical ventilation
3. Insert/remove large-bore chest tubes
4. Insert/remove small-bore chest tubes
5. Perform needle thoracostomy
6. Perform thoracentesis
7. Change, downsize, and/or decannulate tracheostomy
8. Interpret pulmonary function tests
9. Order multi-modal oxygen therapy
10. Order noninvasive positive pressure ventilation
11. Perform intubation/airway management
12. Perform extubation
13. Perform rapid-sequence intubation (RSI)
14. Perform invasive airway access
15. Perform bronchoscopy

C. Gastrointestinal
1. Insert/remove small-bore feeding tubes
2. Perform paracentesis

D. Renal/Genitourinary
    1. Initiate and manage renal replacement therapies
    2. Perform pelvic exams

E. Integumentary
    1. Administer local anesthetic
    2. Incise and drain (e.g., skin, wounds, abscesses)
    3. Perform wound debridement
    4. Prescribe wound care
    5. Perform wound closure

F. Musculoskeletal
    1. Insert/remove intraosseous access

G. Hematology/Immunology/Oncology
    1. Initiate/manage blood-product transfusions

H. Neurology
    1. Perform brain death testing
    2. Perform lumbar puncture
    3. Manage ICP monitor
    4. Manage CSF drain
    5. Manage shunt

I. Behavioral
    1. Order and manage restraints

J. Multisystem
    1. Interpret diagnostic studies
    2. Prescribe durable medical equipment
    3. Prescribe pharmaceutical interventions
    4. Perform ultrasound-guided diagnostic procedures
    5. Perform ultrasound-guided therapeutic procedures
    6. Manage enteral nutrition
    7. Manage parenteral nutrition
    8. Perform moderate sedation
    9. Prescribe and manage thrombolytic therapy
    10. Declare and certify cardiac death
    11. Provide multimodal interventions for pain
    12. Manage end-of-life care

Appendix D

Certified Pediatric Nurse Practitioner – Acute Care (CPNP-AC)

With routine job task analysis (JTA) research completed in 2019, the following procedures were validated for testing on the entry-level Certified Pediatric Nurse Practitioner – Acute Care (CPNP-AC) national board certification exam. A list of 30 possible procedures was surveyed, and the eight (8) procedures below met threshold criteria as being either ordered/managed, performed, and/or supervised frequently enough by CPNP-ACs across the U.S. to be included on the exam.

However, actively practicing pediatric nurse practitioners in acute care who are certified and licensed may perform many other procedures, based upon their state scope of practice, education, and training while on the job, followed by credentialing at a local institution.

Airway adjunct
Central line insertion
Chest tube insertion
Chest tube removal
Lumbar puncture
Procedural sedation
Ventilator management: invasive
Ventilator management: non-invasive

The next CPNP-AC Job Task Analysis is planned to commence in 2023 and will update this list. More information about the CPNP-AC role and content outline can be found here.

Pediatric Nursing Certification Board www.pncb.org September 2021

AACN Standards for Establishing and Sustaining Healthy Work Environments

A Journey to Excellence, 2nd edition

EXECUTIVE SUMMARY

In 2001, the American Association of Critical-Care Nurses (AACN) made a commitment to actively promote the creation of healthy work environments that support and foster excellence in patient care wherever acute and critical care nurses practice. *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence*, issued in 2005, responded to mounting evidence that unhealthy work environments contribute to medical errors, ineffective delivery of care, and conflict and stress among health care professionals. The standards uniquely identified previously discounted systemic behaviors that can result in unsafe conditions and obstruct the ability of individuals and organizations to achieve excellence. AACN called for the creation and continual fostering of healthy work environments as an imperative for ensuring patient safety and optimal outcomes, enhancing staff recruitment and retention, and maintaining health care organizations' financial viability.

AACN's seminal work identified 6 essential standards that must be in place to create and ensure a healthy work environment. They provide an evidence-based framework for organizations to create work environments that encourage nurses and their colleagues in every health care profession to practice to their utmost potential, ensuring optimal patient outcomes and professional fulfillment.

Since the first edition of the standards was released, there has been spirited national and international dialogue about the work environment's impact on nurse retention, team effectiveness, patient safety, nurse and patient outcomes, and burnout among health care professionals. Yet workplace studies confirm that un healthy work environments still exist in many organizations. At no other time in health care's history has there been more turbulence, rapid change, or complexity. Today's work environments demand even more attention to the fundamental issues of these standards, because stakes are high, and patients' lives depend on it.

The original 6 standards remain unchanged. This second edition reflects the emergence of robust evidence acquired since 2005 addressing the concepts described in the standards. The literature strongly supports the tenets of the standards and highlights the urgent need for health care professionals to continue addressing the health of the work environment.

Through this 2nd edition of the standards, AACN recognizes the inextricable links among the quality of the work environment, excellent nursing practice, and patient care outcomes. The organization remains strategically committed to bringing its influence and resources to bear on creating work and health care environments that are safe, healing, humane, and respectful of the rights, responsibilities, needs, and contributions of all people — including patients, their families, nurses, and other health care professionals.

This publication is derived from *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence,* 2nd Ed.

Both documents are available for download at the American Association of Critical-Care Nurses Web site <www.aacn.org>

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

6 essential standards

The 6 standards for establishing and sustaining healthy work environments represent evidence-based and relationship-centered principles of professional performance. Each standard is considered essential in that effective and sustainable outcomes do not emerge when any standard is considered optional.

The standards align directly with the core competencies for health care professionals recommended by the National Academy of Medicine (NAM). They support the education of all health care professionals and echo NAM's call "to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."

The standards are neither detailed nor exhaustive. They do not directly address dimensions such as physical safety, clinical practice, clinical and academic education, and credentialing, all of which are addressed by a multitude of statutory, regulatory and professional agencies, and other organizations.
With these standards we aspire to shine a light on the dimension these frameworks often overlook — the human factor.

This document is designed to be used as a foundation for thoughtful reflection, engaged dialogue, and bold action related to the current realities of work environments. Critical elements required for successful implementation accompany each standard. Working collaboratively, individuals and groups in an organization should determine the priority and depth of application required to ensure each standard is met.

essential Absolutely required; not to be used up or sacrificed. Indispensable. Fundamental.

standard Authoritative statement articulated and promulgated by the profession, by which the quality of practice, service, or education can be judged.

critical Structures, processes, programs, and elements required for a standard behaviors to be achieved.

The standards for establishing and sustaining healthy work environments:

Skilled Communication
Nurses must be as proficient in communication skills as they are in clinical skills.

True Collaboration
Nurses must be relentless in pursuing and fostering true collaboration.

Effective Decision Making
Nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations.

Appropriate Staffing
Staffing must ensure the effective match between patient needs and nurse competencies.

Meaningful Recognition
Nurses must be recognized and must recognize others for the value each brings to the work of the organization.

Authentic Leadership
Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it, and engage others in its achievement.

Appendix F

Example of Decision-Making Tool For APRNs

Ohio Board of Nursing www.nursing.ohio.gov
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APRN DECISION MAKING MODEL

The Decision Making Model is a guide for APRNs to use when determining whether a specific procedure, task or activity is within the APRN scope of practice and, if so, whether the specific procedure, task or activity is consistent with standards of practice, appropriate to perform based on the individual APRN's knowledge and skills, and is appropriate based on the clinical setting.

The Board also publishes Interpretive Guidelines that address specific RN and LPN practices and these are available on the Board website at www.nursing.ohio.gov. However, since it is not possible for the Board to establish Interpretive Guidelines for every procedure, task or activity, the Decision Making Model was developed so APRNs could apply it as needed for their specific practices.

First ask: Is the procedure/activity prohibited by the Ohio Revised Code or the Ohio Administrative Code? If yes, do not proceed.	
Guiding Questions	
Is the procedure/activity consistent with the Ohio Nurse Practice Act, rules regulating the practice of nursing, and Interpretive Guidelines of the Board.	
If **NO**: STOP	If **YES**, ask: Do practice guidelines of a national specialty or advanced practice organization support inclusion of this procedure/activity in your particular practice?

	If **NO**: **STOP**	If **YES**, ask: 1. Do you possess the depth and breadth of **knowledge** to perform this procedure/activity safely? AND 2. Do you possess the depth and breadth of **knowledge** to respond appropriately to complications or untoward effects of the procedure/activity? *At this step of the decision-making process:* You must be able to provide documentation, upon request of the Board, to show evidence of your **knowledge** to perform the procedure/activity. Such knowledge is generally obtained through education emanating from a recognized body of knowledge relative to the care to be provided. Documentation could include: • APRN educational programs; • Preceptorship, fellowship, or internship; and/or • Other formally organized educational experience

		If **NO**: **STOP**	If **YES**, ask: 1. Do you possess the depth and breadth of current **skills and clinical competence** to perform this procedure/activity consistently and safely? AND 2. Do you possess the depth and breadth of current **skills and clinical competence** to respond appropriately to complications or untoward effects of the procedure/activity? *At this step of the decision-making process:* You must be able to provide documentation, upon request of the Board, to show evidence of your **skills and abilities** to perform the procedure/activity. Documentation could include: • APRN educational programs; • Formally organized educational experience; and/or • Return demonstrations or skills check-off	
			If **NO**: **STOP**	If **YES,** ask**:** 1. Is this an accepted standard of care? Would a reasonable, prudent APRN perform this activity in this setting and under these circumstances? 2. Will you assume accountability for providing safe care in performing the procedure/activity?

	If **NO**: **STOP**	If **YES**, you have concluded that the procedure/activity is within your scope of practice. Proceed to agency/institutional education, competency, credentialing or privileging criteria, and other considerations.

Other Considerations

Although the procedure/activity may be within your APRN scope of practice, you should be familiar with other state or federal statutes or regulations that may affect the ability of an APRN to perform the procedure/activity, including, for example, laws and rules of the Ohio State Medical Board or Ohio Board of Pharmacy; laws and rules of the Ohio Department of Health, the Ohio Department of Job and Family Services, or the Ohio Department of Medicaid; or federal Medicare regulations.

It is important for APRNs to determine whether other state or federal laws establish parameters regarding a particular procedure/activity before they perform it. APRNs must also consider applicable policies and procedures of their agency or institution, as well as factors such as payer and malpractice carrier policies.

Additional Information

The Nurse Practice Act and the administrative rules are available for review in their entirety on the Board website at www.nursing.ohio.gov under the "Law and Rules" link.

- In general, the regulations governing the practice of APRNs is found in Ohio Revised Code Sections 4723.01, 4723.151(B) and (C), and Sections 4723.41, 4723.43, 4723.431, 4723.44, 4723.48, 4723.481, 4723.4810, 4723.483, 4723.488, 4723.489, 4723.50,4723.51, 4723.52 and 4723.99, and in administrative rule Chapters 4723-8 and 4723-9, Ohio Administrative Code.

To access other applicable information, law and rules:

- State Medical Board of Ohio: www.med.ohio.gov
- Ohio Board of Pharmacy: www.pharmacy.ohio.gov

Board approved National Certifying Organizations for Certified Nurse Midwives, Certified Nurse Practitioners, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists, can be accessed on the Board website at www.nuring.ohio.gov under the "Practice APRN" link.

Email APRN practice questions to the Board at practice@nursing.ohio.gov

This Model is intended to assist APRNs in determining their individual scope of practice based upon the Ohio Nurse Practice Act and administrative rules, and the individual's education, knowledge, and skills. It is not intended to provide legal advice. Those using the Model should refer to the Nurse Practice Act and the administrative rules in their entirety.

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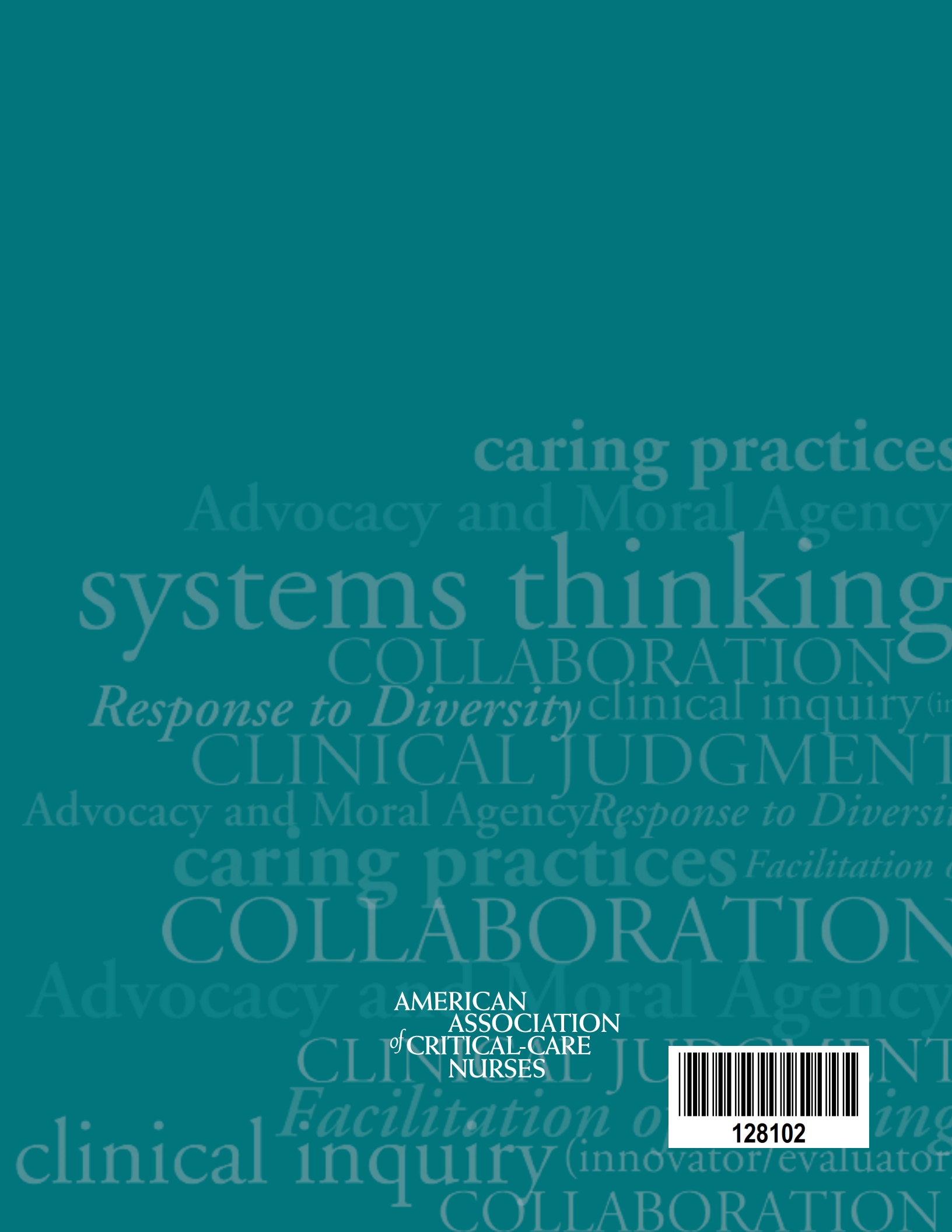

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