CHAPTER

3

The Influence of Contemporary Trends and Issues on Nursing Education

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Three students were having an animated discussion after class.

Mark: I’m tired of all this lecturing! I just want to DO nursing! Why do we always have to discuss things like EBP and critical thinking? What is it anyway? And we’re always having to analyze a situation when it’s perfectly clear what needs to be done! I don’t get it. Just do what the doc orders or what’s in the procedure book. I don’t need to keep looking up stuff when I’ve done it before. Besides, we already have way too much to read for every class!

Katelyn: But listen to this. I heard about a student several days ago who really got into trouble because of a big mistake she made. She did just what you said… followed the provider’s orders and gave digoxin to an 80-year-old patient. She had already written a note that he was complaining of anorexia, nausea, and visual disturbances, but she didn’t take time to look up “dig” toxicity or to really think things through. And guess what? The patient got into a really bad situation. It was lucky that the nurse practitioner read the note, checked the patient, put the pieces together, and got a stat serum “dig” level. She had to administer Digibind! It was so life threatening, and really scary! He’s not out of the woods yet. The student said the NP was nice and helped her understand what she should have done, but the instructor pulled her off the unit and really gave her a serious dress-down because she had not taken a couple of minutes to analyze the situation, to think about what things are danger signs, or to just look up the meds and the patient’s condition at the time—she just followed the provider’s orders. I’d be scared to be the one being grilled at the risk management meeting! She may even fail the course.

Audrey: That sounds like a good example of what our instructors keep telling us. Nursing is about thinking as well as doing. We can seriously harm a patient if we don’t “know” what actually needs to be done. We have to learn enough so we’re competent and know how to use “best practices” for all kinds of situations, and where to get the information fast. We have to really study resources, use our e-books, medical software and whatever, to check things out first and then figure out what we need to do, and fast. Even if we’re busy or just don’t want to stop and look up something.
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**LEARNING OUTCOMES**

After studying this chapter, the reader will be able to:

1. Integrate knowledge of 10 current trends and issues in society and health care into a more holistic perception of their influence on nursing education, students, faculty, and nursing practice.

2. Create a personal philosophy and plan for ongoing professional development and practice that integrates knowledge of current trends and issues.

3. Access current information resources from the Internet related to evolving trends and issues as a component of ongoing learning and preparation for practice.

4. Differentiate among various types of conventional, mobility, and new nursing education programs and the issues associated with them.

**VIGNETTE — cont’d**

*Katelyn:* Why don’t we start our own little study group, to learn how to get a better understanding of each class? Nursing is a lot more than just “doing” skills. We’ve got to be competent in the thinking that goes with the doing. And, there’s got to be a way to organize all this information and learn how to put it together for different situations. Whadaya say? I don’t want to get into trouble like that other student! Come on; let’s get started on those study questions.

**Questions to Consider While Reading This Chapter:**

1. What are the major current trends in society and health care, and how do they influence nursing education and practice?

2. What are the most compelling reasons that nurses require ongoing development and validation of competencies for licensure and continuing practice?

3. What local, state, and national resources and Internet websites are available to learn about the trends and issues that influence nursing education?

4. What are the pros and cons of the many different types of nursing education programs that prepare students for current nursing practice?

5. What educational opportunities exist for graduates of various programs to advance beyond their current preparation, including traditional, mobility, and distance-learning programs?

**KEY TERMS**

**Competency outcomes:** The results, or end products, of planned study and experience that are focused on specific abilities required for practice.

**Contemporary issues:** The problems, changes, and concerns that are current for the present time.

**Core competencies:** The essential cluster of abilities and skills required for competent nursing practice.

**Educational mobility:** The progressive movement from one type or level of education to another, often based on flexible, self-directed, or advanced placement options. Examples are progression from diploma preparation to an academic degree, such as RN to BSN or MSN; BSN to doctoral degree; or non-nursing degree to BSN, MSN, or doctoral degree.

**Education trends:** Shifts in conditions and concerns that emerge from and influence various aspects of society; broad changes in the United States and the world that influence the education and practice of nurses and other providers.

**Performance examinations:** Standardized evaluation based on objective demonstration of specific required competencies; used in conjunction with written tests of knowledge about those abilities. They may require performance in actual or simulated situations, related to physical psychomotor skills or the observable evidence of other skills such as critical thinking, communication, teaching, planning, writing, or analysis and integration of data.
Society as a whole is going through many significant changes, and all of them influence nursing education and health care. Nursing care is becoming more complex, and the role of the registered nurse is more demanding requiring nurses to be active participants in health care decisions. Nurses need to be effective and efficient in understanding how societal, educational, and health care changes influence health outcomes. Our knowledge, thinking, and a broad array of skills all are critical to the kind of nursing care we provide, and they influence how we respond to changes in patients, families, and communities in times of need. Nurse educators must be vigilant in learning about these changes and integrating them into the curriculum. Students also need to be aware of evolving trends and issues and learn how they influence learning and practice.

As American society becomes increasingly diverse and complex, new trends precipitate different issues. This chapter describes 10 contemporary trends that influence the way students (and nurses) learn, become competent practitioners, and meet the needs of patients. Competent nurses integrate these changes into their way of being, to become “thinking” nurses as well as “doing” nurses. Thinking nurses learn to integrate essential knowledge, attitudes, and skills into care that involves best practices and evidence-based practices that promote patient safety and quality care. Some of these trends and related issues include the following: the extreme and rapid changes in technology in patient care and education, significant changes in the demographics of our society, the economic crisis and its consequences, the globalization of knowledge and diseases, the requirement for competent health care providers, the increase in domestic abuse and violence of all sorts, complexity of physical and mental health conditions, ethical issues, and the shortage of nursing faculty and nurses. It also describes the types of nursing education programs, their contribution to the profession, the expansion of innovative nursing programs, degrees and specialties available, and multiple technologic learning methods used. Tables illustrate online resources, important organizations and associations, and some statistics related to types of programs.

INTRODUCTION

Authors identify different lists of trends related to nursing education and practice depending on their experiences and perspectives (Baer et al, 2000; Porter-O’Grady, 2001; Speziale and Jacobson, 2005). Speziale and Jacobson reviewed findings from two national faculty surveys to highlight trends in nursing education; they compared data in the 1998 and the 2004 surveys and observed how each reflects trend changes in society. Lenburg (2002, 2008) used a different perspective and identified 10 trends and related issues; her list is used as the framework to organize this chapter (Table 3-1).

New programs, courses, experiences and changing requirements for the development of new skills pave the way for different opportunities for students to prepare for initial and continuing practice in a rapidly changing society. These trends influence the number and types of nursing programs for basic and experienced students at the undergraduate and graduate levels. Essential differences among basic education programs; innovations in new degree programs, majors, and courses; and mobility and distance-learning programs are reviewed in the context of changes in national organizations and accrediting and regulatory bodies. Students who study and comprehend these trends are better prepared to cope with them as competent health care practitioners and meet the needs of patients from diverse multicultural and demographic backgrounds.

TRENDS AND ISSUES IN CONTEMPORARY NURSING EDUCATION

Knowledge Expansion and Use of Technology and the Internet

With ever-expanding developments in electronic information and communication technology, the volume of information is growing exponentially on a global level. Informatics has become a major part of education and practice (Cipriano and Murphy, 2011). This ability to create, access, and disseminate unlimited information rapidly has enormous benefits. From e-mails to complex research
TABLE 3-1  SUMMARY OF TRENDS AND ISSUES THAT INFLUENCE NURSING EDUCATION

<table>
<thead>
<tr>
<th>MAJOR CONTEMPORARY TRENDS</th>
<th>RELATED ISSUES FOR STUDENTS</th>
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</table>
| Rapid knowledge expansion; increasing use of technology and informatics in education and practice | 1. Choosing the most effective electronic and technology options  
2. Information overload; virtually unlimited global resources, global research opportunities, issues  
3. Identifying current and accurate information; material rapidly outdated  
4. Expanded expectations, limited time, rapid response expected; little time for reflection  
5. Expansion of nursing informatics, content and skills development |
| Practice-based competency: outcomes and evidence-based content | 1. Learning focused on core practice competency outcomes, professional skills beyond technical psychomotor skills; core practice competencies; multiple conflicting versions; which to use?  
2. Integration of evidence-based standards, research findings into practice; emphasis on critical thinking, problem solving  
3. Changes in standards; ensure patient safety |
| Performance-based competency: learning and objective assessment methods | 1. Multiple teaching-learning methods: interactive collaborative, in-class and out-of-class projects; problem-based learning; increasing self-responsibility; accountability for learning and competence; interprofessional learning; using electronic devices, media to access resources  
2. Competency assessment based on performance examinations, specified portfolio documentation; standards-based assessment methods; emphasis on patient safety |
| Sociodemographics, cultural, diversity, economic, and political changes, and global issues | 1. Increased aging population; increasing multicultural, ethnic diversity requires increased learning, respect for differences, preferences, customs; generational issues  
2. Immigration conflicts, protests; consequences for access and health care  
3. Community, faith-based projects, service-learning projects  
4. Global community, globalization health issues; global nursing networks  
5. Social, economic, and political changes influence health care delivery and access to clinical experiences; influence disrespect, conflict, abuse, violence; increased poverty and need  
6. Multidimensional content, client care, clinical learning sites |
| Community-focused interdisciplinary approaches | 1. Interprofessional collaborative learning  
2. Diverse alternative health practices, influence of cultures  
3. Broad scope of nursing; clinical approach; increasing use of diverse experiences throughout community; continuum from acute care to health promotion; from hospitals to home to rural to global settings  
4. Requires more planning, travel time, expenses, arrangements; different skills, communications; critical thinking, problem-solving strategies  
5. Multiple teachers, preceptors, staff instructors, part-time, with varying abilities; time constraints |
| Patient-centered care: engagement, safety, and privacy | 1. All expect value, quality, individual respect, consideration, attention; privacy issues  
2. Patient initiatives for involvement and protection; balance standards and preferences  
3. Increased litigation, medical-nursing errors; focus on safe, competent patient care  
4. Increased individual responsibility, accountability for learning and practice |
| Ethics and bioethical concerns | 1. Alternative solutions to ethical dilemmas; issues regarding diverse beliefs; disputes regarding biotechnology and bioengineering in health care  
2. Many gray zones instead of black-and-white absolutes; separate professional practice responsibilities from personal opinions, consequences for competence, and patient safety  
3. Integrate into professional practice acceptance of the individual’s right of choice regarding life and death issues, health care methods; respect, tolerance for patient’s decisions, ethical competencies for students  
4. Standards of quality care, patient’s rights issues |

Continued
documents and telemedicine across the globe, students are communicating more frequently, with more contacts and at Internet speed; multiple digital chat rooms, blogs, and social network systems are used in nursing education (Skiba, 2009a, b). Use of social media has become so common in nursing that guidelines and code of ethics statements are being developed by employers and by national nursing organizations (National Council of State Boards of Nursing [NCSBN], 2012; Prinz, 2011). Using social media has become a concern for nurses, nursing students, and educators. Using this digital forum to communicate requires an understanding of policies and potential legal implications (Cronquist and Spector, 2011).

Websites allow for rapid access to online and printed material. Digital health-related materials can be updated quickly, allowing educators to create and revise online course content, assignments, and examinations. Using computers for written assignments reinforces the development of effective writing skills and the use of standard protocols required in academic and professional documents. They also help students prepare more effectively for computerized licensure examinations. One study, however, reports that students believe they do not have the essential information technology competencies (Fetter, 2009). One study found that an increase in information technology or computer use, as part of patient care and nursing workflow process, did not take away from direct patient care time and allows nurses to access and analyze information (Cornell, et al., 2010). Further, the Healthcare Information and Management Systems Society (HIMSS) identified that nurses at all levels of education need health informatics competencies (Sensmeier, 2011). Students who become competent and literate in using computers and other digital devices will be more successful in their programs and in practice.

The Internet creates opportunities for distance-learning students, from local to global sites, to participate in networks, team projects, and research that expand the understanding of universal health needs and cultural differences. The Internet and changes in perspectives of nurse educators also makes it possible for nursing courses or entire degree programs to be delivered online.

In addition to laptops, other mobile digital technologies, such as personal digital assistants (PDAs) (Zurmehy, 2010), MP3 players (Skiba, 2009b), and increasingly versatile smart phones, help students, faculty, and nurses access valuable current information to manage complex patient data and thus reduce stress and errors (Jeffries, 2005).

These electronic advances, however, generate several issues. With almost unlimited information available,
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students may actually take more time to navigate online resources than traditional print-based resources and get overly engaged in following links, networking, and using chat rooms. Faculty and students need to work together to promote efficient and effective use of electronic learning tools and networking; reducing overload and frustration requires disciplined focus and clear guidelines and outcomes. Learning from the Internet can help students develop skills in analytic thinking, decision making, and reflective judgment that are essential for selecting valid and reliable resources; these are difficult but essential competencies for evidence-based practice (Zurmehly, 2010). The use of blogs has been cited as a method to increase communication among nursing students and a forum to share medical information (Roland et al, 2011).

In learning to use electronic-based information systems effectively, students acquire competencies required for contemporary, information-intensive nursing practice. In spite of these advances, studies show that health literacy among students is deficient and needs more emphasis (Cormier and Kotrlik, 2009). In contrast, one study did find that students are proficient in health literacy. Furthermore, students understand that without health literacy, the importance of assessing patients’ understanding of education is ineffective (Scheckel et al, 2010).

The Quality and Safety Education for Nurses (QSEN) project, funded by the Robert Wood Johnson Foundation, identified competencies for nurses to achieve knowledge, skills and attitudes (KSAs) to become successful health care providers. A QSEN graduate and undergraduate informatics competency highlights the importance of becoming proficient in using information technology (QSEN, 2012). The National Organization of Nurse Practitioner Faculties (NONPF) core competencies also include information technology and information literacy (NONPF, 2012). Nurses, nursing students, and nurse educators must stay abreast of the rapid changes related to nursing informatics and information technology.

**Practice-Based Competency Outcomes**

One trend that has a powerful influence on nursing education and practice at all levels is the emphasis on competency outcomes and criteria that establish realistic expectations for clinical practice (Cronenwett et al, 2007; Lenburg et al, 2009; NCSBN, 2006). The NONPF has developed one set of core competencies for all graduating nurse practitioners (NONPF, 2012) Competency outcomes, with related criteria (critical elements), specify expected results, the destination students need to reach; they are the measurable results of time and effort spent in learning. The ability to implement realistic practice-based abilities competently therefore is the essential outcome; competence is the target, the end-point to be reached, the purpose of study and education. The related interactive learning strategies are the road map, the means for getting there; the subsequent performance-based assessments confirm that students have arrived at the right place: They are competent for practice (Lenburg et al, 2009). The ability of graduates in practice is the proof (Candela and Bowles, 2008; Pellico, Brewer, and Kovner, 2009).

The outcomes approach requires a mental shift from trying to memorize voluminous readings and class notes (resulting in frustration and the attitude of “just tell me what I need to know”) to actually learning to think like a nurse, to integrate information in problem solving and decision making and providing competent patient care (DiVito-Thomas, 2005). Typical objectives begin with words like describe, discuss, list, or recognize; they are directions for learning, not what nurses do. Outcomes convert the meaning of the content objectives to actions that nurses actually do, such as implement, integrate, plan, or conduct. This change in approach can be confusing at first, but by achieving the end-results/outcomes, students are more prepared to meet the competency expectations of nursing practice with more confidence and success (Glennon, 2006; Klein, 2006). Unprepared new nurses experience stress and frustration in the workplace and require longer orientations and internships to help them gain necessary skills and confidence (Boyer, 2008; Candela and Bowles, 2008).

Accrediting and certifying organizations must mandate demonstrated mastery of skills, managerial competencies, and professional development at all levels (Institute of Medicine [IOM], 2012; NONPF, 2012). Explore the websites in Table 3-2 for the most current information on groups concerned with accreditation, licensure, certification, and practice issues.

Validation of competencies often causes anxiety and stress in some students, faculty, nurses, and others, but they are a major incentive to promote patient safety and effective care (Bargagliotti et al, 1999). Practice competencies to promote patient safety have been studied extensively by nurses and physicians under federal auspices; see

*Text continued on p.43*
### Table 3-2: Online References and Resources Related to Nursing Education

The following list represents examples of Internet resources as beginning points. It is not a complete or “best” list, but a suggested sampling. At the time of this writing, addresses are operational, but many are subject to change, become obsolete, or are discontinued; use them to find other helpful links. Most addresses listed begin with “http://www,” unless otherwise indicated. Note that some have hyphens or other symbols, and some are case-sensitive; be certain of spelling exactly as listed. Find other sites on the Internet using Google, Yahoo, or other search engines.

<table>
<thead>
<tr>
<th>Name of Source</th>
<th>Address</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>allnurses.com</td>
<td>allnurses.com/distance-learning-nursing</td>
<td>Networking site for students, especially in distance-learning programs; exchange information, advice, find resources</td>
</tr>
<tr>
<td>American Academy of Nursing</td>
<td>aannet.org</td>
<td>Information on nursing issues, influence on government, other organizations; promote research, national leadership</td>
</tr>
<tr>
<td>American Association of Colleges of Nursing</td>
<td>aacn.nche.edu</td>
<td>BSN and higher-degree schools; multiple publications, position papers; useful Internet links</td>
</tr>
<tr>
<td>American Association for History of Nursing</td>
<td>aahn.org</td>
<td>Membership, contacts, publications regarding nursing history</td>
</tr>
<tr>
<td>American Holistic Nurses Association</td>
<td>ahna.org</td>
<td>Publications, certificate program, and continuing education course listings</td>
</tr>
<tr>
<td>American Hospital Association</td>
<td><a href="http://www.aha.org/">http://www.aha.org/</a></td>
<td>Hospital links; nursing shortage and workforce issues</td>
</tr>
<tr>
<td>American Nurses Association</td>
<td>nursingworld.org</td>
<td>Links to organizations, publications (American Nurse, OJIN, books); career and job lists</td>
</tr>
<tr>
<td>American Nurses Association</td>
<td>smartbriefs.com</td>
<td>News for the nursing profession; free email of important news.</td>
</tr>
<tr>
<td>American Nurses Credentialing Center</td>
<td>nursecredentialing.org/default.aspx</td>
<td>Information regarding certification programs, requirements, and so on</td>
</tr>
<tr>
<td>American Nursing Informatics Association</td>
<td>ania.org</td>
<td>Links to multiple sites for nursing informatics</td>
</tr>
<tr>
<td>American Organization of Nurse Executives</td>
<td>aone.org</td>
<td>Information; publications regarding nursing leadership, administration</td>
</tr>
<tr>
<td>Commission on Collegiate Nursing Education</td>
<td><a href="http://www.aacn.nche.edu/ccne-accreditation">http://www.aacn.nche.edu/ccne-accreditation</a></td>
<td>Agency that accredits BSN and higher degrees only</td>
</tr>
<tr>
<td>Discover Nursing</td>
<td>discovernursing.com</td>
<td>Lists scholarships, other nursing resources</td>
</tr>
<tr>
<td>Distance Learning Channel</td>
<td>petersons.com/distancelearning</td>
<td>Lists hundreds of distance-learning courses, programs; search, nursing</td>
</tr>
<tr>
<td>Institute of Medicine</td>
<td>iom.edu</td>
<td>Publications, other links via National Academy of Sciences</td>
</tr>
<tr>
<td>Institute for Nursing Centers</td>
<td>nursingcenters.org</td>
<td>Network of organizations focused on nurse-managed health centers, data collection</td>
</tr>
<tr>
<td>International Council of Nurses</td>
<td>icn.ch</td>
<td>ICN resources and links</td>
</tr>
<tr>
<td>International Parish Nursing Resource Center</td>
<td>ipnrc.parishnurses.org</td>
<td>Information, links to congregational, parish resources</td>
</tr>
<tr>
<td>Martindale’s Health Science Guide</td>
<td>martindalecenter.com/Nursing.html</td>
<td>Link to medical and nursing resources; virtual medical and nurse center; excellent resource</td>
</tr>
<tr>
<td>National Coalition Against Domestic Violence</td>
<td>ncadv.org</td>
<td>Information regarding actions, self-protection, policies, resources</td>
</tr>
<tr>
<td>National Council of State Boards of Nursing</td>
<td>ncsbn.org</td>
<td>Information regarding NCLEX and regulations; links to all state boards</td>
</tr>
</tbody>
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TABLE 3-2 ONLINE REFERENCES AND RESOURCES RELATED TO NURSING EDUCATION—cont’d

<table>
<thead>
<tr>
<th>NAME OF SOURCE</th>
<th>ADDRESS</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>National League for Nursing</td>
<td><a href="http://www.nln.org/">http://www.nln.org/</a></td>
<td>Information regarding all schools of nursing testing; educator programs</td>
</tr>
<tr>
<td>National League for Nursing Accrediting Commission</td>
<td><a href="http://www.nlnac/home.htm">http://www.nlnac/home.htm</a></td>
<td>Agency that accredits all types of nursing schools; sets criteria</td>
</tr>
<tr>
<td>National Organization of Nurse Practitioner Faculties</td>
<td><a href="http://www.nonpf.org/">http://www.nonpf.org/</a></td>
<td>Publications regarding nurse practitioner competencies; other helpful links</td>
</tr>
<tr>
<td>National Student Nurses Association</td>
<td><a href="http://www.nsna.org/">http://www.nsna.org/</a></td>
<td>Excellent resources, schools, organizations, career options</td>
</tr>
<tr>
<td>New York State Coalition for Educational Mobility</td>
<td>lpntorn.info</td>
<td>Mobility program for LPNs to earn ASN degrees, example</td>
</tr>
<tr>
<td>Nursing (multiple links to resources)</td>
<td>nursingcenter.com</td>
<td>Links to resources, journals, continuing education, jobs</td>
</tr>
<tr>
<td>Nursing Ethics Network</td>
<td>bc.edu/bc_org/avp/son/ethics</td>
<td>Boston College: many links regarding nursing ethics, related issues</td>
</tr>
<tr>
<td>Nursing Informatics</td>
<td>nursing-informatics.com</td>
<td>Links to informatics resources, journal, courses</td>
</tr>
<tr>
<td>Nurses.info</td>
<td>nurses.info/services_violence.htm</td>
<td>Information and resources for Nurses Worldwide; workplace violence</td>
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<tr>
<td></td>
<td><a href="http://www.ena.org/IENR/Pages/WorkplaceViolence.aspx">http://www.ena.org/IENR/Pages/WorkplaceViolence.aspx</a></td>
<td></td>
</tr>
<tr>
<td>Online Journal of Issues in Nursing</td>
<td>nursingworld.org/ojijn</td>
<td>Free journal; via ANA and Kent State University</td>
</tr>
<tr>
<td>Online Journal of Nursing Informatics</td>
<td>ojni.org</td>
<td>Abstracts, articles regarding technology in nursing available online</td>
</tr>
<tr>
<td>Penn State University, Evidence-Based Practice Tutorial for Nurses</td>
<td>libraries.psu.edu/instruction/ebpt-07/index.htm</td>
<td>Helpful study and practice scenarios and links</td>
</tr>
<tr>
<td>VCU Libraries, Evidence-Based Nursing Resources</td>
<td>library.vcu.edu/ml/bibs/ebnursing.html</td>
<td>Very useful resource for learning about evidence-based practice; definitions and multiple links to best practice guidelines</td>
</tr>
<tr>
<td>REGIONAL NURSING SOCIETIES</td>
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<tr>
<td>Eastern Nursing Research Society</td>
<td>enrs-go.org</td>
<td>Information regarding research in eastern states</td>
</tr>
<tr>
<td>Midwest Nursing Research Society</td>
<td>mnrss.org</td>
<td>Example of a regional nursing organization</td>
</tr>
<tr>
<td>Southern Nursing Research Society</td>
<td>snrs.org</td>
<td>Southern regional organization; research; journal</td>
</tr>
<tr>
<td>Western Institute of Nursing</td>
<td>ohsu.edu/son/win</td>
<td>Information regarding research in western states</td>
</tr>
<tr>
<td>Sigma Theta Tau International Southern Regional Electronic Campus</td>
<td>nursingsociety.org electroniccampus.org</td>
<td>Honor society information; research directory</td>
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<tr>
<td>U.S. GOVERNMENT RESOURCES</td>
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<tr>
<td>Agency for Healthcare Research and Quality</td>
<td>ahrq.gov</td>
<td>For consumers and professionals; research reports; specific populations, topics</td>
</tr>
<tr>
<td>Healthy People 2020</td>
<td>health.gov/healthypeople</td>
<td>Publications; links regarding health</td>
</tr>
<tr>
<td>National Library of Medicine</td>
<td>locatorplus.gov/</td>
<td>National library locator, databases, information</td>
</tr>
<tr>
<td>U.S. Government Division of Nursing</td>
<td>bhpr.hrsa.gov/nursing</td>
<td>Informatics regarding student financial assistance, grants, databases available by state</td>
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Continued
the 2000 report on the website: http://bhpr.hrsa.gov/nursing/nacnep/reports/first/2.htm, and click on the link Collaborative Education to Ensure Patient Safety. In response to the Institute of Medicine report (IOM, 2000), Finkelman and Kenner's (2009) book promotes implementation of the recommendations in nursing education. The Robert Wood Johnson Foundation funded a national initiative, Quality and Safety in Nursing Education (QSEN), to help nursing programs reorganize curricula to focus on patient safety and quality care (Cronenwett et al, 2007). Lenburg’s Competency Outcomes and Performance Assessment (COPA) model has been used since

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<tr>
<th>NAME OF SOURCE</th>
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<tbody>
<tr>
<td>U.S. Government resources</td>
<td>USAsearch.gov</td>
<td>Excellent links to multiple government resources, federal, state, local contacts</td>
</tr>
<tr>
<td>U.S. Government consumer</td>
<td>healthfinder.gov</td>
<td>Links to federal, state health agencies; consumer support gateway</td>
</tr>
<tr>
<td>U.S. Government search site</td>
<td>medlineplus.gov</td>
<td>Links regarding disease, health, links to resources, publications; organizations, agencies, clinical trials, groups; health library</td>
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### ONLINE REFERENCES AND RESOURCES RELATED TO NURSING EDUCATION — cont’d

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<td>California State University, Dominguez Hills</td>
<td>csudh.edu</td>
<td>Statewide mobility program; distance-learning program</td>
</tr>
<tr>
<td>Case Western Reserve University</td>
<td>cwru.edu</td>
<td>Multi-option; international; research; nursing informatics</td>
</tr>
<tr>
<td>Excelsior College</td>
<td>excelsior.edu</td>
<td>External degrees: ADN, BSN, master’s programs; online courses</td>
</tr>
<tr>
<td>George Mason University</td>
<td>gmu.edu</td>
<td>Campus and mobility programs; WANRR (research resource)</td>
</tr>
<tr>
<td>Grand Canyon University</td>
<td>gcu.edu</td>
<td>Online nursing programs; different degrees</td>
</tr>
<tr>
<td>Indiana University/Purdue University</td>
<td>iupui.edu</td>
<td>Multiple programs and sites; nursing informatics</td>
</tr>
<tr>
<td>NOVA Southeastern University</td>
<td>nova.edu</td>
<td>Multiple degree programs in nursing, campus and distance online learning</td>
</tr>
<tr>
<td>University of Alabama, Birmingham</td>
<td>uab.edu</td>
<td>Campus and distance programs</td>
</tr>
<tr>
<td>University of Colorado Health Sciences Center</td>
<td>ucdenver.edu</td>
<td>Undergraduate and graduate programs, courses, on campus or Internet assisted</td>
</tr>
<tr>
<td>University of Kansas</td>
<td>kumc.edu</td>
<td>Campus and distance programs</td>
</tr>
<tr>
<td>University of Maryland</td>
<td>umd.edu</td>
<td>Multiple programs; mobility; nursing informatics</td>
</tr>
<tr>
<td>University of Phoenix</td>
<td>phoenix.edu</td>
<td>Multiple online Internet programs; courses</td>
</tr>
<tr>
<td>Virtual Nurse</td>
<td>virtualnurse.com</td>
<td>Links to websites; online programs, career, education, health resources</td>
</tr>
<tr>
<td>Western Governors University</td>
<td>wgu.edu</td>
<td>Cooperative arrangements among several states offering academic degrees; online courses, programs</td>
</tr>
</tbody>
</table>
the early 1990s (Lenburg, 1999, 2009, 2011). Additionally, as the populous becomes more diverse, the importance of evaluation of cultural competence cannot be overlooked (Waite and Calamaro, 2010). These and other efforts focus on the imperative to improve competency outcomes to promote patient safety.

**Performance-Based Learning and Assessment**

Trends related to learning and evaluation methods are changing fundamentally, due in part to changing technology and the increased focus on patient safety. The emphasis on competency outcomes and criteria for acceptable practice has prompted leaders in nursing education to promote innovative programs and learning methods (IOM, 2012) as well as more interactivity and engagement interspersed with lectures. Passively listening, reading, and passing written tests does not necessarily promote competence in the core performance skills expected in practice. Increased emphasis on critical thinking and learning to integrate principles is more effective than trying to remember "all the content," which often leads students to retreat and just want to pass the test. Competency-based learning creates an entirely different atmosphere that is focused on learning concepts and encourages collaboration between teacher and learner to achieve actual practice competencies (Lasater and Nielsen, 2009).

Practice-based competence uses terms like interactive learning, collaborative learning, and competency-based learning. This trend requires changes in the roles of teachers and students. The teacher is less a “lecturer” and more a facilitator and coach, providing direction for learning stated outcomes; the student is more actively accountable and responsible for achieving competence in designated knowledge and practice skills. The question is: What are the most effective ways to learn such actual performance skills as assessment, communication, critical thinking, and patient teaching? Listening to lectures and reading is less effective than active engagement and application in real practice situations. Performance skills are learned more effectively through participation in interactive strategies (Clayton and Dilley, 2009; Lenburg et al, 2009). In this new paradigm, instructors focus on the most essential content; create practice-based case studies and simulations; and set the stage for students to engage in problem solving, critical thinking, and integration of concepts, knowledge, and evidence-based practice (Horan, 2009). They provide feedback and validation that cannot be gained through books or the Internet. Memorization of basic facts is still important, but it is insufficient when nursing practice emphasizes skills, such as assessment, critical thinking, communication, patient teaching, caring, and advocating for patients. The focus on practice competence helps students learn how to access and integrate ever-changing information as required in actual practice, rather than trying to remember "all the content." Learning to access and use digital resources on mobile devices has been found to be more effective when introduced early into the nursing curriculum and embedded throughout the program (Zurmehly, 2010). Additionally, technology has become integrated into our lives, both personally and professionally, so much that academic environments need to incorporate various technologies into distance education programs in an effort to assist students to become effective health care providers (Jones and Wolf, 2010).

Many nurse leaders cite critical thinking skills and implementation of evidence-based practice as the most fundamental skills for competent practice. Tanner (2000) emphasizes that this is not the nursing process, as some think. del Bueno (2005) writes about the crisis in the lack of critical thinking in nursing practice. New partnerships with agency staff are designed to promote clinical learning and how to think like a nurse (MacIntyre et al, 2009). A recent systematic review that reviewed 12 studies on simulation found that six of the studies found gains in critical thinking skills through the use of simulation (Cant and Cooper, 2010). Critical thinking is an essential part of applying evidence-based practice, using research findings to guide actual practice (Ireland, 2008).

A trend in many programs is the development of study tracks or majors in evidence-based practice, such as the one implemented by Arizona State University in 2006 (www.asu.edu/graduate/studies/asucert.html). The Academic Center for Evidence-Based Practice (ACE) at the University of Texas San Antonio, which was developed as a center for excellence (http://www.acertrashc.edu/), provides up-to-date information about evidence-based practice. Additionally, many other universities have developed evidence-based practice centers. In 1997, the Agency for Healthcare Research and Quality (AHRQ) developed an evidence-based practice center program (http://www.ahrq.gov/clinic/epc/).

Simulation, in various forms, is another major performance-based learning strategy. Mannequins have become more essential and incorporate sophisticated computerization to promote more realistic learning and
critical thinking (Bruce et al, 2009; Hawkins et al, 2008; Horan, 2009; Rush et al, 2008; Smith-Stoner, 2009a; Wagner et al, 2009). Another form of simulation is the use of standardized patients and telemedicine technology to achieve outcomes. More recently, faculty are using Web-based broadcast of simulations to increase learning (Smith-Stoner, 2009b). Cited within a systematic review (Cant and Cooper, 2010), the Objective Structured Clinical Examinations (OSCE) are the most valid assessment measurement. These authors assert that more studies are needed that use the OSCE as an evaluation measure.

Other interactive learning strategies include portfolio learning (Norris et al, 2012) and peer-to-peer learning (Robinson and Niemer, 2010). Higgins (2006) describes how peer teaching helps students at risk. Skiba (2009a,b) describes and evaluates new learning technology methods in each issue of Nursing Education Perspectives.

Interactive strategies are even more important when the location of clinical learning is considered. More and more diverse settings are used because these are places where nurses’ expertise is needed. In addition to hospitals and extended care facilities, clinical learning often takes place in alternative settings, such as nurse-run clinics in schools, daycare and senior centers, and prisons (Kirkham et al, 2005). Over the past decade, service-learning projects have also helped students learn actual practice skills throughout the community (Bentley and Ellison, 2007; Clayton and Dilley, 2009; Hunt, 2007). Another form is faith-based learning projects with nurses in churches and congregations (Brendtro and Leuning, 2000; Kotecki, 2002). Many interactive clinical-related learning strategies and more traditional clinical assignments increasingly engage practicing nurses as preceptors (Wieland et al, 2007; Murray, 2007).

The change to competency outcomes and practice-based learning requires changes in evaluation methods that focus on valid, actual performance of required competencies in realistic scenarios; paper-and-pencil tests and inconsistent subjective clinical observations by instructors or preceptors are not adequate. Structured, objective validation of competence requires performance examinations that specify the core skills and related critical elements (the application of mandatory principles) that must be met according to established practice standards (Boyer, 2008; Lenburg et al, 2009; Rentschler et al, 2007). In addition to performance of nursing skills, structured portfolios are used to document other competencies (Norris et al, 2012).

Needless to say, this more interactive approach in clinical and classroom courses is difficult for some students and creates issues; faculty and students have to change traditional habits and expectations of each other. Sometimes students think it is easier just to figure out “what the teacher wants” and “study for the test” rather than engage in learning to think and integrate best practices through teacher-assisted interactive exercises. Such exercises, however, help students learn to make effective decisions, and to collaborate in the group process, and manage time and resources. It may cause some anxiety, but performance examinations that require 100% accuracy of the mandatory critical elements (principles) provide more reliable evidence of practice competencies (Boyer, 2008; Lenburg et al, 2009). This kind of competence is what consumers need, employers expect, and practitioners must deliver. The increase in reported medical-related errors vividly emphasizes the need for more effective validation of performance competence in schools and the workplace (Boyer, 2008; IOM, 2000; Finkelman and Kenner, 2009).

Sociodemographics, Cultural Diversity, and Economic and Political Changes

From rural to metropolitan areas throughout the United States, the population is undergoing significant changes in sociodemographic, cultural, and economic composition. These trends generate serious issues and consequences for education, health care, and many aspects of the socioeconomic-political systems. The following brief overview is a framework for learning how these trends and issues affect nursing education and practice (Sullivan, 2009).

• People are living longer, and the number of the very elderly is increasing more rapidly than other age groups. This means more people live with chronic disease and disability; many live in institutions, substandard conditions, or alone. All are subject to increasing needs for health care and assistance. As a result, nursing and other provider programs have increased geriatric content and clinical experiences; geriatric patients require very different care than younger populations. Since 2000, nine Hartford Centers for Geriatric Nursing Excellence have been developed to advance the knowledge and care of older adults (http://www.nursingsociety.org/leadership/geriatricacademy/hartford/pages/hartford.aspx) The current political debate about health...
care reform is concerned about all age groups and regardless of the outcome, nursing will continue to focus on quality care and competent practice (AACN, 2009d; Croney, 2007; Holroyd et al, 2009; National League for Nursing [NLN], 2008b).

- The number of diverse ethnic minorities and illegal immigrants is expanding throughout the United States, with multiple socioeconomic consequences. The diversity often is unwanted and leads to disrespect, intolerance, conflicts, abuse, and violence. The Southern Poverty Law Center is a national organization that promotes tolerance in schools, monitors militant hate groups, and initiates lawsuits against violent offenders (Southern Poverty Law Center [SPLC], 2009). Increasingly, health care providers need to learn about different cultural values and health practices and integrate them into care to the extent possible. They need to incorporate and teach tolerance and understanding of cultural diversity as well as positive health practices (Kersey-Matusiak, 2012). In 2008, the American Association of Colleges of Nursing (AACN, 2008b) developed end-of-program competencies for graduates of baccalaureate nursing programs for integrating cultural competencies into undergraduate education (www.aacn.nche.edu/Education/pdf/competency.pdf). The Essentials of Baccalaureate Education for Professional Nursing Practice (2008) mandates the inclusion of culturally diverse nursing care concepts in the curriculum. Professional ethics requires that health care providers separate their personal values and beliefs from their professional responsibilities, even to those whose beliefs are different (Cagle, 2006; Helms, 2006; Online Journal of Issues in Nursing [OJIN], 2009a; Tippitt et al, 2009). The number of families who become uninsured, jobless, homeless, and survive in poverty is increasing. The economic crisis during the first decade of the twenty-first century has resulted in fewer financial resources for health care and ordinary expenses, and thus more people eat unhealthy diets, go without medicines or treatments, and obtain care in emergency departments. More than half of family bankruptcies are due to overwhelming health care debt. Ehrenreich (2009) describes the incredible cycle of hunger, illness, thefts, and incarcerations that poor people experience in the United States (see Table 3-1). Bentley and Ellison (2007) and Hunt (2007) describe other service-learning experiences that help students learn about providing health care to needy groups. Clayton and Dilley (2009) report an example of a service learning project that engages students in soup kitchens for the homeless. The economic crisis also has resulted in lack of funds for healthy school programs, nursing education, hospital staffing, and material support for the sick, poor, and jobless. The issues are how to provide care and improve the health of those with little means, knowledge, or will; how to fund it; and how to reverse their condition (Rose, 2009).

- Domestic abuse of women and children and various forms of violence are increasing in homes, schools, and public places (Esposito et al, 2005; Stop Violence website, 2009; see Table 3-2). The incidence of violence has increased even in nursing schools and in hospitals, including vertical abuse among nurses (American Nurses Association [ANA], 2009c; Clark, 2007; Thomas and Burk, 2009). Substance abuse, long a pervasive problem in society, has become a serious problem for nursing students and nurses (Monroe, 2009; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). This has consequences for the safety and health of nurses, patients, and others; the increase in stress and anxiety often triggers violence and mental health and economic problems.

- The United States is experiencing an epidemic of obesity, with major consequences on health and the health care system. It leads to the most prevalent health problems that strain health care facilities and financial resources. It is paramount for health care providers to teach prevention of obesity and its consequences in schools. Learning to help people change their dietary habits is a major role for nurses (OJIN, 2009b) and other health care workers.

- The traditional definition of family has changed, as evident in the number of single individuals living with other singles, single-parent households, and same-sex couples (with and without children). These nontraditional families often have limited finances and lack access to nursing and health care. They also may be resented by those with more traditional values and attitudes. Nurses must learn to respect and provide essential care regardless of differences.

- Disrespect for others, abuse of noisy mobile devices in public, and disregard for common courtesy has changed the nature of social interactions. Nursing students who use class time to send digital messages, use cell phones, or search the Internet are
disrespectful of those who want to learn and the teacher who is trying to help them learn. This is part of the larger trend of declining civility and integrity, with increased cheating and falsification in school and work (Anastasi et al, 2009; Clark, 2007; Tippitt et al, 2009). Such incidents trigger anger and retaliation when excessive. In health care facilities, abuse of patients also is increasing. Nurses often need to mediate health care related situations, and effective communication skills are essential (Schlariet, 2009).

As suggested, an important part of nursing education includes trends in society and the issues that result. Nurses work with those in all aspects of society, and thus, course content and interactive practice-based learning that incorporates these issues is essential. One of the most significant issues for students is learning to distinguish the meaningful differences in beliefs, values, and expectations among patients and their responses to illness, treatments, and caregivers. This is why nursing programs include, and students need to learn from, the areas of study that support effective nursing care, such as sociology, cultural diversity, psychology, ethics, religion, economics, history, and literature. Learning the experiences of diverse peoples, including patients and coworkers, their customs, beliefs, health practices, and expectations not only is interesting but also expands human understanding, tolerance, compassion, and the creativity essential for effective professional practice (SPLC, 2009).

**Community-Focused Interprofessional Approaches**

The societal trends described here, along with the large-scale economic and political influences to reduce health care costs, may indirectly promote prevention and interprofessional initiatives. Many lay and professional health-conscious groups are working to change the national orientation from “illness care” to more efficient and effective “health care.” Another contributing factor is the increasing emphasis on health of the family as a whole and on entire communities and populations. *Healthy People 2010*, as described by Zahner and Block (2006), outlines goals for a broad-based population health set by government agencies (Centers for Disease Control and Prevention [CDC] and Merck Company Foundation, 2007; see Table 3-2). *Healthy People 2020* has expanded on *Healthy People 2010*, with the current mission cited to identify health care initiatives, increase awareness of health, identify measurable objectives and outcomes, improve practice through evidence, and identify research, evaluation and data collection methods (http://www.healthypeople.gov/2020/about/default.aspx).

As more citizens live longer and develop acute and chronic disabilities, nurses work in a widening range of settings, such as ambulatory clinics, nursing homes, hospices, home care, assisted living facilities, faith-based initiatives, and alternative integrative health care practices (Anastasi et al, 2009; Helms, 2006). Regardless of the setting, community health care involves an interprofessional team, often coordinated by nurses, and students need to learn these diverse roles. The concept of community care agencies therefore has changed. Hospitals are only one of many community health care resources, along with wellness and senior centers (Newman, 2005). These changes require a different philosophy of care and competencies that emphasize interprofessional and interagency collaboration. This health care culture incorporates concepts of shared responsibility for health promotion among individuals, family, community, and multiple care providers. Nursing education is influenced by these trends to promote family and community health and healthy lifestyles, and increased interprofessional learning and collaboration (Holroyd et al, 2009; IOM, 2003; see Table 3-2).

With extensive global travel and commerce, the health community now encompasses the world. Illness can arrive on any airplane, ship, or bus and spread throughout the country. An example is the pandemic of the (H1N1) “swine flu,” which has spread to every continent and continues to cause illness and deaths. Nurses are on the front line of care and defense and have raised concerns about sufficient protection. Similarly, other infections, such as reemerging strains of tuberculosis (Benkert et al, 2009) and methicillin-resistant *Staphylococcus aureus* (MRSA) spread rapidly and are resistant to treatment; nurses and other providers need to become even more diligent in preventing the spread of organisms (ANA, 2009a; CDC, 2007; Lashley, 2006).

Consistent with the trend toward global health, nurses are engaged in the global health community through collaborative networks, research projects, and shared publications (NLN, 2005b; Critchley, 2009). Programs incorporate global content, and students learn to participate in international health research projects and communication through the Internet and have direct learning experiences in countries abroad (Bentley and Ellison, 2007; Carlton et al, 2007; Ramal, 2009). The International
Council of Nurses (ICN, 2009) provides many opportunities for students to network and learn from each other; its periodic international conferences are a major resource for students and nurses to promote world health (ICN, 2009; see Table 3-2, ICN website, and student bulletin board). These experiences promote cultural understanding and respect for health conditions outside, and inside, the United States; they help students integrate the influence of environment, education, and culture on health conditions regardless of location.

These trends challenge students to prepare for a wide spectrum of nursing practice that depends on competencies such as clinical decision making (Flin et al, 2008), communication, collaboration, and leadership. Students need to learn how to manage illness and preventive health care for diverse clients dispersed throughout the community as well as to provide critical care to hospital patients who are sicker and go home quicker. Although very helpful, learning in diverse settings throughout the community presents some issues. For example, dispersed clinical learning requires more planning, travel, expense, and time; learning time is much shorter at each location; community-based group projects take more time; and students have less time with instructors because faculty can be only at one location at a time. In many settings, however, students work only with preceptors or staff who help them gain the competence and confidence they need, but who also have other responsibilities.

Patient-Centered Care: Engagement, Safety, and Privacy
As patients have become more knowledgeable about illness care, health promotion, and the consequences of errors in care, they have become more assertive about their right to competent care and privacy of information. The 2002 Health Insurance Portability and Accountability Act (HIPAA) law mandates protection of an individual’s privacy by health care providers and throughout society and has changed many previously careless and harmful practices. The economics and politics of health care and access to comprehensive information via the Internet have promoted more consumer activism through advocacy groups and Internet connections to influence health care policy and standards. Patients use Internet resources, sponsored by the government and private entities, to become more informed about illness and health care (see Table 3-2). As informed and engaged patients, they are better able to make effective decisions in collaboration with health care providers. This makes critical thinking, communication, and teaching essential nursing competencies. This also means that students (nurses) need to change their approach from “giving patient care” to “working with the patient and family” as members of the health care team.

Another major issue affecting nursing education is the increasing number and consequences of serious medical errors, as reported in the IOM study (2000). These errors have led to an astonishing number of deaths and an increased number of expensive lawsuits, which further increase the cost of health care and tarnish the belief in the quality of available health care. Nursing faculty, administrators, and regulators therefore are increasingly concerned with ensuring the competence of students and nurses (Finkelman and Kenner, 2009; IOM, 2003). Medical-error issues have precipitated the increased requirements for competency-based education and performance assessment in schools of nursing and other health disciplines, in annual employment evaluations, and in agency accreditation criteria, all for patient safety.

Many injuries and deaths in medical institutions are preventable, and Medicare recently decided that it will no longer pay for such preventable incidents, many of which are attributed to nurses. Thus preventive care is being emphasized even more in nursing education. QSEN, the COPA model, and similar initiatives in every specialty organization are designed to change nursing education and practice to promote competence and patient safety (AACN, 2006; Cronenwett et al, 2007; IOM, 2003; NCSBN, 2006; NLN, 2009a).

Ethics and Bioethical Concerns
Another trend affecting nursing education is related to the multicultural, multiethnic population and patients who have different ways of responding to illness, treatment, and care providers. This raises ethical issues of who is “right” and who has the “right to decide.” This is particularly relevant for freedom of choice and end-of-life issues (Moulton and King, 2010). As described, one difficult issue, particularly for students and novices, is the ethical necessity to differentiate personal beliefs, values, and preferences from professional practice responsibilities. Many ethical dilemmas require students, nurses, and other providers to accept the values of others and the concept of “a gray continuum of values” instead of the black-and-white interpretations based on one’s own beliefs. Some of the most controversial
issues relate to the right of individual choice regarding abortion, organ transplant, stem-cell research, preference in sexual partners, and the patient’s right to die a dignified death. Other issues emerge from the growing use of alternative health remedies outside the mainstream of traditional Western medicine, such as herbs and acupuncture (Anastasi et al, 2009). Dishonesty among nursing students, nurses, and other professionals is increasingly alarming and threatens patient safety (Fontana, 2009; McCabe, 2009; Roberson, 2009). Chapter 9 presents a comprehensive discussion about ethics in health care and important issues students should be knowledgeable about for competent nursing practice.

**Shortage of Nurses and Faculty**

The shortage and aging of nurses and nurse educators is a trend that has precipitated serious issues for students, teachers, and health care consumers (AACN, 2009e,f; Buerhaus et al, 2009; Falk, 2007; NLN, 2009b). During the recent recession, nurses older than 50 years of age reentered the hospital workforce (Buerhaus and Auerbach, 2011). These authors assert that when this older hospital workforce retires, a hospital shortage will re-emerge, challenging administration to use the experienced workforce to mentor younger nurses. The current lack of a nursing shortage is likely to follow with a decrease in available workforce and hospitals, and policymakers need to take note to address this coming trend (Staiger et al, 2012).

Students are assigned to multiple and diverse community clinical settings, some of which may be short-staffed, making it difficult for them to find qualified preceptors. Staff nurses who act as clinical instructors or preceptors may or may not be prepared for these roles or receive adequate orientation. Students, therefore, need to learn to take more individual responsibility and initiative to gain essential core competencies. The findings from a study (Holmlund et al, 2010) conducted in Sweden were consistent with other studies that found group supervision is an effective method to guide student personal and professional growth along with informing management and preceptors of student development.

Students in distance-learning and Internet-based programs who are dependent on staff nurses as preceptors and evaluators need to be even more assertive and creative (Rush et al, 2008). Online learning environments can be simulated to mimic real-world situations that allow for faculty to evaluate student learning from a distance (Phillips et al, 2010). New methods are created in partnership with agencies to promote more effective clinical learning opportunities for students without overburdening staff (MacIntyre et al, 2009).

Although the number of student applicants was low in recent years, the current problem is that an alarming number of well-qualified applicants are being denied admission to schools of nursing (see AACN and NLN websites for news releases and reports). The causative trends are lack of prepared nurse educators, limited
space, and other administrative constraints. Faculty are aging and retiring, but the number of prospective qualified replacements is severely limited (AACN, 2012). Some schools are expanding enrollments by using more part-time, adjunct, and clinical faculty and by expanding the use of online courses and simulations. Moreover, the number of students in master of science in nursing (MSN) and doctoral programs is not adequate to meet current needs. Nursing leaders and organizations are working vigorously with state and national governments and private entities to reverse these trends by seeking increased funding and promoting recruitment and development efforts nationally (see AACN at www.aacn.nche.edu/Government/index.htm, and NLN at www.nln.org/governmentaffairs/factsandfigures.htm).

This trend presents many hardships for students, faculty, and nurses, but difficult situations promote creative initiatives and solutions. For example, many organizations and associations have initiated collaborative partnerships to improve education in all types and levels of nursing education; some are statewide or regional arrangements (Allen et al, 2007; Horns et al, 2007; Hunt, 2007; Krueken et al, 2008; Murray, 2007). (See later section on flexible education, mobility, and distance-learning programs.) The NLN has implemented initiatives to improve nursing education and faculty development (see the AACN and NLN websites for position statements regarding innovations and transitions in nursing education). It also initiated the NLN Centers of Excellence to recognize outstanding schools, and its national nurse educator certification program (NLN, 2005a) to promote faculty development and expertise.

Disasters, Violence, and Terrorism
Nurses have always worked in situations emanating from disasters, abuse, and violence in families and communities, and in military conflicts. Domestic violence, especially against women and children, has increased as has violence in the workplace and in schools. This has precipitated an increased emphasis in nursing education (SAMHRS, 2012) and in state regulations of reporting and responding to violent incidents. Criminal acts and substance abuse have become more common in hospitals and other health care agencies and in schools of nursing, threatening the safety of patients and staff (ANA, 2009c; Esposito et al, 2005; Monroe, 2009). As a consequence, criminal background checks are required for all students (and employees) and by agencies providing clinical experience (Farnsworth and Springer, 2006). Population expansion, especially in urban areas, and mass disasters, such as hurricanes, floods, and earthquakes, have precipitated the need for more nurses to get prepared to function effectively along with other first responders. Adelman and Legg (2009) describe details about preparedness and opportunities for nurses who want to learn more. State boards of nursing, such as California (www.rn.ca.gov/pdfs/disaster2010.pdf), and other organizations also provide information.

Since the horrific terror attacks on September 11, 2001, in New York City, more nurses (and all other health care personnel and first responders) are more prepared to respond to acts of terrorism and disasters. Many nursing programs have added courses or even entire programs of study for specialized preparation as first responders, emergency nursing, and flight nursing (Steed et al, 2004; Weiner et al, 2005; ANA, 2006; Adelman and Legg, 2009; Whitty and Burnett, 2009). As one response to increasing mass casualty events, Vanderbilt University convened a group of nurse leaders in 2001 and subsequently developed competencies required in such events and formed the Nursing Emergency Preparedness Education Coalition as an international education site (www.nursing.vanderbilt.edu/incmce). All nurses will not become first responders, but all nurses and students should gain enough knowledge to know their limitations, who and how to notify, and how they could work with more qualified responders. Chapter 15 also provides more information about disaster preparedness for nurses.

Increasing Professional and Personal Responsibilities
In this context, another trend with multiple issues has become evident. Students, teachers, and nurses confront increasing life responsibilities and associated stressful demands on time and resources. Many cope simultaneously with the expansion of information and technology; changing health care systems; more interactive and out-of-class methods of learning; multiple care settings; higher expectations for competence; shortage of nurse preceptors and teachers; and multiple cultural, ethical, and legal aspects of an ever-changing society. Many also are responsible for the care of dependent children and aging parents.

At the same time, contemporary conditions require nurses to keep current through planned ongoing professional development. Complexities in practice, emphasis on reducing errors, and increasing consumer activism
increase the need for nurses to document continuing competence for initial licensure, relicensure, and recertification. Changes in state and multistate regulations increasingly focus on the need for initial and continuing competence (IOM, 2009). Many states require continuing education, and some mandate a portfolio approach to validate continuing competence (see websites for NCSBN and specific states, such as California, Kentucky, Oklahoma, and Tennessee). The ANA has cited the continuing competence of nurses as one of its focus issues of concern since the late 1990s (see ANA website and past issues of *The American Nurse*, 2000-2012).

The high stress levels associated with these professional and personal demands have consequences for one’s own health and that of those around them. These issues illustrate how important it is for everyone involved in the educational process to be more caring, understanding, respectful, and helpful to each other. Teachers, students, administrators, staff nurses, employers, family, and friends need to learn anew the meaning of “a caring community” in the context of rapid and complex change.

These trends in society, nursing, and academic programs present issues of how to incorporate this additional knowledge into the already overloaded program of study. The issues for students include knowing how to access and use unlimited information, prioritize learning, implement evidence-based practice, deal with ethical dilemmas professionally, and develop competencies required for effective response to contemporary issues. Above all, students must focus on learning to think critically, reflectively, ethically, and compassionately as essential professional skills (IOM, 2011).

### DIVERSITY IN NURSING EDUCATION PROGRAMS

A brief review of the major types of education programs that prepare nurses for licensure and advanced practice sets the stage for summarizing some contemporary trends related to flexible, online, and other distance delivery methods in nursing education. A brief description of the types of programs is provided in Table 3-3 and on the NLN and AACN websites (AACN, 2012a,b,c);

<table>
<thead>
<tr>
<th>TABLE 3-3 TYPES OF NURSING EDUCATION PROGRAMS</th>
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<tr>
<td>TYPES OF PROGRAM AND CREDENTIAL</td>
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<tr>
<td>Practical or vocational nurse program: prepares for LVN or LPN license</td>
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<tr>
<td>Diploma program: prepares for RN license</td>
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<tr>
<td>Associate degree in nursing: prepares for RN license</td>
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<tr>
<td>Bachelor’s degree in nursing (BSN): prepares for RN license</td>
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<tr>
<td>Master’s degree in nursing (MSN)</td>
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<td>Doctoral degree in nursing</td>
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Licensed Practical or Vocational Nurse Programs

Practical nurse programs provide the shortest and most restricted option for individuals seeking a nursing license. Licensed practical nurse programs (LPN), named licensed vocational nurses (LVN) in California and Texas, usually are 9 to 12 months in length and may be offered by high school adult education programs, community colleges, vocational and proprietary schools, and hospitals. Each state board of nursing sets responsibilities and scopes of practice. The LPN/LVN graduate is required to work under the supervision of a registered nurse (RN) or physician, and the scope of practice focuses on technical nursing procedures. LPN/LVNs may be employed in hospitals, nursing homes, offices, and other structured settings.

In the mid-1990s, more than 1100 LPN or LVN programs produced approximately 44,000 graduates. National data on the current number of schools and graduates are not readily available because of the multiple providers of programs; however, it appears that their numbers continue to be high. Regardless of the increasing complexity of patient care, many individuals choose to begin a career in nursing as an LPN/LVN. Once licensed, many graduates continue their education in mobility programs to become RNs. Many use “1 plus 1” type programs to earn an associate degree; others use the multiple entry-exit programs (MEEP). Some BSN programs accept LPN graduates based on outcomes of written and performance examinations for advanced placement.

Hospital Diploma Programs

The oldest, most traditional type of program that prepares for RN licensure is the hospital-based diploma program. These programs initially were developed in the United States in the late 1800s in general hospitals in cities such as Boston, New York, Hartford, and Philadelphia and subsequently spread across the country. They followed the Nightingale model and began as training programs taught by physicians, usually only several weeks in length. In time, nurse graduates began developing and teaching courses from the nursing perspective and subsequently obtained additional education as educators and administrators. Ultimately the length of programs was extended, and by the mid-1900s most programs were 3 years in length and had fairly uniform courses of study and clinical hours. Linda Richards and other early graduates wrote initial nursing textbooks and began offering specialty training to staff hospitals and clinics (Kalisch and Kalisch, 1995). Richards also became a nurse consultant to help develop other schools in the United States and later in Japan, initiating international collaboration.

As the number of hospitals increased, the need for nurses likewise increased, and essentially, every hospital developed its own training program as its main source for nursing staff. At their peak from 1950 to 1960, more than 1300 diploma programs were operational. By 2012, only 64 diploma schools remained (https://www.ncsbn.org/NCLEX_Educational_Program_Codes.pdf). Diploma programs now are more similar to associate degree programs, typically 2 years in length; many have arrangements with colleges so that students can simultaneously earn an associate or baccalaureate degree.

Associate Degree Programs

In the late 1950s, a very different trend in nursing education emerged in response to social, political, and educational changes in society and to a growing shortage of RNs. During World War II, the need for RNs who were prepared more quickly than in diploma programs became critical; the 2-year Cadet Nurse Corps was developed and proved to be very successful. From this experience, some educators realized that nurses and others could be prepared in less time and still meet RN licensure and practice requirements. After the war, Congress made funds available to publicly fund community colleges that offered 2-year associate degree programs in many technical fields. In addition, military benefits for college tuition allowed thousands of men and women to rise above the heritage of their parents to earn a 2-year college degree and fill jobs needed by burgeoning business and industry.

At the same time, the increasing complexity and expansion of medical care required more and better-prepared RNs. A few nurse educators began to create a new 2-year associate degree nursing program in community colleges, which required college courses in arts and sciences and a more integrated approach to nursing content and clinical learning. These pioneers reasoned that nursing belonged in a college setting, as in other
disciplines, to provide a better education for nurses and to establish more respect and recognition for nursing’s contribution to the community’s health. As the number of community colleges grew and the need for nurses increased, associate degree nursing (ADN) programs became a logical program for development and expansion. Orsolini-Hain and Waters (2009) provide a brief and interesting historical account of ADN education.

ADN education is a vivid example of how changes in society influence the evolution of nursing education; it was another significant “first” in nursing and an important part of the evolving professionalization of nursing as a discipline. For the first time, it was possible for all RNs to be educated in a college setting and obtain a college degree. ADN programs were so successful that they became the new career pathway for nurses, and now the majority of practicing RNs are ADN graduates.

In 2000, approximately 885 ADN programs were operational, and by 2011 the number increased to over 1000 programs (NLN*, 2012). This trend of acceptance and growth of ADN programs along with the slowly increasing 4-year BSN programs and progressive mobility options established the educational framework for current nursing education.

**Baccalaureate Degree Nursing Programs**

In 1924, Yale University offered the first separate department of nursing whose graduates earned the baccalaureate degree. The 28-month program required scientific studies and clinical work and had the prestige and authority of other departments, with its own dean and budget (Kalisch and Kalisch, 1995). About the same time (1923 to 1924), a true 4-year nursing (BSN) degree program opened at Western Reserve University (now Case Western Reserve University). The nursing school later was named after its main benefactor, Frances Payne Bolton, and today it offers many specialized programs for undergraduate and graduate students from throughout the world. This early beginning of BSN programs was another first in the history of nursing as a profession. Nurse leaders from those early years until today believe that nurses provide more comprehensive and competent care when they get a solid foundation in the arts and sciences, in addition to nursing content.

Generic BSN programs typically require 2 years of arts and sciences followed by 2 years of nursing courses. RN to BSN programs are growing in number (AACN, 2012), and the AACN’s 2011 survey found that 14,124 students with non-nursing degrees were enrolled in accelerated programs. As in other programs, BSN courses focus on the care of patients with medical, surgical, pediatric, obstetric, and psychiatric conditions, although course sequencing and names differ considerably from school to school. BSN programs focus more emphasis on the family and community and health promotion and illness prevention; a large part of clinical experience is in diverse community settings. They also require courses such as research, management, leadership, and statistics. The AACN 2011 survey (2012) reported 687 BSN programs, 603 generic, 591 RN to BSN, and 107 accelerated programs for non-nursing graduates. Graduates of BSN programs take the same NCLEX-RN® licensure examination as diploma and ADN graduates. Most specialty areas require the BSN degree for practice and as preparation for specialty certification. Admission into master’s programs usually requires a BSN or other degree.

**Master’s Degree Nursing Programs**

In the 1960s and 1970s, the number of BSN graduates increased, but so did the need for more qualified clinicians, educators, and administrators in response to the complexity of health care. The federal government responded with support for the development of MSN and BSN degree programs. Nurse leaders lobbied and obtained federal funding for building construction and increased student tuition. Traineeship and fellowship grants were made available to thousands of RNs that enabled them to earn BSN and advanced degrees to meet these needs. Different MSN program options are available; the most typical are for BSN graduates, although an increasing number are designed for graduates of non-nursing degree programs, called accelerated or second-degree programs. Second-degree graduate nursing programs, in which graduates do not receive a BSN but are eligible to sit for the NCLEX-RN® licensure examination, are growing in number. It has been cited that students in these programs are self-directed adult learners who pass the RN licensure examination at high pass rates (Miller and Holm, 2011).

Until the late 1960s, MSN programs primarily focused on preparing educators and administrators,
but then the curriculum shifted to an overwhelming emphasis on clinical practice. By the 1990s, the negative and the positive consequences of this decision became apparent with more competent clinicians but less well-prepared educators and administrators. Most MSN programs are designed to prepare advanced nurse practitioners and clinical specialists in various specialty areas. The extraordinary and rapid changes in health care since the early 1990s highlighted the cost-effective and quality care benefits of using advanced practice nurses in primary health care and other specialty areas. With intensive and persistent legal activities, nurses won battles to change state laws to permit nurse practitioners to write prescriptions, receive reimbursement for care, and operate independent nurse practices and health centers. As a result of this expanded scope of practice, an increasing number of nurses have obtained MSN degrees and advanced practice certification. Most nurses in specialty practice, managers, administrators, and educators now are required to have a master’s or doctoral degree. The AACN and NLN offer descriptions and numbers of different types of programs on their websites (see Table 3-2). Additionally, in 2008 the consensus model for advanced practice registered nurse (APRN) regulation: licensure, accreditation, certification and education was published (AACN, 2008c). The Licensure, Accreditation, Certification and Education report was published and outlines four APRN roles: nurse anesthetist, nurse midwife, clinical nurse specialist, and nurse practitioner followed by six population foci. This document provides data to guide nursing licensure, accreditation of programs, certification, and educational programs (https://www.ncsbn.org/7_23_08_Concensus APRN_Final.pdf).

**Clinical Nurse Leader**

In 2000, the national movement to enhance quality and safety in health care led to discussions between the AACN, nurse executives, and other health care leaders that led to the development of a new nursing role—the clinical nurse leader (CNL). In July 2002, the AACN board created the TFER 2 (Task Force on Education and Regulation). Its focus was the nurse competencies needed in current and future health care systems to improve patient care and what the “new nurse” role might look like. This work resulted in the publication of the White Paper on the Role of the Clinical Nurse Leader (CNL) in 2007 (AACN, 2009a). The CNL is a master’s-prepared generalist clinician, not an advanced practice nurse, who oversees the care coordination of a distinct group of patients, evaluates patient outcomes, and has the decision-making authority to change care plans when necessary. The CNL actively provides direct patient care in complex situations, serves as a lateral integrator who provides centralized care coordination for a distinct group of patients, and puts evidence-based care into practice to ensure that patients benefit from the latest innovations. A CNL is a leader in the health care delivery system with expertise in quality improvement and cost-effective resource utilization (Rosseter, 2009). The CNL is not an advanced practice nurse, nor is the CNL prepared in an area of clinical specialty; however, the CNL can consult with a Clinical Nurse Specialist as needed, and, further, the CNL can provide evidence-based care to complex patients (Harris et al. 2011). The Commission on Nurse Certification, an autonomous arm of the AACN, began certifying CNLs in 2007. By winter 2012, more than 1850 CNLs were certified. As of 2011, 99 colleges and universities were offering CNL programs that prepare graduates to sit for the CNL certification examination (www.aacn.nche.edu/cnl/cnl-certification/pdf/ExamHndbk.pdf).

**Doctoral Programs**

Changes in society and health care and the trend of needing more well-educated nurse leaders and researchers led to the initiation of doctoral programs for nurses. The first doctoral program for nurses was developed at Teachers College, Columbia University, and the first nurse graduated in 1932 with a doctor of education degree (EdD). In 1934, New York University offered a PhD program for nurses. More than 30 years elapsed before doctoral programs in nursing (instead of for nurses) were offered (e.g., the doctor of nursing science degree [DNS or DNSc]).

For the past few decades, three types of doctoral degrees in nursing were available: (1) the doctor of philosophy (PhD) for those interested in research; (2) the DNS or DNSc for those interested in advanced clinical nursing practice; and (3) the doctor of nursing (ND) for those with BS or higher degrees in non-nursing fields who want to pursue a career in nursing leadership. The ND degree, which prepared nurses for basic licensure (NCLEX-RN®), was first offered at Case Western Reserve University in 1979. Shortly after, Rush University, the University of Colorado Health Sciences Center,
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and others offered this degree. Nursing schools have transitioned and no longer offer the ND.

Beginning in 2000, AACN leaders developed and implemented a new clinical-focused doctoral degree: the doctor of nursing practice (DNP) (AACN, 2012; see AACN webpage for updated information and statistics). The DNP is conceived as preparation for contemporary advanced nurse practitioners; it is viewed as the clinical equivalent to the research-oriented PhD nursing degree. The AACN has recommended that all advanced practice education programs move from the master’s to the doctoral level by 2015. The DNP is still controversial, although programs continue to gain support (Hathaway, et al, 2006; Kaplan and Brown, 2009; Leners et al, 2009). Some nurse leaders think introducing another level of preparation is not in the best interest of nursing and will exacerbate the faculty shortage further (Chase and Pruitt, 2006; Tanner, 2005). Although the DNP prepares clinicians, it does not formally prepare educators. However, individuals who have a DNP degree frequently serve in faculty roles.

In March 2012, the AACN reported that from 2010 to 2012 the number of students enrolled in DNP programs increased from 7,034 to 9,094. During the same period, the number of DNP graduates increased from 1,282 to 1,595. Additionally, as of March 2012, 184 DNP programs are enrolling students in schools of nursing in 40 states nationwide, 65 of which are accredited by the CCNE and 110 of which are pursuing accreditation (AACN, 2012).

FLEXIBLE EDUCATION, MOBILITY, AND DISTANCE-LEARNING PROGRAMS

Various types of nontraditional mobility programs were initiated in the 1970s (Lenburg, 1975) and have evolved over the past four decades (Benjamin-Coleman et al, 2001). Resisted for more than 20 years by more traditional educators and organizations, mobility programs now are commonplace. The AACN and NLN websites attest to the growing number of programs that offer some form of flexible, alternative program, in addition to position statements on technology in nursing education, distance-learning, and online programs. This well-developed trend is based on the success of these programs, the documented needs of students, the nursing shortage, and the expansion and acceptance of electronic learning technology (Shovein et al, 2005). Distance or mobility programs include those for LPN or LVN to ADN and BSN; diploma and ADN graduates to BSN and MSN; and BSN to MSN and doctoral programs. Almost all use some form of Internet-based courses, and some are entirely online. Some require periods of intensive on-campus classes or assigned clinical experiences with preceptors (see Table 3-2).

The most controversial but pace-setting distance-learning program in nursing was developed under the New York Board of Regents as “the external degree program.” Initially named the NY Regents External Degree Program (NYREDP), it later was renamed Excelsior College. Its ADN program, initiated in 1972, and the BSN, in 1976, were fully accredited by the NLN shortly thereafter, albeit with considerable difficulty. This innovative college provides quality degree programs in many disciplines for adult learners underserved by traditional programs by using assessment methods to document prior learning and theory and performance examinations to validate current knowledge and competence. The nursing programs enroll thousands of students and are accessible regardless of geographic location; the students primarily are LPNs or RNs, some of whom also have other degrees or health-related certificates. Early studies documented their competence in the workplace (Lenburg, 1990). It initiated a master’s degree program in 2000 with two specialty options. Over the years, many nursing programs have accepted and modified the distance-learning and assessment approach originally developed by the NYREDP and continued as Excelsior College. The integration of electronic learning technology with assessment methods makes nursing degrees accessible to an increasing number of nurses seeking additional preparation (see Table 3-2).

Career ladder programs designed as “1 plus 1” or “2 plus 2” options have been offered for many years by some schools and through several statewide programs. Multiple mobility programs are available for LPNs to obtain an ADN degree, such as one offered by the New York Coalition for Education Mobility (2004). RN to BSN programs are available in approximately 600 schools as of 2011 (AACN, 2012). In addition, some 165 programs admit ADN graduates into MSN programs (AACN, 2012). With the shortage of nurses and nurse educators, some schools are finding ways to streamline RN to BSN programs.

Changes in social, political, financial, and philosophic trends; the extensive use of communication and learning technology; verified success from past experiences; and the continuing shortage of nurses have combined to make education mobility and distance-learning opportunities
a necessity and a reality nationally and internationally. Whereas the NLN continues to support all levels of education programs, the AACN and other organizations vigorously support the BSN for “entry into practice” and the professionalization of nursing (IOM, 2010). In 2003, the New York State Board of Nursing approved a proposal that would require future graduates of diploma and ADN programs to earn a BSN degree within 10 years to be eligible for renewal of licensure; as of this writing, it has not been passed. The New York Organization of Nurse Executives supports this effort and describes the rationale for it on its website (NYONE, 2006).

In October 2010, the IOM released The Future of Nursing: Leading Change, Advancing Health, which provides a blueprint for transforming the nursing profession. A key message of this IOM report was that nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. A variety of innovative strategies that include online education and simulation as well as consortium programs will need to be increased to create a seamless pathway from ADN to BSN, ADN to MSN and BSN-DNP and PhD. This will effect the needed transformation of nursing education. (IOM, 2011).

The escalating nursing shortage and the aging of the current nursing workforce and nurse educators have prompted more schools to offer flexible mobility options and types of programs. Some target potentially underrepresented groups, such as men, minority groups, and those with existing academic degrees. The most rapidly growing are the accelerated, fast-track, or second-degree programs, designed for non-nurses with other degrees. In 2011, the AACN reported 235 accelerated BSN programs and 63 accelerated master’s programs available at nursing schools nationwide. In addition, 33 new accelerated baccalaureate programs were in the planning stages, and 10 new accelerated master’s programs were also taking shape. For a list of accelerated nursing programs, visit http://www.aacn.nche.edu/Education-Resources/APLIST.PDF.

Trends and issues that influence nursing education make it even more important to comply with quality standards that emphasize competency outcomes. Changes in number, diversity, and qualifications of students and shortage of faculty and finances make it necessary to develop more efficient and effective learning strategies for on-campus and distant students. Although mobility and electronic options are more convenient, they present issues. In addition to learning to access multiple digital resources, students also need discipline and determination to pursue courses and clinical learning when a teacher is not physically present or accessible. Regardless of methods, they must achieve required competencies in spite of other responsibilities and learn to integrate critical thinking, reflective judgment, and evidence-based practices in patient care. In contrast to previous decades, organizations and schools now require more creative, responsive programs and expect more documented competence from students and faculty (Box 3-1). Although these trends pose challenges for nursing students, faculties, and employers, they move nursing toward more competent professional practice and improved patient safety (Boyer, 2008; Lenburg et al, 2009).

**SUMMARY**

This chapter presented 10 major trends and related issues in nursing education programs and an overview of multiple types of nursing programs. They have a significant influence on the content, learning process, and evaluation methods used in all types of programs and have influenced the development of new degrees and majors. They have had a remarkable effect on the persistence of various types of programs for entry into practice and on the increasing acceptance of diverse mobility and distance-learning programs. Regardless of the type of program, most students now use the Internet to access courses, electronic databases, and other learning resources and integrate evidence-based practice and critical thinking. As students integrate current trends and attempt to resolve issues, they create the trends for the next generation; they are participating in nursing history in the making. The most profound trend in nursing education is learning to learn, to reason, and access relevant resources to solve problems. As Alvin Toffler wrote, “The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn.”

Additional resources are available online at: [http://evolve.elsevier.com/Cherry/](http://evolve.elsevier.com/Cherry/)
BOX 3-1 SELECTED ORGANIZATIONS RELEVANT TO NURSING EDUCATION: GENERAL DESCRIPTION AND PURPOSE

American Academy of Nursing (AAN) — The organization of leaders in all facets of nursing: practice, education, administration, research, organizations, and government; the think tank of the profession; promotes advancement of all aspects of nursing; publishes position papers, conference proceedings, and documents to advance nursing.

American Association of Colleges of Nursing (AACN) — The organization of deans and directors of baccalaureate and higher-degree nursing programs; establishes standards for programs concerned with legislative issues that pertain to professional nursing education; publishes the Journal of Professional Nursing, The Essentials of Baccalaureate Education (2008), and other related documents pertaining to the BSN and higher-degree education.

American Nurses Association (ANA) — The major national nursing organization concerned with broad scope of practice issues; standard of practice, scope of practice, ethics, legal, and employment issues; a federation of state nurses associations; publications relate to an array of practice issues and standards.

Commission on Collegiate Nursing Education (CCNE) — A subsidiary of the AACN with responsibility for establishing and implementing standards and criteria and for accreditation of baccalaureate and graduate degree programs in nursing.

National Council of State Boards of Nursing (NCSBN) — The organization of all state boards; coordinates licensure activities on a national level; creates and administers licensure examinations (NCLEX); developed computerized licensure examinations; works with other organizations to promote nursing standards and regulation and establish interstate licensure protocols.

National League for Nursing (NLN) — The national organization of nurse educators, with long-standing commitment to four types of basic programs (LPN, diploma, ADN, and BSN); includes lay citizens concerned with nursing and health care on its board. NLN also has councils for nursing informatics, research in nursing education, wellness centers, and multiple types of print publications. Initiated a certification program and examination to certify excellence of nursing educators; also established the Centers for Excellence for nursing programs that meet designated standards.

NLN Accreditation Commission (NLNAC) — Formed in 1997 as a subsidiary of the NLN with responsibility for establishing and implementing standards and criteria and for accrediting all types of schools of nursing.

National Organization of Nurse Practitioner Faculties (NONPF) — An organization of nurse practitioners in multiple specialties; sets national standards and criteria for programs and certification.

National Student Nurses Association (NSNA) — A national organization of statewide student nurse associations; concerned with education and career issues; provides student perspectives to other national nursing organizations.

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