NURSING JURISPRUDENCE LAWS IN OHIO

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Nursing Jurisprudence Laws In Ohio

ANCC Accredited NCPD Hours: 3 hrs.

Target Audience: RN/APRN

Need Assessment

One of the significant factors for poor quality of health care services is human agents. Human force plays a substantial role in the evolution and progression of health care issues and is enumerated as one of the main components of each organization, which has always been emphasized by human resources development experts. It seems that achieving the objectives of organizations is highly dependent on the capacity of human resources. Nurses are the key members and play the major part of service-providing system in almost all countries. Nurses should practice with adequate knowledge on legal and ethical issues, principles and professional attitude. Improved job performance followed by a positive outlook and job satisfaction will enhance the quality of patients' care and increased productivity, hence as reported in different studies, the internal factors are far more than external factors in job motivation among nurses.

Objectives

- Discuss the scope of Nursing Practice in the State of Ohio
- Appraise the various Standards of Nursing Practice
- Analyse the patient safety regulations in nursing practice
- Adapt with the regulations of Ohio Board regarding quality improvement, preventive care, integrative primary health care and evidence based practices
- Justify the Ethical concerns in Professional Nursing Practice
- Describe nursing competencies in integrative primary healthcare

Goal

The goal of this article is to combine experiences of advanced practice nursing in general practice in Ohio concerning the continuity of advanced practice roles, independent of setting and within the professional boundaries.

Introduction

There is a scarcity of primary care providers in the United States, the effects of which may be exacerbated by the Patient Protection and Affordable Care Act, which increases access to health insurance coverage without necessarily increasing the supply of providers. ***As the point in which most Americans interface with the health care system, primary care plays a prominent role in ensuring access and quality and in promoting lower cost service delivery through the application of preventative medicine and screening.***

In contrast to physicians, Nurse practitioners and Physician assistants commonly enter primary care. Estimates vary but suggest that between 52% and 60% of Nurse practitioners and 43% and 50% of Physician assistants work in primary care. Indeed, ***rural practices often rely on Nurse practitioners and Physician assistants in place of physicians, since physicians less commonly elect to work in these otherwise underserved areas.*** The same is true for nursing homes, community health centers, and other settings where physician presence is more limited.

Research confirms that the quality of care provided by Nurse practitioners is high. Patients who receive primary care from NPs are often more satisfied with the care provided than those served by physicians. Research also suggests that in addition to increasing access to care, Physician assistants provide care comparable in quality to that provided by their physician supervisors. Moreover, greater presence of nurse practitioners and Physician assistants results in equal or better quality of nursing home care, including fewer potentially avoidable hospitalizations and other favourable outcomes.

One study suggests that nurse practitioners and Physician assistants contribute to improvements in nursing home quality by providing care that complements rather than substitutes for care provided by physicians. Although patients may initially prefer physicians, they often choose an nurse practitioner or Physician assistant rather than wait longer

> **" Scope of practice is defined as the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is governed by requirements for continuing education and professional accountability. "**

to see a physician. In fact, according to one recent survey, substantial numbers of patients prefer nurse practitioners and Physician assistants even when wait time is not a factor. Furthermore, although half of patients surveyed would prefer a physician as their primary care provider, 22% would choose a Nurse practitioner or Physician assistants; the remainder indicated no preference.

Although Nurse practitioners and Physician assistants are certified nationally, state scope-of-practice laws determine the extent to which they may practice independently. These ***laws regulate the level of educational attainment needed, the amount of prescriptive authority available, and the level of physician involvement required.*** Potentially problematic is substantial variability in restrictiveness, "With barriers to full deployment of [NPs/PAs] in some states, full utilization of [NPs/PAs] in others, and many shades in between". ***The Institute of Medicine recently called for regulatory standardization. This recommendation reflects recognition that scope-of-practice legislation in some states is very specific and detailed;*** while in others it is vague and open to interpretation. It also reflects recognition that some states regularly update their scope-of-practice regulations in light of broader health care system changes but most do not. Of primary concern is that the scope with which nurse practitioners and ***Physician assistants may practice depends largely on idiosyncratic political and regulatory considerations, rather than practitioner ability and education.***

Considerable cross-state variation in nurse practitioners and Physician assistant authority makes understanding their potential role in reducing the primary care shortage difficult. ***Recent calls for regulatory standardization emphasize the need to understand the variety of practice regulations, their impact on health system performance, and their effects on patient access and quality.*** Before such standardization can take place, however, it is necessary to document the evolution of the regulatory landscape. [2, Rank 3]

Ohio Board of Nursing

The Board licenses and regulates registered nurses (RNs), licensed practical nurses (LPNs), Advanced Practice Registered Nurses (APRNs), Dialysis Technicians (DTs), Community Health Workers (CHWs) and Medication Aides. The Board's top priorities are to efficiently license the nursing workforce and remove dangerous practitioners from practice in a timely manner to protect Ohio patients.

Scope of Practice

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Need for Nursing Board and Regulations

According to Schmitt and Shimberg, regulation is intended to three basic inevitabilities. (as shown in Figure 1)

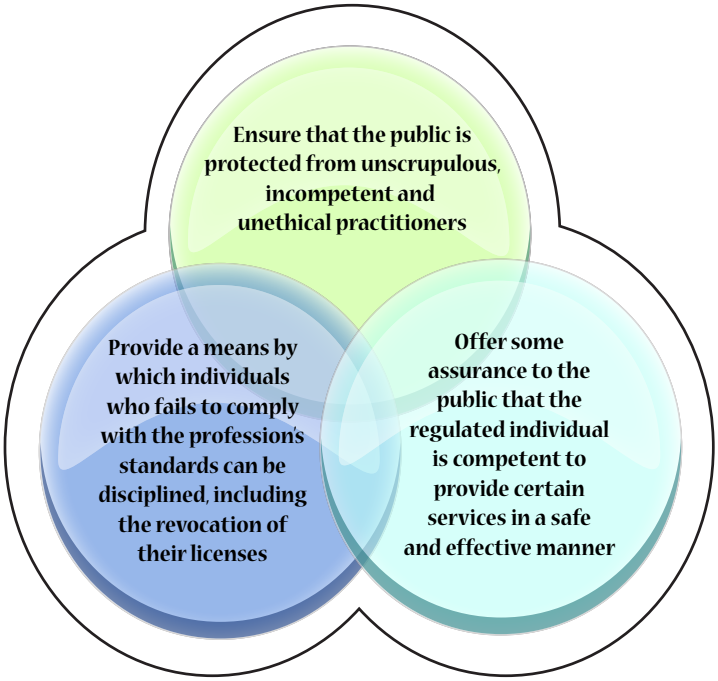

Figure 1: Need for Nursing Regulations

Basic norms or assumptions have been kept while providing a framework for nursing practice (as shown in figure 2)

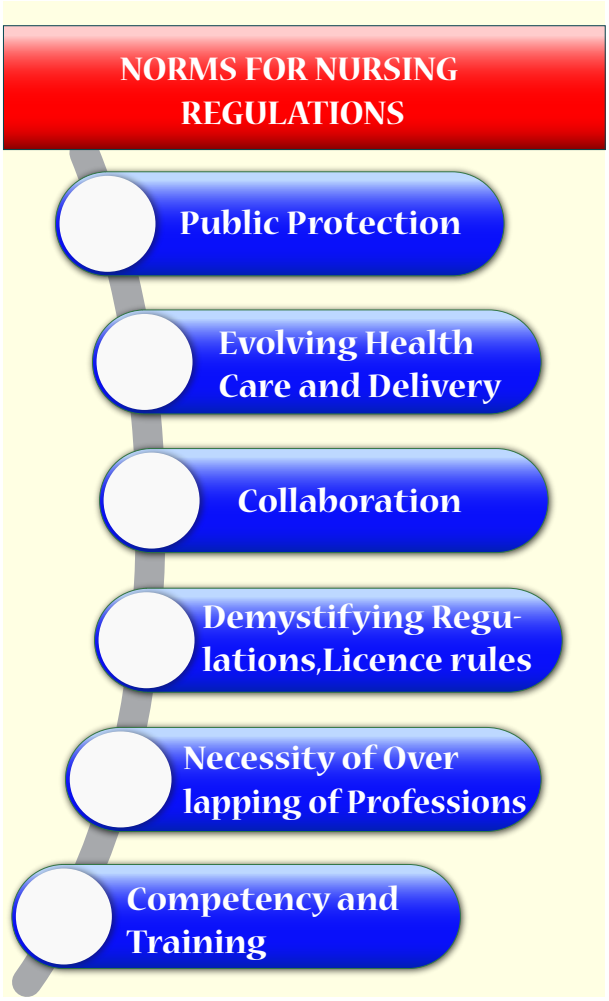

Figure 2: Norms Related to Scope of Practice

Public should have the top priority in scope of practice decisions, rather than professional interest. The public should have access to providers who practice safely and competently. Healthcare practice acts also need to evolve as healthcare demands and capabilities change. Competent providers will refer to other providers when faced with issues or situations beyond the original provider's own practice competence with proper answers to all Questions. One activity does

not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service. No professional has enough skills or knowledge to perform all aspects of the profession's scope of practice.

Registered Nurses (RN)

Ohio Board defines the scope of RN practice as: "Providing to individuals and groups of nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioural, social, and nursing sciences." (as shown in Figure 3)

Figure 3: Scope of Practice for Registered Nurses

Registered Nurses have independent licensed authority to engage in all aspects of practice specified and must have an order from an individual who is authorized to practice for administration of medication or treatments or for the regimen that is to be executed. Based on the "health status assessment" RNs determine the nursing care needs of the patient and the resulting nursing regimen that will be executed which "may include preventative, restorative, and health-promotion activities." (as shown in Figure 4)

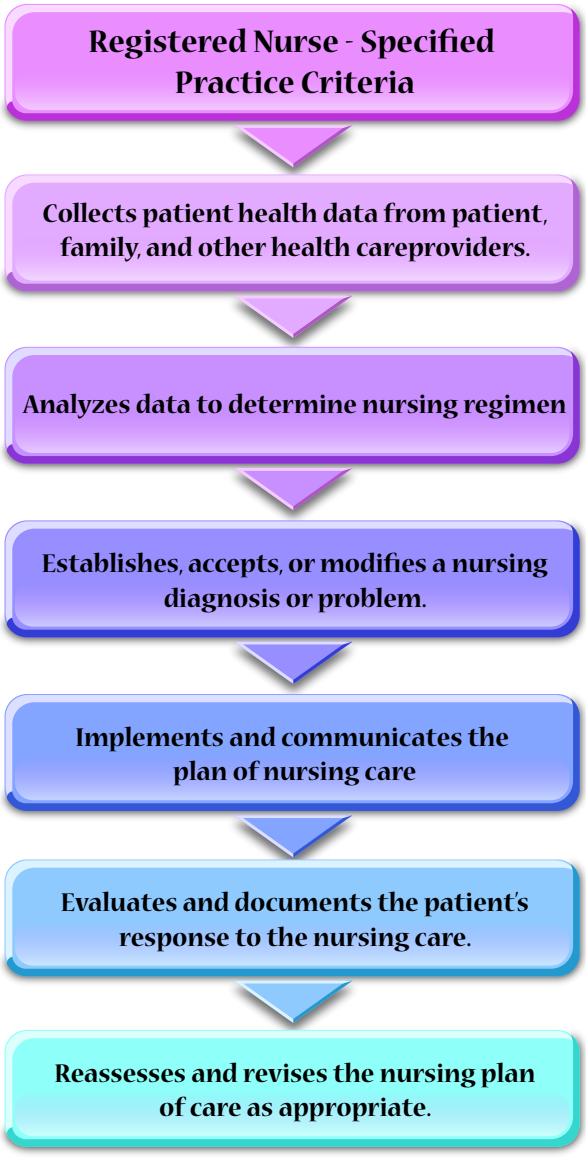

Figure 4: Registered Nurse- Practice Criteria

Supervision of Nursing Practice is specified within the definition of ***Registered nurse*** practice, noting that RNs teach, administer, supervise, delegate, and evaluate nursing practice. ***It is the "practice" of nursing that the Registered nurse supervises and evaluates, rather than a person's employment performance.*** The supervising registered nurse must be continuously available through some form of telecommunication with the supervised nurse.

Licensed Practical Nurses (LPN)

Ohio Board of Nursing defines the scope of Licensed Practical Nurses practice as "Providing to individuals and groups nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences at the direction of a registered nurse or any of the following who is authorized to practice in this state: a physician, physician assistant, dentist, podiatrist, optometrist, or chiropractor." (as shown in Figure 5)

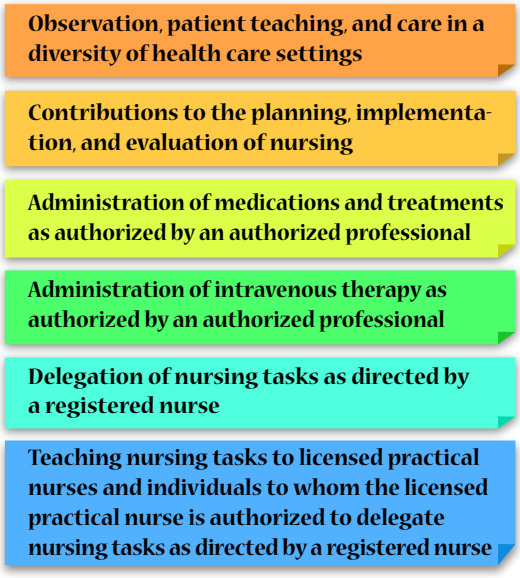

Figure 5: Scope of Practice for LPNs

Licensed Practical Nurses have a "dependent" practice, which means the LPN is authorized to practice only when the practice is directed by a registered nurse or any person who is authorized to practice in the state.

The "direction" required for Licensed Practical Nurse practice is further defined as "communicating a plan of care to a licensed practical nurse"

The Licensed Practical Nurse is accountable to identify the Registered nurse or other authorized health care provider who is directing the Licensed Practical Nurses' practice. Engaging in practice beyond the Licensed Practical Nurses authorized scope is prohibited (as shown in Figure 6)

Figure 6: Prohibited Practice Criteria for LPNs

The Licensed Practical Nurses contribute to all steps of the nursing process by communicating with the registered nurse or the directing authorized health care provider concerning the patient's status and needs. (as shown in Figure 7) When a registered nurse is directing Licensed Practical Nurses practice, it is the registered nurse who establishes the nursing regimen and communicates the nursing practice needs of the patient.

Figure 7: Licenced Practical Nurse-Practice Criteria

IV therapy procedures should be done by IV therapy certified Licenced Practical Nurses and others are prohibited from performing. Supervision of employee performance and other employment requirements are established by the employer and may encompass responsibilities beyond the licensed practice of nursing.

Both the Registered Nurse and Licenced Practical Nurse implement the nursing process in the provision of nursing care in accordance with the Ohio Board rules. The scope of Licenced Practical Nurse practice does not include assessing health status for purposes of providing nursing care that is included in the Registered Nurse scope. Although it is the Registered Nurse who reviews and assimilates the patient's health status data and information into the nursing assessment for purposes of providing nursing care, the Licenced Practical Nurse is authorized to contribute to this process by obtaining responses to health questions posed to the patient, performing physical examinations, recognizing changes in patient status or complications.

Definitions by Ohio Board of Nursing

Certified nurse practitioner: A registered nurse who has met the requirements as per the board regulations, and holds a current valid advanced practice registered nurse license issued by the board

Clinical judgment: Application of the nurse's knowledge and reasoning within the context of the clinical environment in making decisions about patient care.

Direction: Direction is communicating a plan of care to a licensed practical nurse. Direction by a registered nurse is not meant to imply the registered nurse is supervising the licensed practical nurse in the employment context.

Licensed nurse: A registered nurse or a licensed practical nurse who holds a current valid license to practice nursing in Ohio.

Nursing diagnosis: It is the identification of a patient's needs or problems which are amenable to nursing intervention.

Patient: The recipient of nursing care, which may include an individual, a group, or a community.

Nursing Board Mission and Standards of Practice

The mission of the Ohio Board of Nursing (Board) is to actively safeguard the health of the public through the effective regulation of nursing care. Competent and safe nursing practice begins with education programs that prepare individuals for practice. The Board approves pre-licensure education programs to assure the programs maintain academic and clinical standards for preparation of entry-level nurses. ***The Board regulates 189 pre-licensure nursing education programs and a total of 50 various types of training programs.***

Using Nurse practitioners (NPs) and physician assistants (PAs) to fill the gap between service need and care capacity may alleviate the primary care crisis, as they provide a cost efficient means of supplying much of the hands-on care otherwise provided by better paid and more highly trained physicians. ***Nurse practitioners are registered nurses with graduate degrees, who have also completed additional clinical training.*** In 2010, 84% of Nurse practitioners had a master's degree, 4% had a doctorate; the remaining 12% only had a bachelor's degree, having begun practicing before additional graduate work was required. States license Nurse practitioners and/or require that they pass a national board certification exam. ***Physician assistants are part of a physician-led team; thus in contrast to NPs, they rarely practice independently but instead perform tasks delegated by physician supervisors.*** Forty percent of Physician assistants hold bachelor's

degrees; 43% master's degrees; the remainder (17%) qualify to practice through on-the-job training or prior experience. Physician assistants must pass a national certification exam and, like Nurse practitioners, are licensed by the states.

Primary Care Standards

The impact of the primary care shortage in Ohio became more salient with the advent of health care reform, as not enough physicians were available to meet the primary care needs of large numbers of newly insured state residents. Ohio primary care serves the following standards (as shown in Figure 8)

Figure 8: Primary Care Services- Ohio

Increased use of primary care is associated with decreased risk of morbidity and mortality and ***with reductions in hospitalizations and costs.*** However, one in five Americans live in primary care shortage areas, where the ratio of the population to primary care providers is greater than 2,000 to 1. Without concerted action, this ratio is unlikely to change in the immediate future. Just 37% of doctors serve in primary care although it accounts for 56% of physician office visits. Furthermore, only one in four medical students is planning a career in primary care. It is expected that by 2015, the United States will face a shortage of 33,100 primary care practitioners. The primary care physician workforce is also unevenly distributed. Rural and inner-city areas with high proportions of low income and minority populations, who often have greater health needs, have lower supplies of primary care providers than their higher income, less racially/ethnically diverse counterparts. Although there was a slight reduction in regional workforce variation from 1979 to 1999 due to a 51% growth in the aggregate supply per capita, most physicians practiced in regions with an already high supply of doctors. [1, Rank 5]

Customer Service Standardss

Ohio Nursing Board identifies customer service duties (as shown in Figure 9) in employee Position Descriptions. Ohio Revised Code requires that "Each state agency shall develop, and as it becomes necessary or advisable may improve, customer service standards for each employee of the agency whose duties include a significant level of contact with the public. The agency

shall base the standards on the job descriptions of the positions that the employees hold in the agency." Customer service, are reviewed annually in conjunction with the performance evaluation. Incorporation of customer service goals is added in employee performance reviews including that of nurses. Standards/goals are reviewed during the annual performance evaluation for employees for each performance review period. Goals related to each customer service duty, as identified in the employee's position are included in the employee's performance evaluation. Supervisors monitor employees' success in achieving the implementation of the customer service standards through the performance evaluation process.

Figure 9: Customer Service Standards

The Board incorporates customer service standards in its Strategic Plan. Program Managers monitor and evaluate employees' success in achieving the objectives of the strategic plan and report the outcomes on a semi-annual basis. Outcomes are presented to the members of the Board of Nursing for their review.

A possible reason for the less successful outcomes may be organisations failure to identify who the customer is and what is important. Important predictors of customer/ patient satisfaction are identified. (as shown in Figure 10) [14, Rank 4]

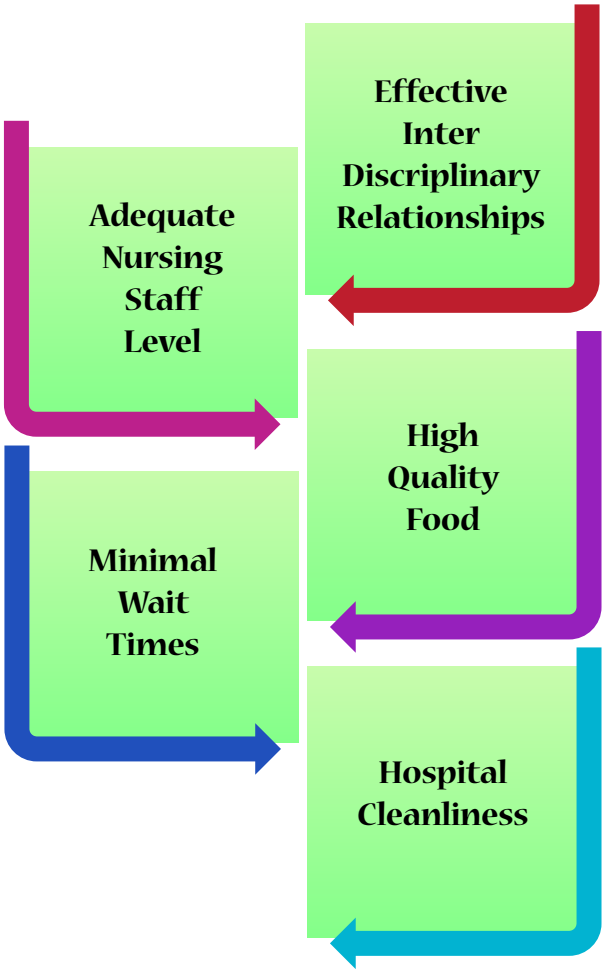

Figure 10: Predictors of Patient Satisfaction

Standards Related to Patient Safety

The Board is providing information and guidance about nursing practice based on the Nurse Practice Act and the administrative rules.

- When a licensed nurse, certified nurse midwife, certified nurse practitioner or clinical nurse specialist is providing direct nursing care to a patient or engage in nursing practice or interacting with the patient, the nurse shall display the applicable title, relevant licensure as per the regulations and rules of Ohio Board of Nursing.
- A licensed nurse shall delegate a nursing task, including medication administration, only in accordance with the regulations and guidelines of the Administrative Code – Ohio Board of Nursing.
- A licensed nurse shall implement measures to promote a safe environment for each patient and shall delineate, establish, and maintain professional boundaries with each patient.
- At all times when a licensed nurse is providing direct nursing care to a patient the licensed nurse shall maintain the standards (as shown in Figure 11)

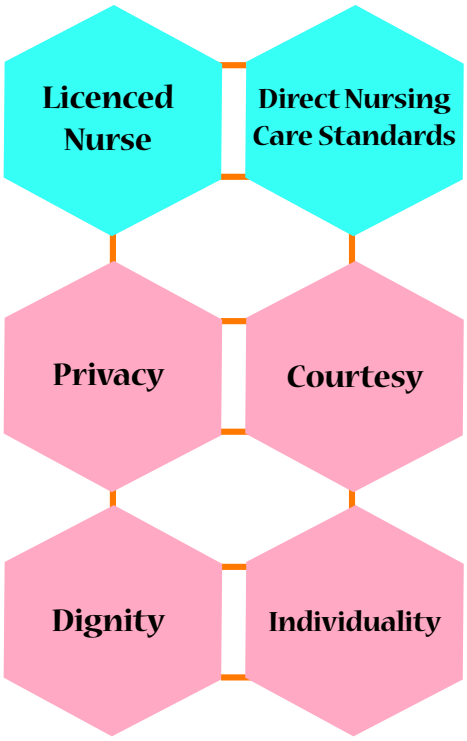

Figure 11: Direct Nursing care standards

- Unacceptable comportments are also defined by the board of Nursing Ohio.(as shown in Table 1)

Unacceptable comportments of a Nurse
• Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a patient
• Engage in behavior toward a patient that may be interpreted as physical, verbal, mental, or emotional abuse.
• Misappropriate a patient's property
• Seek or obtain personal gain at the patient's expense
• Inappropriate involvement in the patient's personal relationships or financial matters
• Sexual conduct with a patient and verbal behavior that is seductive or sexually demeaning to a patient

Table 1: Unacceptable behaviours of a Nurse

- A licensed nurse shall, in a complete, accurate, and timely manner, report and document nursing assessments or observations, the care provided by the nurse for the patient, and the patient's response to that care and, report to the appropriate practitioner errors in or deviations from the current valid order.
- A licensed nurse shall not falsify, or conceal by any method, any patient record or any other document prepared or utilized for nursing practice including the case management documents or reports or time records and billing documents.
- Current valid license to practice nursing or a current valid certificate to practice as a dialysis technician or medication aide in Ohio should be obtained when a licensed nurse functioning in an administrative role as dialysis technician, or medication aide under the nurse administrator.
- Only a registered nurse shall supervise or evaluate the practice of nursing, under the rules of the board but in matters other than the practice of nursing, a non-nursing supervisor may evaluate a nurse employee.
- Supervision requires that the registered nurse be continuously available through some form of telecommunication with the supervised nurse, and take all action necessary, including but not limited to conducting periodic on-site visits, to insure that the supervised nurse is practicing in accordance with acceptable and prevailing standards of safe nursing care as set forth.
- Evaluation requires that the registered nurse conduct periodic on-site visits sufficient to enable the evaluating nurse to evaluate the evaluated nurse's performance.
- A licensed nurse shall not make any false, misleading, or deceptive statements, or submit or cause to be submitted any false, misleading or deceptive information, or documentation to the board or any representatives, current and prospective employers, temporary, agency, or locus tenens assignment in which, or for whom, the nurse is working, other members of the patient's health care team or to law enforcement personnel.

Standards for Nursing Process

The nursing process is cyclical in nature and requires that the nurse's actions respond to the patient's changing status throughout the process. The following standards shall be used by a registered nurse, using clinical judgment, in applying the nursing process for each patient under the registered nurse's care (as shown in Figure 12)

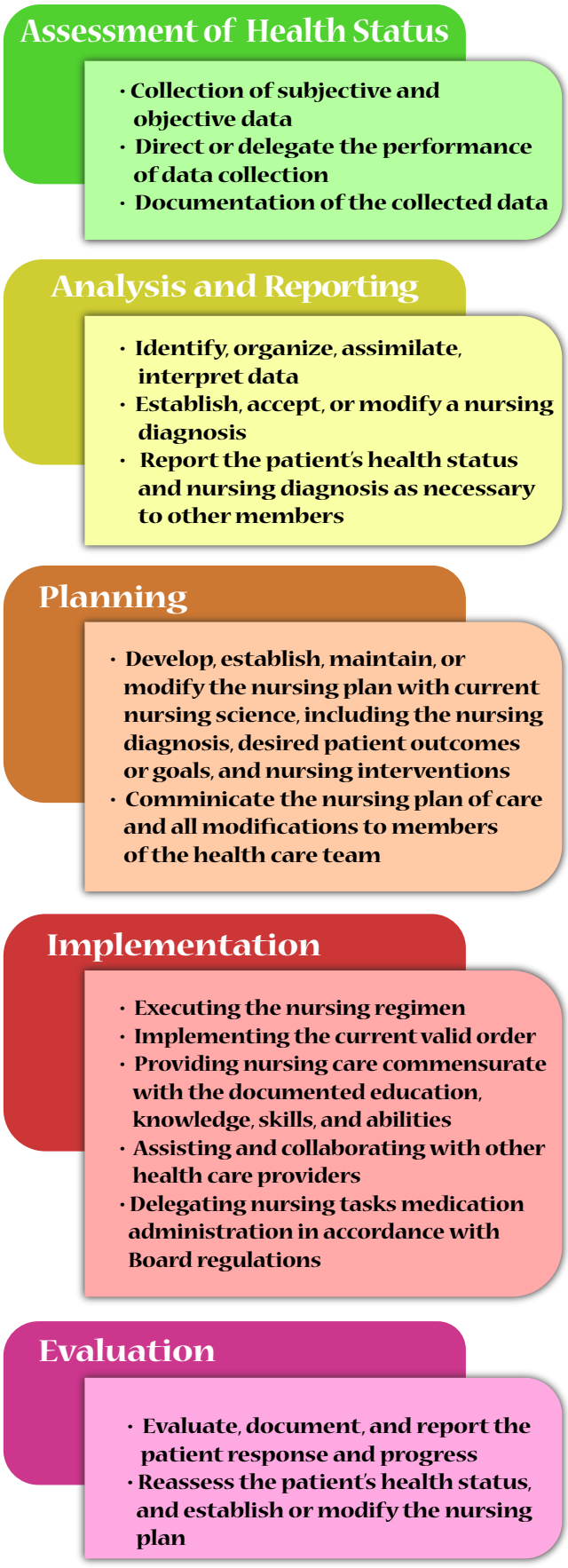

Figure 12: Standards for applying Nursing Process for a REGISTERED NURSE

The licensed practical nurse shall contribute to the nursing process in the practice of nursing as set in the Revised Code and in the rules of the board. (as shown in Figure 13)

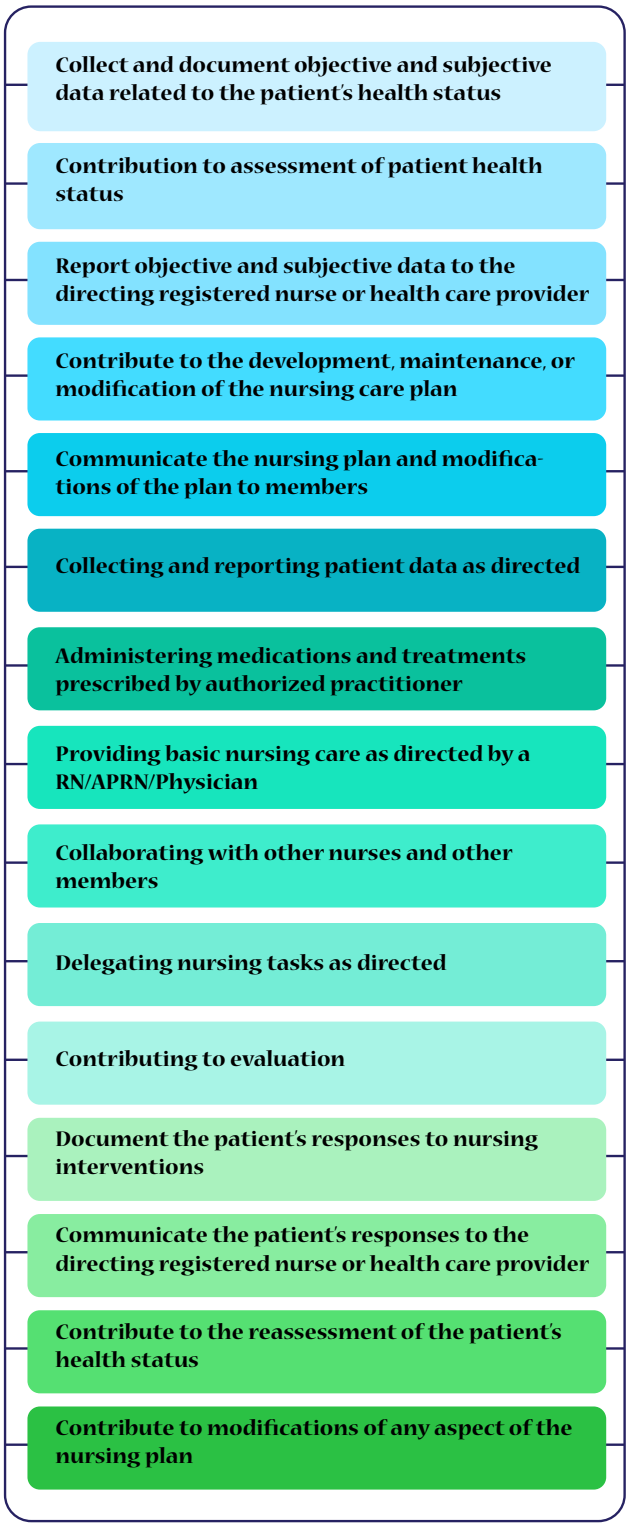

Figure 13: Standards for applying Nursing Process for a LICENCED PRACTICAL NURSE

The nursing process is cyclical in nature so that the nurse's actions respond to the patient's changing status throughout the process. The licensed practical nurse is directed in providing nursing care by the established nursing plan. The following standards shall be used by a licensed practical nurse in utilization of the nursing process.

Standards Relating to Competent Practice as a Registered Nurse

- A registered nurse shall provide nursing care within the scope of practice of nursing for a registered nurse. The nurse should maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice.
- A registered nurse shall demonstrate competence and accountability in all areas of practice in which the nurse is engaged including.
- Consistent performance of all aspects of nursing care and recognition, referral or consultation, and intervention, when a complication arises.
- A registered nurse may provide nursing care that is beyond basic nursing preparation for a registered nurse, provided.
- The nurse obtains education that emanates from a recognized body of knowledge relative to the nursing care to be provided.
- The nurse demonstrates knowledge, skills, and abilities necessary to provide the nursing care.
- The nurse maintains documentation satisfactory to the board when the nursing care is to be provided
- The nursing care does not involve a function or procedure that is prohibited by any other law or rule.
- Take any other action needed to assure the safety of the patient.
- A registered nurse shall, in a timely manner, report to and consult as necessary with other nurses or other members of the health care team and make referrals as necessary.
- A registered nurse shall maintain the confidentiality of patient information. The registered nurse shall communicate patient information with other members of the health care team for health care purposes only, shall access patient information only for purposes of patient care and shall not disseminate patient information through social media, texting, emailing or any other form of communication.
- To the maximum extent feasible, identifiable patient health care information shall not be disclosed by a registered nurse unless the patient has consented to the disclosure of identifiable patient health care information.

- The registered nurse shall use acceptable standards of safe nursing care as a basis for any observation, advice, instruction, teaching, or evaluation and shall communicate information which is consistent with acceptable standards of safe nursing care.
- When a registered nurse provides direction to a licensed practical nurse the registered nurse shall first assess the condition of the patient, type of nursing care the patient requires, complexity and frequency of the nursing care and the training, skill, and ability of the licensed practical nurse with resources available.

Standards Relating to Competent Practice as a Licensed Practical Nurse.

- A licensed practical nurse shall function within the scope of practice of nursing for a licensed practical nurse as set forth in Revised Code and the rules of the board.
- A licensed practical nurse shall maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice.
- They should demonstrate competence and accountability in all areas of practice
- A licensed practical nurse may provide nursing care in accordance with division Revised Code
- The nurse obtains education that emanates from a recognized body of knowledge relative to the nursing care to be provided and demonstrates knowledge, skills, and abilities necessary to perform the nursing care.
- Maintains documentation satisfactory to the board requirements set forth
- The nurse should have a specific current valid order or direction from an individual who is authorized to practice and is acting within the course of the individual's professional practice and the nursing care does not involve a function or procedure that is prohibited by any other law or rule.
- Take any other action needed to assure the safety of the patient.
- A licensed practical nurse shall consult as necessary with other nurses or other members of the health care and maintain the confidentiality of patient information obtained in the course of nursing practice.
- When a licensed practical nurse is directed to observe, advise, instruct, or evaluate the performance of a nursing task, the licensed practical nurse shall use acceptable standards of safe nursing care as a basis for that observation, advice, instruction, teaching, or evaluation and shall communicate information that is consistent with acceptable standards of safe nursing care.

Indications for Not Implementing an Order

A registered nurse or licenced practical nurse should not implement an order in certain circumstances. (as shown in Figure 14)

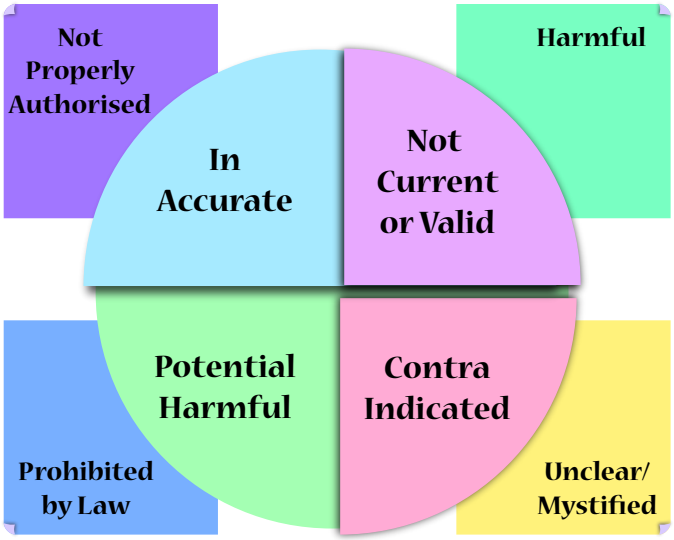

Figure14: Indications for not Implementing an Order

Standards for Specialty Nurses

Figure 15: Specialty Nurses Cadres

- Function within the scope of practice of nursing for a registered nurse as set forth in the Revised Code and the rules of the board.
- When the practice of a certified nurse midwife, certified nurse practitioner, or clinical nurse specialist is evaluated, the evaluation shall be provided by a collaborating licensed physician or podiatrist, or an advanced practice registered nurse holding a current, valid license with the same designation as the individual being evaluated. When the practice of a certified registered nurse anesthetist is evaluated, the evaluation shall be provided by a supervising licensed physician, podiatrist, dentist or a certified registered nurse anesthetist whose license is current and valid.
- A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist may provide care within their specialty provided
- The nurse obtains education that emanates from a recognized body of knowledge relative to the nursing care to be provided and should demonstrate knowledge, skills, and abilities
- The nurse maintains documentation satisfactory to the board

Specialty Certification

A registered nurse with a current, valid license to practice nursing in Ohio may use a title or initials denoting specialty certification in a particular area of specialty in nursing granted by a national certifying organization that has established standards for practice qualifications, formal education, continuing education, or other demonstration of knowledge in specialty practice. ***The title to be used by the registered nurse who focuses in a particular area of specialty in nursing shall be the title granted by the national certifying organization to those nurses who meet the requirements for specialty certification*** established by the national certifying organization. ***The registered nurse may use such title or initials following the title "Registered Nurse" or the initials "RN".***

No person shall use any title or initials implying or representing specialty certification unless that person has been granted a specialty certification title in nursing by a national certifying organization as set forth by Board of Nursing.

Applying for the Fields of Nursing Professionals

Professionalization is an important characteristic of in-service careers. The concept of professionalization is expressed in the terminology of many job groups and has a long history, especially in social context. ***Dynamic feature and multiple interpretations of professionalization result in numerous definitions with different functions and nature.*** Over the years, many people spoke about professionalization in nursing and its features. Therefore, there are multiple definitions and characteristics for professionalization in nursing. Also, researchers used different methods and tools for its assessment and evaluation.

Nursing profession status is an inter-profession and intra-profession challenge. Whether there exist nursing professionalism or not, remains a challenge among nurses, sociologists, and historians. For many years, other scientists considered nursing as a semi-professional career. Until 1970s, nursing profession was considered as a female work and women were considered as barriers to professionalization in nursing due to their high workload and part-time work. At that time, ***some fac-***

> **" Social understanding about nursing made the society consider nurses as cost-benefit health care providers and independent decision makers. Therefore, nursed could receive more funds and governmental financial aids "**

tors such as slow formation of scientific fundamentals of nursing, disagreement in educational requirements for nurses, lack of academic education at the entry level of nursing courses, and lack of theory and theory-based research were considered as barriers for nursing as a profession.

Gradually, development of education standards and professional certificates led nursing move to professional status. ***Having stronger powerful basis for theory and practice and professional education in nursing discipline brought about social cognition.***

Today's rapid changes in value systems in society caused nursing to encounter more ethical and philosophical challenges at providing care to its clients. These changes also created new nursing environments that require professional nursing. Accordingly, nursing professionalization definition and its attributes need to be clarified and adapted with rapid changes. For this purpose, concept analysis is a suitable method.

Concepts are the building blocks of theories. They have important role in theory development. Concept analysis is one of the strategies in concept development. In this strategy, the basic elements of a concept for understanding its structure and function are assessed. ***During concept analysis process, a researcher, theorist, or clinician becomes familiar with different attributes and definitions of concept and its function.***

Evolutionary approach of Rodgers in concept analysis is based on contemporary philosophical thinking on concepts and their roles in knowledge development. In this approach, dynamic features of concepts over time and different social contexts are emphasized. From evolutionary perspective, instead of emphasis on what it is, more discovery and assessment are mostly focused. Consequently, this process results in a form of cyclical concept development. With this approach, the final results are the starting point for more concept analysis. ***Purpose of concept analysis in this approach is to explain the concept and its attributes*** more clearly for its further development.

Accordingly, the purpose of the study is assessment of nursing professionalization concept to understand more about its attributes, antecedents, and consequences. Since the contemporary nursing believed human and other nursing phenomena have constantly a changing and interrelated context, it seems that nursing professionalization is also better understood in the context. This perspective is congruent with evolutionary approach in concept analysis. [3, Rank 5]

Registered Nurse

In the Global Nursing Working Environments category, discrepancies in work environments of clinical nursing specialists due to globalization might transform evidence-based nursing practice or research to support inequalities in the global village. The main concern is that global care chains demonstrate the south to north migration of nurses and this global movement reinforces inequities.

Migration is structured by the power hierarchies embodied in class, ethnicity, gender, nationality and race especially in the era of Global Nursing shortage described how the Norwegian welfare state is becoming a global employer and global nurse recruitment generates transnational spaces of care. Furthermore, ***international nurse recruitment is not a win–win situation and the idealized image of social justice and gender equality needs to be critically examined.***

Power hierarchies and global justice or fairness is a deeper human right need to be discussed in practical contexts in nursing education. ***By training nurses to discover stereotypical behaviour, hidden prejudices and normative structures,*** nursing education has the opportunity to explain how to counteract inequities. Consequently, it is important that the use of suitable solutions follows local contexts in nursing practice and research.

The consequences of power hierarchies in clinical nursing healthcare systems cause differences in nursing, a loss of identity for nurses and a risk for deskilling in the profession. Gender and class are often constituted as otherness. Moreover, identity such as the Self is relative and changing compared with the other argued that Western societies have used their hegemonic position of interpretation to antagonize those who are non-Western. Throughout colonial history, there have been descriptions of qualities such as the other; to be childish, irrational and depraved in contrast to the Self which has been ascribed with qualities as rational, mature, virtues and normal.

The present culture, historically and still today, has monopolized science, knowledge, and clinical practice and health-promoting models. It is our lack of concern about the social disadvantage of others at local, national and global levels that leads to serious health disparities. Furthermore, ***social justice is highlighted as being of importance for nurses.*** These cases have to be further investigated. Education can prevent inequalities by training nurses to make conscious choices in nursing activities when power hierarchies occur in healthcare systems. The Nursing Workforce Management category highlighted futuristic modifications of the existing standards. (as shown in Figure 16)

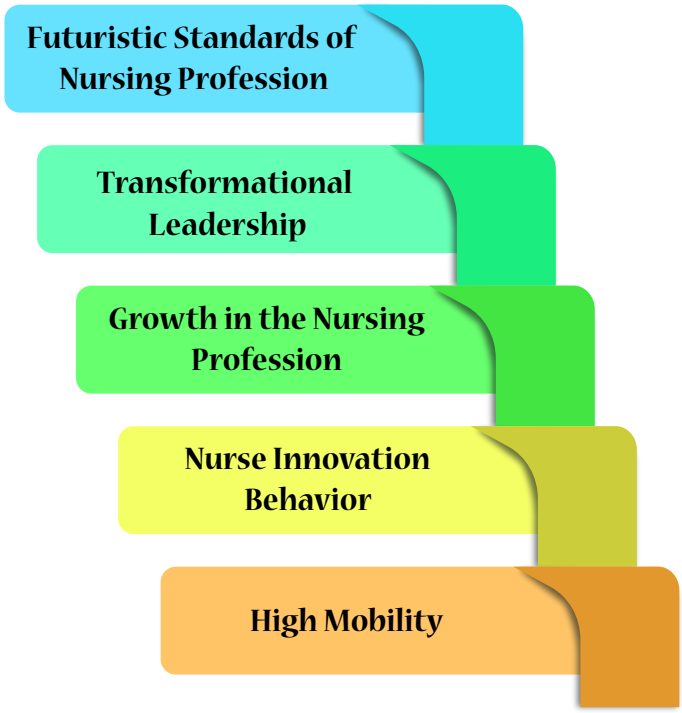

Figure 16: Nursing- Futuristic Standards

However, ***nurse migration and the export of nurses create business and profits for many countries, organizations and agencies.*** This raises the question of how inequality in nurse migration has become a moral problem. ***US researchers concluded that analyses of linkages between globalization, migration and care are essential.***

Nursing education and practice are challenged in meeting the expectations of nurse professionals and in guaranteeing growth in the nursing profession. [4, Rank 5]

The World Health Organization calls for principles which reduces migratory efforts of nurses and improves the standards among developing countries (as shown in Figure 17)

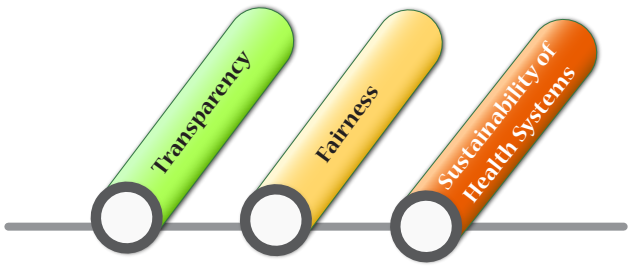

Figure 17: WHO Suggestions for Standard Improvement of the Nursing Profession

Licensed Practical Nurse

Nursing education provides a great opportunity to promote global competencies and explain diminishing aspects important for the nursing profession in nursing practice. Furthermore, a mission is to prepare students to train global awareness by actions and reflection on their experiences.

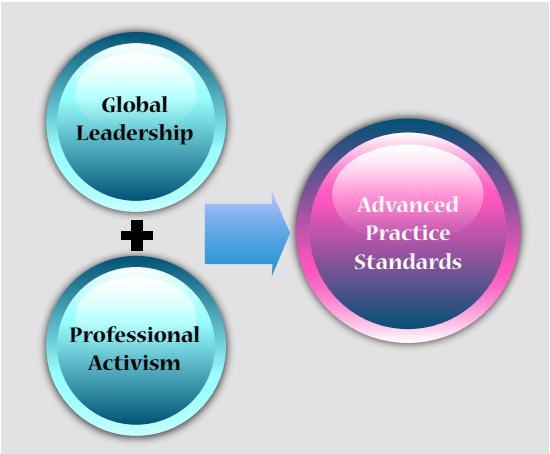

Figure 18: Drift of Standard Setting in Nursing Profession

Advanced Registered Nursing Practice Competencies have shifted in focus to engagement in a global leadership and professional activism.

According to research findings, they recommend an ethical framework and nursing actions as useful tools in the efforts to

reduce inequities and inequalities in Global Nursing practice. The LPN Networking explains strategies that could be helpful and used to further develop joint creative projects. Moreover, global leadership was described as being of vital importance.

Accordingly, ***there is a need for innovation in nursing practice to accommodate the huge challenges facing the future of nursing.*** Work in different healthcare systems and team building together with a long-term innovation climate is important for Global Nursing Networking. In both nursing education and practice, there are great opportunities for nurse professionals and faculty to collaborate in the global community. The results showed that the UK and the USA are active participants writing about Global Nursing issues, which means that it is essentially a Western perspective that is being shown.

This is a question of concern as the concept of a global representation might also be connected to values that have their origin in colonialism. Researchers stress the importance of postcolonial awareness in nursing when dealing with matters of globalization. Post-colonialism has been described as the response to the marginalization of Western cultures' values and norms. This is a concern as the Western context needs to undergo a series of changes to tackle its colonial past even in nursing. This is a critical aspect in advocating for a global agenda in nursing. [4, Rank 5]

> **" In countries with nurse export, there is a lack of healthcare professionals, which in turn results in a lack of health care, an economic imbalance and vulnerability among people. Accordingly, in developing countries, nurse recruitment hinders people in their ability to make use of their political liberties. "**

Expert Nursing Practice

The concept of expert nursing practice comes from more than intuition or instinct, and it is the result of a complex pattern recognition process that occurs as a patient's presentation is subconsciously cross-referenced with the nurse's knowledge base. It is crucial that when we speak of pattern recognition, we are not describing our abilities in terms that imply good nurses are telepathic, medical intuitive or that our newly licensed members are too inexperienced to respond therapeutically in complex or critical situations.

Literature refers to pattern recognition as clinical judgment and focuses on the importance of the nurse's inner environment including past experience, the context or external environment, and the nurse-patient relationship or engagement.

Recognizing, articulating, and acting on the patterns we recognize with our patients are essential for ensuring those we work with are in the best environment and position for healing/health. Appreciating and building upon the wealth of knowledge that beginning students already have about what it means to care and be cared for would provide a unifying entry point for nursing studies, especially for programs that are currently organized using a body system/disease framework. ***Situated caring provides a rationale for everything from bed making to highly technical tasks.***

It provides a reason for holding someone's hand or making sure a draw sheet is wrinkle free and for calling an interdisciplinary team meeting or family conference to discuss how care could be best provided in challenging situations. ***Situated caring provides a motivating force for nurses to engage in political and policy issues, in their institutions and communities and at the state and national levels.*** Situated caring becomes a philosophy, a theory, and a context. In education, theory is often seen as divorced from practice, at least within the eyes of the students. Situated caring has the potential to become a part of every action, thought and perspective of each student and nurse.

Theory is not separated from but is integral to nursing praxis. ***An approach to discussing situated caring that would be especially appropriate for schools that emphasize evidence-based practice is to have students gather the evidence for nursing, as a discipline distinct from medicine, psychology, or social work.*** As a beginning exercise, this forces students and faculty to consider broadly what constitutes knowledge and evidence for practice.

This Concept-based education is not new and has been used effectively for decades to teach integrated nursing care related to concepts including aging, behavior change, comfort, culture, fluid and electrolyte imbalance, infection control, shock, spirituality, and transitions.

Curricular changes in nursing are progressively resulting in the elimination of courses and content in nursing theory and history at the undergraduate level. In actuality, knowledge and application of nursing theories, especially those that explicitly emphasize the unitary relationship between human beings and their internal and external environments, should be used to ground the introduction of courses such as genomics. [6, Rank 4]

The response to concerns about a lack of a theoretical base for nursing has created the current emphasis on mid-level theories related to concepts, including the model of behavior change or the theory of experienc-

ing transitions. While ***mid-range theories are considered more accessible to researchers and clinicians, they still require a nursing perspective that considers phenomena holistically, dynamically, and within context.*** How students conceptualize human beings and health, appreciate the impact of environment, and view the role of nursing are critical to their formation as nurses and essential to the development of health care providers with a unique and distinct perspective and approach to care within the multidisciplinary team.

Through an emphasis on integrality within the nursing meta-paradigm we can achieve the radical transformation called for on nursing education that require nursing students to learn to put their patients' experience in context, including the cultural background, the patient's environment, illness experience, and relationships with the patient and the family. [5, Rank 3]

The literature on Nurse practitioners and Physician assistants regulations across states and over time is limited and incomplete. No single source provides an accounting of the changes in Nurse practitioners and Physician assistants authority. Several studies have synthesized state Nurse practitioners' regulations but focus only on individual years and/ or a limited range of regulatory characteristics. They used data from the 2012 Pearson Report (which catalogues NP regulations by state) to present Nurse practitioners regulations in that year, as part of a discussion of proposals to increase Nurse practitioners authority intended to reduce the primary care shortage.

> **" The meta-language of nursing contains the basic building blocks or foundation for the discipline and profession of nursing. The basic elements of the discipline need to be explored from an integral or holistic nursing perspective throughout nursing education programs and especially in introductory and fundamentals courses. "**

One solution for change in nursing challenges is proposed which highlight that Global Networking can be used to design new education models that suit global healthcare needs, pooling teaching resources, designing and using databases across organizations to track and project faculty needs.(as shown in Figure 19)

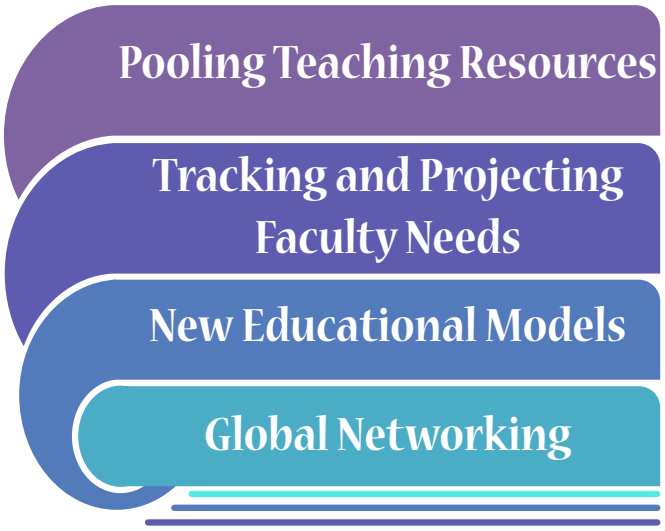

Figure 19: Changes in Nursing Challenges – How to Solve?

The Practice of Nursing as a Registered Nurse

Researchers used the 2007 Pearson Report and found that states that had only the state's Board of Nursing as a regulator granted Nurse practitioners more authority than states where the Board of Nursing shared regulatory authority with other groups (usually physician led). Researchers consulted each state's Board of Nursing to characterize Nurse practitioners regulations in 2001. They found that many states had recently broadened Nurse practitioners' scope-of-practice, specifically granting greater prescriptive authority. ***Researchers examined Nurse practitioners regulations over time, specifically those addressing Nurse practitioners ability to practice without physician oversight, and found that in states that allow independent Nurse practitioner practice there were more frequent routine checkups and less emergency room usage.***

Other studies look at the relationship between state Nurse practitioners regulation and various labor market outcomes but, again, only for individual years and/or a limited range of regulatory characteristics, for example, used the Pearson Report to look at the relationship between state regulations and growth in the nurse practitioners workforce. Researchers used Pearson data to examine the relationship between Nurse practitioners regulation of independent practice and/or prescription authority and receipt of primary care from Nurse practitioners by Medicare beneficiaries, finding that beneficiaries residing in less restrictive states had a greater likelihood of receiving care from nurse practitioners. Because state Nurse practitioners regulations were classified into three general levels of restrictiveness, detailed information on state regulation of Nurse practitioners was not reported.

Research on Physician assistant regulations is especially limited. Results indicate that Physician assistants were increasing in number, increasingly female, and increasingly subject to more stringent educational requirements. Few investigations examined trends in both Nurse prac-

titioners and Physician assistants' regulations, and in few instances is detailed information regarding specific regulations provided. This thorough examination of nurse practitioners and Physician assistant regulations across states over the 1990s found that NP and Physician assistants scope-of-practice increased over the 1990s, as did their use.

Nurse practitioners and Physician assistants scope-of-practice laws, if liberalized, would increase entry-to-practice, with positive benefits for patient outcomes. Thus, it is expected that providing ***Nurse practitioners and Physician assistants with increased prescriptive authority and the ability to practice with reduced levels of physician involvement should both enhance their ability to provide care and draw additional entrants into the field, thereby improving patient access to primary care.***

It is possible that concomitant adoption of more stringent educational requirements could, over the short term, serve as a barrier to aspiring Physician assistants and Physician assistants, thereby, reducing entry-to-practice, with adverse implications for patient access. On the other hand, since demand for professional services and inability of the medical profession to supply the demand has contributed to the development of the NP and Physician assistants professions, it is possible that in the future there could be graded levels of these midlevel professionals, akin to the distinction between associates degree-level physical/occupational therapy assistants from doctoral-level physical/occupational therapists. [3, Rank 5]

Nurses are the largest group of professionals within the global health care system, with a total of 19.3 million nursing and midwifery personnel in the world. The current and growing shortage of registered nurses (RNs) in health care systems is thus a global concern. In fact, the European Commission has estimated that there will be a shortage of 590,000 nurses by the year 2020. In the United States, employment of RNs is expected to grow faster than the expected average for all occupations. ***Most countries within the Organization for Economic Cooperation and Development (OECD) have reported a nursing shortage, which is predicted to get worse because the current nursing population is aging.*** This shortage of RNs influences the delivery of health care and negatively affects patient outcomes; an ***insufficient nurse staffing level is associated with negative patient outcomes and decreased nurse job satisfaction.***

From the society's and healthcare's points of view, professional turnover is a more significant form of work transitions

than organizational turnover. Those ***RNs, who are leaving the profession, are reducing the total number of nurses in the manpower, which has an impact on the present nursing shortage and is leading to a permanent loss of productivity. Nurses leaving the profession take their implicit knowledge, experience, and contribution from the organizations and also from the nursing workforce.***

The financial investments used on nurse's education, orientation, and continuing education are lost. Moreover, nurse turnover is also costly to organizations (as shown in Figure 20)

Figure 20: Nurses Turnover and Burden on Organisation

It results in the direct and indirect costs of filling the positions, and second, because of the loss of organizational productivity and knowledge. At the same time of this global nursing shortage, many nurses are considering leaving their job, profession or are out of the nursing workforce. Nurses' intention to leave the profession varied from 4% up to 54% across the studies internationally.

Turnover intention appears to be a multistage process consisting of psychological, cognitive, and behavioral components and has been found to predict the actual decision to leave the profession. (as shown in Figure 21)

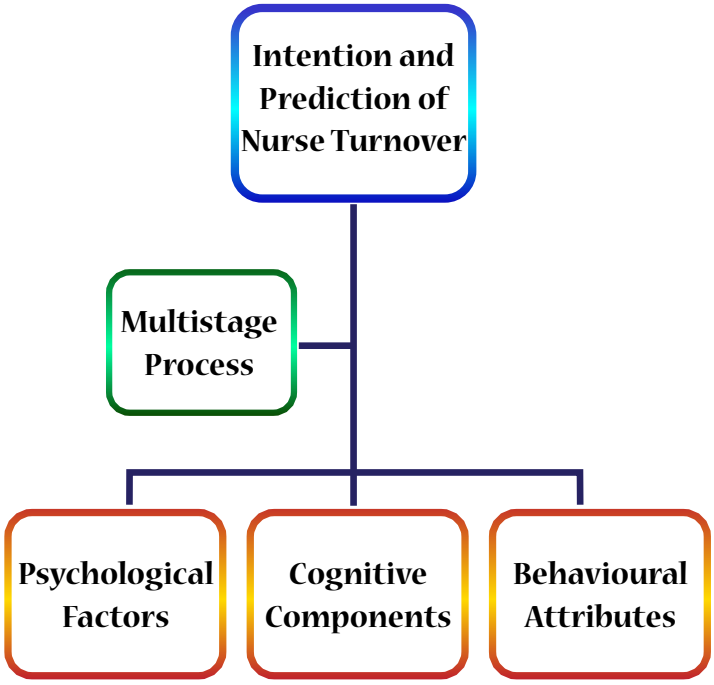

Figure 21: Nurses' Turn Over and Fcators Affecting Turnover Intention

The majority of leavers began the process with serious consideration in the final year preceding leaving, and the actual decision to leave was then made within the 6 months prior to determination. One year prior to changing careers, actual career changers were actively looking for a new career and had a high intention to leave their current job. Furthermore, another

study revealed that nurses left nursing within 6 months of their decision to leave. Several specific factors are related to young RNs' intentions to leave the profession (as

Figure 22: Nurses Turnover and Imbalance to Professional Standards

shown in Figure 22)

An imbalance of effort and reward, high psychological demands, and higher job strain, influence young nurses' intention to resign from their nursing careers and ultimately result in Professional standard deviations.

The final decision to leave the profession is likely to be the result of an individual reflection process with multiple underlying causes. The youngest generation of nurses are most willing to leave the job and the nursing profession. Researchers have reported that ***in the United States more RN graduates left their first nursing job (26%) than nursing profession (2%) during the first two years in career.*** According to a study, in most European countries the intent to leave the profession was highest in the age groups between 25 and 35 years of age. In another study, diploma-qualified nurses' movement into other activities was highest around the age of 28 and declined thereafter. The rate of leaving the nursing profession for a better job was highest at the age of 32. However, conflicting findings also exist. Also older nurses were having higher intention to leave the profession than younger nurses.

According to a study, graduates of a younger age are more vulnerable to early career burnout, which is associated with the intention to leave the profession. In another study, both the survey questionnaire and the open-ended questions showed that young nurses' intentions to leave the profession were connected with the highly demanding work, burnout and dissatisfaction with salary levels. [3, Rank 4]

Quality Improvement in Nursing Care Practices

A close examination of the process of intervention implementation suggests that it was successful in engaging practice members in developing a sense of shared purpose and identity that enabled some participants

to discover, envision and implement meaningful change objectives and learn from the change process. ***Quality Improvement (QI) is most likely to be embraced by members in practices where there is a perceived urgent practice need or concern, clear system and practice leadership support for change, a perception of flexibility around options for change, and, where there is a history of previous success implementing change.***

First, the current conditions of daily practice often impede practice change. Primary care practices face tremendous productivity pressures in today's health care environment. In addition, practice resources are shallow. In the current stretched-thin environment, practices have limited capacity for change. They are under strong pressure just to get through and survive the day. Thus, even if motivation is generated by the initial stages, competing demands and limitations mitigate against being able to translate this motivation and vision into changes that may make more work in the short term, even if they have the potential to be beneficial in the long term.

Second, the approach was a compromise on two levels. Logistically, the Quality Improvement intervention was squeezed into busy practice days, rather than rolled out in off-site day-long or multi-day retreats, as it typically has been used in industry. Embedding the introduction and implementation of the intervention within usual work days was necessary to achieve the initial buy-in of staff members at busy participating practices. Yet, the truncated schedule meant abbreviating important elements of the Quality Improvement process; the crafting of a resonate change topic and the sharing of personal stories that are both the source of new organizational images and set a climate for collective dreaming by helping people open up about deeply held desires and yearnings.

> **" Evidence-based practice in nursing has been defined as patient-centered care that integrates the evidence available, nursing expertise, and the values and preferences of the individuals, families, and communities who are served which takes place within the context of the practitioner-patient interaction and relationship, which involves knowing the patient, empathy, and trust. "**

Furthermore, schedule restrictions meant that the intervention did not necessarily have the time to generate buy-in and strong instrumental support of the practice and systems leaders (a key initial condition

for practice engagement) or allow motivated, engaged practice participants to gain a sense that the envisioned changes could be supported in day-to-day practice. This adapted approach may have impeded the effectiveness of Quality Improvement and discouraged practices from initiating truly transformative change by encouraging a quick and easy change objective.

Additionally, in order to try to find a balance between changes that were fully practice-initiated and those that related specifically to preventive service delivery, we engaged practices in two Quality Improvement cycles: the first on a totally practice-initiated topic, the second on preventive service delivery. A shared motivation among practice members is considered important for quality improvement success, however, many practices found the topic less engaging than the change objective that they self-identified as being more important. The compromise of trying to rush through two topics in already over-extended practices may have been self-defeating.

The familiarity and comfort with Appreciative Inquiry may not have been strong enough to make the researchers proficient at adapting the approach to an untried setting and timeframe. The training and previous exposure to the process were around two to three day intensive intervention retreats in business settings and skill at helping to craft an affirmative topic that is strategic, attractive and positive instead of problem focused were un-tested. In successful examples of Quality Improvement, the management and leadership of organizations were intensely involved in setting the appreciative topic and throughout the design and implementation stages. Additionally, a goal of Quality Improvement is to change the way people talk about and perceive their organization, to generate a new, or at least expanded self image that plays out in how people perform. The timeframe, the practice's availability, and the initial study time spent identifying practice change objectives made their approach ill-suited to molding practice culture or facilitating the transformational changes that Quality Improvement has produced for others.

One way to act on these interpretations of the findings would be to apply Quality Improvement only in highly selected settings in which time, high-level buy-in and follow-through resources are present. There are hopeful signs that when primary care practices are given reduced workloads they are more able to make substantial practice inprovements. System changes that provide primary care with the time and resources necessary to fulfill its essential role in a functional health care system will provide increased opportunities for application of study findings.

Another approach is to build on what has been learned here about when the Quality Improvement process may be most helpful, and how it can be tailored to the unique characteristics of each setting. A quality Improvement topic that reflects a shared practice vision and purpose is more engaging to practices than an externally decided change topic. In particular, this service could not be searched because you are not connected to the Internet. Please connect and try again. process can be helpful to practices needing to address issues where self-reflection and clarity of practice values are important. A topic reflecting shared values can energize people on a personal, meaningful level and allow practice members to coalesce around a common goal.

Figure 23: Challenges in Quality Improvement Process

Based upon the level of enthusiasm they observed in practices when a shared vision was identified it may be an important consideration when trying to choose and implement a practice improvement. Further study incorporating efforts to uncover and take advantage of existing practice motivations, in addition to finding ways to develop enabling practice conditions, may inform the development of creative multi-faceted interventions that can better mesh with external guideline goals to improve quality management in healthcare. [10, Rank 3]

Multifaceted Capabilities of Trained Nurses

This sub-theme also ***emphasizes increasing course credits with a content of policymaking in the health system in order to acquire multifaceted capabilities and train nurse managers with policymaking abilities especially at the top policymaking levels.*** It is evident that nurses who have acquired skills and knowledge in areas related to nursing, such as, teaching, research, management, and even areas such as, epidemiology, health economics, etc., have a better chance at entering policymaking fields. With regard to nursing education at the master's level and the nursing level, there is a shortage of trained nurses with master's degrees who can assume social responsibilities in the name of nurse leaders in order to

further advance the healthcare system, and at the PhD level, there is a shortage of training in policy analysis, research in policymaking fields and models.

Researchers have emphasized the addition of public health policymaking courses for a better understanding of policymaking processes as a major need of preparing nurses at the graduate level. So far, various programs have been designed with the purpose of preparing nurses or nurse managers for a more effective and active presence in policymaking fields, management and for revision making. In Florida, nurse managers and students can also benefit from these programs in graduate studies. For example, the Leadership for Change program is mostly the reinforcement of leadership skills and change management, Nevertheless, for gaining more benefit from the Leadership for Change program, taking some other courses are also necessary, such as courses in the Management Business Organization (MBO), mini-MBOs, health policymaking, health economics and entrepreneurship.

We should not forget that these courses do not easily provide us with the prerequisites for entering the field of nursing policymaking; in fact, entering this field requires a series of capabilities, which is only partially reinforced through these courses. On the same note, it is true that policymaking has its own particular theoretical foundations and that we need to boost our brain if we are to advance in policymaking; yet, policymaking is not merely an intellectual activity; more than anything, it is a practical tool for making changes.

Nursing rule addresses one of these courses in his article titled Leadership Empowerment Organization (LEO), and writes, although programs like the LEO have strengthened the managerial skills of nurse managers, we cannot expect anyone to be an influential clinical manager just by passing these courses, as this end will only be achieved by using practical opportunities to show leadership prowess. In other words, we have to see if the hats have been altered or the heads as well. Years spent on fulfilling nursing credits might have kept some students away from the mission and goals of the discipline of nursing and the purpose of training nursing workforce. This change in beliefs has affected their participation in areas of decision-making for nursing and patient issues.

In a study on the preparation of nursing students for future presence in the domain of policymaking, researchers conclude that, without training students who believe in nursing, conditions will not be provided for the future presence of nurses in the policymaking domains. They there-

fore consider strengthening the students' belief in nursing a prerequisite for preparation programs. Findings of a study also show that, since faculty members and the educated class of nurses -a class to which nursing policymakers also generally belong- have acquired new titles, they no longer wish to carry the title of nurse. In our society, the nursing title can facilitate the acceptance of the nurses' opinions in decision-making and policymaking sessions.

Nevertheless, this title has not greatly resulted in the growth of nurses' participation in decision-making processes. In a study conducted, it is argued that there is a greater expectation of nurses with titles to participate in policymaking debates, since they possess a broader viewpoint. But it seems that, despite their degrees and education, the performance of these nurses has not changed much with regard to policymaking processes. The present study addresses another performance aspect of nursing graduates, that is, the lack of confidence in their practical skills, both in terms of patient safety and role-modelling in nursing.

Clinical settings form the first place all nurses walk into as nursing students. ***The practical skills of nursing graduates often working as nursing instructors can lay the foundation of patient safety and role-model setting in the nursing profession for nursing students.*** In another study one participant quoted Nurses with titles only possess theoretical knowledge and therefore cannot participate in clinical functions. There is thus not much hope for them to improve the clinical performance of nurses.

> **"Clinical nurses with novel, practical ideas for bringing about change to the structure of nursing can also be periodically invited to participate in policymaking sessions for practice standards improvement"**

In other study conducted, the lack of top-notch instructors for guiding and supervising students, unsuitable role-model setting, shortage of nurses with graduate degrees in clinical settings and the contrast between knowledge and performance in clinical settings have been highlighted. Policymaking from an educational perspective and the remoteness of policymakers from clinical settings comprised another issue raised by participants of a study, which is particularly effective in the clinical practicality of the policies and decisions made. Wherever nursing leaders were engaged in clinical management, they acquired more

benefits from policymaking sessions on clinical issues.

A look at the composition of nursing board members at the state level in the United States also shows operational level presence at this position. Although the composition of members depends on state laws, it often includes people from various academic and occupational levels. For instance, state boards are mostly composed of Registered Nurses and Advanced Practice Registered Nurses, and to a lesser extent, Licensed Practical/Vocational Nurses with lower academic degrees and occasionally Consumers or patients as well.

A large part of general deficiencies in nursing education pertain to the foundation of nursing education in our country. In US, nursing education does not provide the conditions in which nurses are trained in a way that they acquire primary capabilities for an active presence in decision-making domains.

One of the most crucial capabilities that should be conveyed to the students through nursing education is skillfulness and specialization in the science of care, by means of which nurses can appear in nursing policymaking domains of the health system with greater dignity as specialists in the area of care. Researchers considered the existence of bits and pieces from the biomedical education system deep within nursing education as responsible for the failure to properly transfer the knowledge of care to students.

The educational method used for nursing education has been modeled after medical education and is based on teaching diseases rather than care issues caused by the disease. Since the third decade of the 19th century, physicians established nursing programs to provide services to physicians in treating patients. This medical training model mostly emphasizes nursing duties and techniques rather than the process of care. The obvious outcome of this role-model setting is fostering obedience in nurses. Such nurses will rarely be able to participate in professional decision-makings by applying critical thinking.

An impediment to the participation of nurses in clinical decision-makings is the educational policy in which nursing education follows the role of medical education. It is asserted that nurses should themselves be the founders of theories and methods for improving the quality of nursing education. Researchers also point out the biomedical educational structure in nursing instructors' method of teaching.

Quoting a nursing student, they write, teachers allocate a large proportion of a two-hour session of class to explaining and

emphasizing diseases and their pathophysiology and mostly convey medical information, so that when they switch their focus to topics of nursing care, the students are no longer in the mood to listen. Poor community feedback on nursing policymaking was proposed by the present study as another deficiency in nursing education. When nursing education policies reflect the health needs of the community, they will appear more prominently on the agenda of macro policymakers. [9, Rank 5]

Comparison of Regulations with Other Streams in Health Care

Many states increased entry-to-practice requirements. Institution of more stringent educational requirements of Nurse practitioners (NP) and Physician assistants (PA) may improve quality and efficiency, while increased practice authority may facilitate greater use of Nurse practitioners and Physician assistants as a strategy for addressing the primary care gap facing the nation. Since this gap is expected to grow as health insurance coverage becomes more widely available, monitoring the regulatory trends in Nurse practitioners and Physician assistants practice is important.

Nurse practitioners and Physician assistants regulations have varied widely across states and over time. This variation permits studies that assess the impact of state policies affecting Nurse practitioners and Physician assistants practice on patient access, cost, and quality. Such studies are needed in order to understand how to best shape regulations to achieve better patient care. Some research along this line has already been conducted; for example, previous research suggests that states with restrictive Nurse practitioners regulations had lower rates of Nurse practitioners workforce growth, whereas states with less restrictive regulations had more patients who received primary care from Nurse practitioners.

Additionally, research has examined labor market impacts of Nurse practitioners regulation. One study using Current Population Survey data found that ***in states where Nurse practitioners had higher levels of autonomy, physicians and Nurse practitioners earned less, while Physician assistants earned more.*** The authors hypothesized that this happens because when Nurse practitioners were granted high levels of autonomy, physicians were less likely to hire them and more likely to hire Physician assistants because they did not want to share responsibility for providing care with Nurse practitioners. On the other hand, Physician assistants were more likely to be hired as they are required to be under the supervision of a physician.

Other research, also relying on

nationally representative data sources, found that greater Nurse practitioners authority increases Nurse practitioners income, reduces physician income, and has a differential impact on Physician assistants income. In contrast, increased Physician assistants authority had little effect on Physician assistants income but was associated with reduced NP and increased physician income. Importantly, cross-state variation may impact overall system performance to the extent that states with more stringent regulations do not benefit as much from the high quality, low cost care that NPs and Physician assistants provide.

It is important to note that the extent to which Nurse practitioners and Physician assistants provide patient care depends, in part, on factors other than scope-of-practice, including, for example, the impact of insurance reimbursement practices on provider income. Future research should consider the relative importance of Nurse practitioners and Physician assistants reimbursement, scope-of-practice, and other considerations in impacting both the attractiveness of entering the profession to potential Nurse practitioners and Physician assistants, as well as the extent to which Nurse practitioners and Physician assistants can be used to meet national needs. It may be the prevailing mix of payment and regulation that results in differential use of Nurse practitioners and Physician assistants across states, and that keeps Nurse practitioners and Physician assistants from practicing up to their fullest potential in helping to meet the nation's primary care needs.

"According to the US Centers for Disease Control and Prevention (CDC) national surveys conducted between 2002 and 2012, one-third of adults and 12% of children and adolescents in the United States use complementary and alternative medicine (CAM). The Institute of Medicine has recommended that all healthcare providers become familiar with CAM approaches, so they can properly counsel their patients regarding their use."

The regulation of Nurse practitioners and Physician assistants differs, and as a consequence, the information available for the two varies somewhat, with, for example, participation in an accredited program being a dimension of Physician assistants but not Nurse practitioners regulation. Differences such as this preclude uniform apple-to-apple comparisons of state regulatory regimes toward Nurse practitioners and Physician assistants . This was problematic because the published reports presented regulations in consistent, and thus comparable and more quantifiable ways, but the laws

and regulations the reports were abstracted from were less clear and easily interpretable. It is possible that the compilers of these reports and the authors of this article interpreted specific laws in different ways.

Nevertheless, the data reported in this article present a detailed picture of how state practice regulations developed during the first decade of the 21st century. It provides researchers with a more nuanced sense of regulatory change than the older, more limited data used in prior investigations. The current data are also important because they permit a better understanding of the different regulations of Nurse practitioners and Physician assistants . Future research could use this information to develop an overall measure of regulatory stringency which can be tracked over time. Research could also use this information to better understand the political, economic, social, and programmatic factors that result in the adoption of specific Nurse practitioners and Physician assistants regulations, or changes in overall regulatory stringency, across states over time.

This would result in a better understanding of the characteristics of states that lead to more or less restrictive regulatory policies affecting the use of Nurse practitioners and Physician assistants . ***The great deal of regulatory variability could also be used to study relationships among overall regulatory stringency and specific state regulations, the primary care workforce, and other indicators of system performance such as cost, quality, and access.*** Results from these studies could inform policy about best practices, with respect to regulatory regimes that lead to the most desirable outcomes, including closing the gap between demand and supply in primary care. [6, Rank 5]

Nursing Competencies in Integrative Primary Healthcare

Integrative healthcare (IH) reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing. By definition, ***IH addresses the biomedical as well as sociocultural determinants of health and takes a broad view of health creation and disease prevention.*** In focusing on prevention, patient empowerment and activation, and treating not only the patient but the family and the community, ***IH has the potential to significantly contribute to the prevention and treatment of many if not all of the chronic health problems causing morbidity and mortality in our society today, including obesity, cancer, cardiovascular***

disease, diabetes, violence, and depression.

Integrative health includes both conventional and licensed complementary and alternative medicine (CAM) practitioners. Published evidence is accumulating regarding both the clinical effectiveness5 and cost effectiveness of IH. Yet due to a shortage of trained providers and limited resources, the principles and practice of IH have not been widely incorporated into the conventional healthcare delivery system in the United States. This is particularly true for the medically underserved communities most at risk for health disparities.

To address this gap in access to Integrative health-care, the federal ***Health Resources and Services Administration (HRSA) during the past 4 years has supported an educational initiative to incorporate evidence-based integrative medicine curricula.*** (as shown in Table 2)

Addressing CAM challenges : Evidence based for health professionals	
Goal: Developing a core set of IH competencies and educational programs that will span the inter professional primary care training and practice spectra to help produce a workforce prepared to close this gap	
INITIATIVES	*Preventive medicine residency education*
	Expansion of primary care with complementary and alternative approaches
	Health professions training programs
	Inter professional learning strategies..
	Specific training for practitioners for applications of integrative medicine

Table 2: Addressing CAM Challenges for Practitioners

HRSA funding was awarded to the University of Arizona Center for Integrative Medicine which, in collaboration with the Academic Consortium for Integrative Health and Medicine (the Consortium), has now established the National Center for Integrative Primary Healthcare (NCIPH).

The ultimate goal of the NCIPH is education of interprofessional teams that will be highly effective in embedding the principles of IH with a focus on prevention and elimination of health disparities in primary care. This goal is especially critical given the shifts in the healthcare landscape being brought about by the implementation of the Affordable Care Act (ACA).

As our healthcare system struggles to provide quality care for more than 30 million potential new patients and moves toward team-based, collaborative, interprofessional care with a stronger emphasis on

prevention, it becomes more critical that our primary care workforce be versed in the principles of whole-person, patient-centered, integrative health. New skills needed for IH-trained practitioners include these principles (as shown in Figure 24)

Figure 24: Advanced Skills for an Integrative Health Practitioner

These are just a few of the core skills of Integrative health care that have generally been absent or underemphasized in conventional primary care training, yet they are critical for successful functioning in the new healthcare delivery model

The National Center for Integrative Primary Healthcare will advance the incorporation of competency and evidence-based IH curricula and best practices into primary care education and practice. Targeted primary care disciplines include family medicine, internal medicine, pediatrics, preventive medicine, nursing, public health, behavioral medicine, pharmacy, chiropractic, acupuncture, naturopathy, physician assistants, nutrition, and others. In order to accomplish our goal of building effective and knowledgeable interprofessional integrative team care and to begin to break down the storage that divide the professions in terms of training and practice standards, the National Center for Integrative Primary Healthcare leadership made a strategic decision to engage as wide a spectrum as possible of professions involved in primary care to create a common set of competencies in IH. [7, Rank 4]

Identification of Facilitators and Obstacles of Integrative Health Competencies

To identify the potential facilitators and obstacles to adoption of the meta-competencies and discipline-specific sub-competencies within the participating disciplines, a competencies adoption questionnaire was created. The questionnaire was designed as a tool for mapping the initial competencies adoption strategy for each discipline and then following that process

over time. Responses were discussed at the meeting and stimulated a brainstorming process around adoption among attendees. Despite the diversity of fields represented and varying degrees of development of integrative health competencies in the fields, several common themes emerged from this informal analysis. ***The necessity of wide dissemination via multiple avenues was a common goal and identified as an important factor in promoting adoption.*** Dissemination strategies ranged from traditional avenues such as publications and presentations at national conferences to more grassroots avenues such as lectures, networking with colleagues, faculty and program directors, and working within professional organizations to garner support.

Suggestions for widespread dissemination included obtaining the support of specific influential organizations, such as national councils of colleges or educational organizations, accrediting bodies and program directors, and aligning sub-competencies with educational goals and competencies of national organizations within the field. Specific attributes of the proposed curriculum thought to facilitate adoption were identified, including high-quality content, cost, ease of use, and ability to meet an existing curricular need. Systemic factors influencing adoption, including the presence of an evidence base for curriculum content and the need for reimbursement for IH services in primary care, were also identified. Readiness for adoption ratings ranged from 3 to 10, with an average of 7 indicating that most participants believed fields were leaning toward adoption.

Obstacles to adoption were also identified. The most frequently mentioned pertained to competing priorities and finding time in the curriculum. Also mentioned was a lack of knowledge of or interest in IH. Bias against or resistance to IH principles was also viewed as an obstacle. Curriculum attributes such as medically-focused language, educational level, and implementation costs may either facilitate or impede adoption.

As the competencies adoption process described above indicates, although we have

> **" The development of the new evolving infrastructure for healthcare in the United States—based on the medical/ health home model and the role of Accountable Care Organizations that will focus on prevention and patient engagement as strategies to control cost and deliver quality care—provides a tremendous opportunity to incorporate INTEGRATIVE HEALTH care principles more deeply into our system. "**

succeeded in developing a set of consensus competencies for the primary care professions in IH, the next phase of the National Center for Integrative Primary Healthcare curriculum project promises new challenges. The competencies will have an impact only if they are coupled with a high-quality, relevant curriculum that can be incorporated into primary care training programs across the country in order to prepare trainees to actually become competent in integrative health. The National Center for Integrative Primary Healthcare curriculum team is now working to develop an online program keyed to the interprofessional meta-competencies, which will be piloted later this year in training programs and subsequently revised and refined for wider distribution.

A number of potential barriers will need to be addressed during the course of this project, including finding time in already overloaded schedules, securing buy-in and commitment from overextended faculty and program directors, and addressing the lingering criticisms of integrative health as non–evidence-based that persist in some sectors of the primary care system. One major challenge in the implementation of this new curriculum will be the fact that, as we have learned from other curriculum development projects such as the Integrative Medicine in Residency programs for family medicine and pediatrics, gaps in training programs cannot be filled by online educational content alone.

Significant attention must also be paid to developing needed onsite experiential and clinical activities in order to assess the impact of the knowledge in IH skills. Faculty development to prepare onsite faculty for this role is an essential piece of this process as well. A final challenge will be the development of effective strategies to assist educators in measuring the degree to which their learners have mastered the competencies. Despite these challenges, our intent is that these competencies will become required material for all primary healthcare professions, embraced by accrediting agencies as a critical and necessary element of primary healthcare training, and that the availability of a high-quality, evidence-based curriculum will facilitate the implementation of these competencies with long-term benefit to the healthcare system. [9, Rank 4]

Preventive Role of Practicing Nurse

The integration of more into primary care can affect cancer screening and recommendations in several different ways. This integration has the potential to increase the overall percentage of the population ever receiving specific cancer prevention and screening recommendations, as was shown

in an intervention study included in this review. For example, colorectal cancer screening uptake in the US is substantially lower than for breast or cervical cancer screening. The US Preventive Services Task Force (USPSTF) recommends any of three different tests for colorectal cancer.

In the descriptive or intervention research they identified, only 15 studies during a 21 year period, Advanced Practice Registered Nurse (APRN) /Physician assistants are involved in recommending screening and prevention. The limited research is somewhat surprising, because a team approach, including physicians and APRN/Physician assistants, has long been recommended for improving healthcare. After receiving the appropriate training, Advanced Practicing Registered Nurses expect to provide or recommend chronic disesaes preventive interventions such as Pap tests, mammograms and Fecal Occult Blood Test (FOBT) while studies only reported on physicians working concurrently with other practitioners to screen for cervical cancer and colorectal cancer. With the enactment of the Affordable Care Act, millions of previously uninsured or underinsured will gain access to healthcare. A better understanding of the potential roles of APRN/PAs in meeting this demand for cancer prevention and screening is critical.

These tests have different screening intervals, involvement of specialists, levels of invasiveness and other characteristics, potentially requiring detailed discussion to allow patients to make informed decisions about screening. Currently, less than 25% of physicians report actually working with Advanced Practicing Registered Nurse to provide colorectal cancer screening. However, ***one challenge with moving forward with team-based health care is that physicians do not always want to work with nurse practitioners.***

In a time constrained primary care setting, Advanced Practice Registered Nurse might play a critical role in improving discussion about options and ultimately improving uptake of chronic diseases and cancers. Alternatively, research featuring Advanced Practicing Registered Nurse might focus on improving all aspects of cancer control among specific populations, such as those previously uninsured or with key risk factors.

Lack of health insurance and lack of prior screening has been consistently associated with late stage of disease at diagnosis for breast, cervical, and colorectal cancer. Tobacco use and obesity are associated with many chronic diseases and the role of Advanced Practicing Registered Nurse in encouraging healthy behaviors could

improve a variety of health outcomes of the US population. Future research is needed that investigates that relationship between a visit with an Advanced Practicing Registered Nurse and other primary care provider types within team-based primary care that oversamples racial and ethnic minorities and lower socioeconomic status populations.

Most of the studies were cross-sectional and did not assess cancer prevention or screening outcomes longitudinally. Surprisingly, only three studies reported results of interventions, therefore not allowing for a quantitative analysis of using Advanced Practice Registered Nurse for cancer screening or prevention recommendations. Few reported the type of Advanced Practice Registered Nurse or Physician assistant provider separately, included comparison groups, or were based on well-described samples. In addition, studies that did include comparison groups did not consistently report on statistical significance of comparisons.

Inconsistencies in outcome measure reporting among these studies impacted our ability to compare guideline adherence and patient populations. Few studies evaluated whether screening recommendations were consistent with evidence-based guidelines for patient age at initiation or frequency. This is particularly important because both overuse and underuse of screening can have adverse patient outcomes. Most of the studies neglected to report patient demographics or key covariates, such as weight, body mass index, and comorbidities, hindering our ability to determine if either physicians or Advanced Practicing Registered Nurse are providing cancer screening based on guidelines.

Outcome measures were most commonly reported using either provider or patient self-reported data about recommendations and did not report on receipt of service or a documented change in behavior. Further, primary care addresses multiple preventive services, but only about half of the studies included more than one aspect of cancer control and no studies address post-treatment survivorship care. Future research should address these limitations and be conducted in longitudinal cohorts with comparison groups of well-described provider types, document patient receipt of screening or prevention recommendations, and assess multiple cancer control recommendations. Use of standardized measures, including for patient characteristics associated with guideline recommendations, evaluation of guideline adherence and longer term patient outcomes will also be important.

The studies we identified were fairly heterogeneous in terms of patient populations, geographic region, provider type, and

type of a comparison group. Additionally, included studies used a variety of approaches to measure cancer screening and prevention, such as physician, non-physician provider and patient self-report. As a result, synthesis of findings was descriptive rather than quantitative. Findings are generalizable only to the primary care setting. [6, Rank 3]

Capacity Building Through Evidence Based Practices (EBP) from Nursing Process

It is within the purview of the Central Nursing Organization (CNO) and other senior nursing leaders to define the organization's mission and culture for nursing scholarship. Given the well-articulated barriers to evidence based practice gleaned from the literature, it is no wonder that it can take years to translate the evidence into practice. Therefore, this ***leadership team plays a pivotal role in narrowing this gap by building the capacity for nursing scholarship.***

Senior Nursing Leaders Responsibilities

It is ultimately the responsibility of the Central Nursing Organization supported by other senior nurse leaders, to overcome individual and organizational barriers to evidence based practice ***At the helm of successful hospital-based nursing research and evidence based practice programs are nursing leaders who have made it their mission to make evidence based practice transparent across all nursing roles.*** They accomplish this mission by implementing a comprehensive infrastructure that builds and sustains the capacity for innovative, evidence-based nursing practices. As a result, these organizations achieve exemplary outcomes for both nurses and patients.

In settings where nursing scholarship is truly embraced, nursing leaders foster a culture shift in the day-to-day practice of the nurse. Nursing care that is steeped in tradition is no longer acceptable. The new norm establishes an expectation that nurses question their practice, seek answers from the best evidence, and apply it to their practice. When evidence is lacking, nurses are charged with using the research process to generate and disseminate new knowledge that may ultimately lead to innovations in practice.

Building the Capacity for Scholarly Work

Building the capacity for scholarly work of the nursing staff requires a major redesign of the nursing infrastructure. Tradition-based hierarchical models in which staff nurses are the least empowered of all nurses to make practice decisions are abandoned for a collaborative governance structure (CGS). The CGS is based on the belief that staff nurses own their practice and are responsible for advancing and sustaining it. This paradigm shift gives

staff nurses the authority and accountability for making practice decisions that are guided by the results of research and other sources of evidence.

The creation of a collaborative governance structure involves implementing new structures and processes, as well as the addition of material and human resources needed to support the scholarly work of the nurse. New committees and advisory councils, including a nursing research committee (NRC), are established. Communication processes are defined to facilitate interactions among nursing departments and the various collaborative governance structure committees and advisory councils. Many organizations involved in this work recommend that an evidence based practice model be selected to guild the evidence based practice and research processes. Building the capacity for advancing the scholarly work of staff nurses takes time. It may be at least 3 to 5 years before organizations garner the benefits of this work, as evidenced by increasing numbers of nurses from all levels of the organization fully engaged in finding answers to pressing clinical questions through their involvement in evidence based practice and research projects. [3, Rank 4]

Barriers to Evidence-Based Research at Nursing Level

Despite the external and internal motivators for staff nurses to be involved in Evidence Based Projects (EBP) and research, there is a plethora of reasons, at both the individual and organizational level, that create barriers for staff nurses in the acute care setting. Although staff nurses frequently need information to support daily practice and have access to health science libraries, they rarely use them. They are more likely to ask peers or access the Internet rather than use the library or search electronic databases. For those nurses who know how to access the evidence, the volume of literature available for consideration is overwhelming. The demands associated with patient care limit the time nurses have to become involved in EBP activities during scheduled work hours. Staff nurses have reported that they lack the knowledge and skill necessary to formulate searchable clinical questions, conduct literature searches, critique and synthesize the literature, and change practice based on the evidence. Negative attitudes about research make nurses less likely to participate in projects designed to advance nursing practice.

Another frequently cited barrier has to do with nurses' self-reported lack of confidence in their ability to engage in EBP. This barrier relates directly to nurses' educational preparation. With the aging nursing workforce, many staff nurses are graduates of nursing schools in which the curriculum did not emphasize EBP and research. In a recent study, there was a significant differ-

ence between the views of nurses having a baccalaureate or higher degree in nursing compared with their diploma and associate degree peers. The former group had a stronger belief that nursing should be a research-based profession and that EBP is essential for professional nursing practice.

These knowledge gaps and attitudinal differences among staff nurses are further exacerbated by practicing in organizations that lack adequately prepared nurses to mentor staff through the EBP or research process. Insurmountable barriers to EBP are a result of additional organizational characteristics and cultures. Impediments for staff nurses include working in organizations that fail to value EBP, allocate protected staff time and resources to support scholarly work, or promote nurses' autonomy to change practice. [10, Rank 3]

Current and Future Challenges on Nursing regulations

Regulatory Scope of Practice for Advanced Practice Nurses

Both nurse practitioner and Clinical nurse specialists are considered advanced practice nurses. ***Nurse practitioners are defined as RNs who have additional education in recognized programs, preferably at the graduate level.*** They demonstrate advanced competencies to practice autonomously and collaboratively to perform assessments, order laboratory and diagnostic tests, diagnose, prescribe medications and treatments, and perform procedures, as authorized by legislation and their regulatory scope of practice, as well as performing an advanced nursing role that includes consultation, collaboration, education, research, and leadership.

Clinical nurse specialists are registered nurses (RNs) with a graduate degree in nursing who have expertise in a clinical specialty and perform an advanced nursing role that includes practice, consultation, collaboration, education, research, and leadership.

Nurse practitioners and Clinical nurse specialists function in alternative or complementary provider roles. Those working in alternative roles provide similar services to those for whom they are substituting, usually physicians. Those working in complementary roles provide additional services that are intended to complement or extend existing services. The intention of the alternative role is typically to reduce cost or workload or to address workforce shortages while maintaining or improving the quality of care; in contrast, the intention of the complementary role is to improve the quality of care.

Nurse practitioners improved resource utilization and access to care,

increased primary care services in the community, and reduced costs. Over the past few years, a number of literature reviews and systematic reviews have summarized the findings of studies evaluating nurse practitioner s. The reviews have consistently shown no difference in the health outcomes of patients receiving nurse practitioner care when compared to patients receiving physician care, but often both quality of care and patient satisfaction are higher with nurse practitioner care.

Researchers reporting RCTs (Randomized control trials) may also find the following recommendations helpful. A clear brief description of the sequence generation (e.g., random number table; computer random number generator) is needed to allow the reader to determine if the process should provide comparable groups. A description of allocation concealment (e.g., sequentially numbered, opaque, and sealed envelope) is important for the reader to determine if allocation to groups could be manipulated.

While blinding of participants is not possible in a study incorporating nurse practitioner s or Clinical nurse specialists , a description of procedures used to blind outcome assessors and/ or the description of valid outcome measures is needed to assess the quality of the study.

Completeness of outcome data for each outcome measure and group, including the description of missing data and details of all participants excluded, lost to follow-up (e.g., dropped out of study or died), or reincluded at each stage, also needs to be reported. If researchers do not report outcomes that were measured or key outcomes that would be expected, a clear description is needed of the reasons for failing to report the outcome. [6, Rank 5]

Addressing Disparities in Nursing Access Among Diverse Populations

Ethnically diverse and medically underserved populations are deprived of potentially beneficial approaches when their health-care team lacks training. For example, the NCIPH (National Center for Integrative Primary Healthcare curriculum) will train primary care professionals to offer sound advice on such topics as herb-medication interactions; dietary supplement contamination and adulteration; the role of mind-body therapies in treatment of chronic pain and stress-related conditions; and the applications of acupuncture, manual, and movement therapies. [8, Rank 5]

Although complementary and integrative therapies are used by approximately one third of US adults, use among most minorities and individuals with lower income or education is less common.

For example, in 2012, 38% of non-Hispanic whites reported complementary and alternative medicine use in contrast to only 19% of blacks and 22% of Hispanics. Using yoga as an exemplar, national usage increased substantially from 3.8% in 1998 to 8.4% in 2012. However, in 2007 yoga was used by 6.5% of whites vs 3.3% of blacks; 6.6% of non-Hispanics vs 2.9% of Hispanics; 9.5% in college-educated individuals vs 1.9% in non–college educated individuals; and 8.6% of individuals in the highest income quartile vs 4.9% of individuals in the lowest quartile.

Barriers to accessing complementary and integrative therapies among diverse populations include affordability, availability, and awareness. Limited disposable income, lack of integrative services in low-income, racially diverse neighbourhoods, and lack of knowledge about integrative health often prevent low–socioeconomic status minority populations from benefitting from complementary and integrative therapies. This disparity is concerning given increased evidence of the safety and effectiveness of different complementary and integrative therapies. For example, yoga is now considered moderately effective and safe for chronic low back pain, which disproportionately impacts racial and economically diverse populations.

Moreover, racially diverse populations are amenable to trying new integrative approaches if they are made affordable and available and if patients are made aware of and understand them. As federal, private, and academic stakeholders invest millions of dollars into integrative health research, education, and clinical services, it is imperative that diverse socioeconomic and multicultural communities and vulnerable populations have equal access to evidence-based complementary and integrative therapies.

The National Center for Integrative Primary Healthcare curriculum will provide adequate training in integrative primary healthcare to the interprofessional workforce and offer services to these patient populations, particularly in federally qualified community health centers. This will address multiple challenges. Vulnerable patient populations experience risk from potential interactions and adverse effects of some integrative approaches when their primary care providers are not routinely trained in complementary and integrative therapies.

Establishing and Maintaining Confidence Among Advanced Practice Nurses

Advanced practice nurses gained confidence from participation in further training and this assurance was noticeable to colleagues and clients. However, researchers found that ***professional development played virtually no part in solidifying the***

role of the advanced practice nurse within general practices. Nurse Practitioners and specialists like Diabetic Nurse Educators (DNEs) who, by the nature of their position, had more education than other nurses in the practice, believed that the path to recognisable status was increasingly independent practice. They resented practicing nurses being given extended duties after they had completed a relatively small amount of training that was mostly funded by the practice. They also believed that this devalued their on the job training and more comprehensive, self-funded education, giving the advanced practice nurses the impression that practice decision makers did not value the nurse's overall worth to the general practice particularly highly.

Figure 20: Nurses Turnover and Burden on Organisation

Strengthening the field of advanced practice nursing requires certain elements (as shown in Figure 25)

Eliminating boundaries between general practitioners and advanced practice nurses

Clarification was both a means of strengthening and weakening boundaries between General practitioners and advanced practice nurses. In practices where there was a mature relationship between the two, clarifications was an empowering force that kept communication channels open and provided opportunities for wider consultation about matters central to the running of the practice. However, other associations were not so productive. In these relationships, advanced practice nurses used clarification as a means of rebuilding their own confidence. This only resulted in trivialising the duties of the advanced practice nurse to the extent that they had to be formalised in a more detailed way with protocols.

Establishing and maintaining the value of advanced practice nursing

An unexpected finding was the dialectic verbalised by general practitioners concerning the value of their consultation time versus the recovery of costs incurred through the provision of an advanced practice nurse. On the one hand, general practitioners were happy to hand over some of the more time-consuming responsibilities of care to nurses to see more patients themselves and, presumably, bring more money into the practice. However, there was a limit to this pattern because nurses are, in the main, salaried from the total earnings of a general practice and recover very little in the way of rebates for their services. This balancing act placed the advanced practice nurse at a considerable disadvantage when compared to a revenue earning GP in terms of justifying their position in the long term.

Legitimacy of advanced practice nursing in general practice

Advanced practice nursing does not have a legitimate foothold in general practice. Despite patients, nurses and doctors being able to articulate problems concerning confidence, boundaries and value, there had been scant progress towards organising this niche of practice in any sustainable way. Critical theorists would claim that this maelstrom is subtly encouraged by the medical profession as a means of asserting and supporting their dominance in the general practice sphere. However, the uncertainty surrounding advanced practice nursing in general practice is the result of a complex set of related factors that have sabotaged attempts to gain professional recognition for over a decade. [8, Rank 2]

Ultimate changes of the traditional assumptions of practice

While this could be interpreted that the General practitioner had confidence in the ability of the advanced practice nurse, pragmatically, it meant that tasks of lower clinical importance were delegated. The result of this custom was that advanced practice nurses became unsure of what they were supposed to doing and hesitant to assume additional responsibility when it was offered. Advanced practice nurses were also inclined to default to tasks such as patient flow in the absence of other meaningful work. While important to the day-to-day running of the practice, this task could have been delegated to more junior nurses or indeed reception staff.

Advanced practice nurses were not automatically bestowed with the level of trust that their skills and abilities demanded. It appeared that colleagues either side of the advanced practice nurse, were better placed in this way because they held positions and

performed duties that were more easily recognised and understood by patients. To gain respect from General practitioner advanced practice nurses felt that they had to display skills that were more medically oriented, however, these skills were not accepted by their less qualified nursing colleagues who themselves felt undervalued and overworked. Nurse practitioner, who had statutory and nominal advantage over their advanced practice nursing counterparts, still prioritised the nursing component of their practice and was dismayed when their consultations were time restricted.

Assumptions by General practitioner that they are responsible for everything that transpires within the practice are, therefore, dangerous because they may give colleagues the (wrong) impression that they are somehow absolved from any culpability deriving from their own care decisions. If patients also expect General practitioner to retain final say over their care, the advanced practice nurse is, in effect, performing a function that has little relevance. This situation has the potential to create environments where there is a reliance on standing orders and protocols, which only diminishes opportunities for independent practice by advanced practice nurses.

This traditional view of peer-to-peer referrals is supported by time honoured practices such as referral letters written in standardised, long winded formats that act to exclude newcomers to the arena who do not have a solid grasp of the nuances involved. Given that some General practitioner also resented advanced practice nurses making diagnoses, it is possible that the pushback from specialists was a means of preserving the last bastion of a closed fraternity.

There was a tendency for General practitioners to relinquish duties to advanced practice nurses for reasons other than the skills and abilities of the nurse. This also applied to situations where the General practitioner retained sole responsibility for the task. In many cases, General practitioner handed over tasks that they had no interest in, did not enjoy performing or took up too much of their consultation time. This created an uneasy tension between General practitioner and advanced practice nurses because it appeared that General practitioner were the sole arbiter of what the nurse could or could not do.

Assimilating practice with integrated health

The competencies and advanced thoughts on professional development have led to the integrated health competencies forward within specific disciplines. Strate-

gies for adoption and dissemination were described and will be used to evaluate and track the adoption process moving forward. Identification of potential obstacles provided insight for both the adoption process and curriculum development.

Increasing accountability of APRNs

The concept of accountability was used by both General practitioners and patients to justify an unwillingness to increase the responsibility of advanced practice nurses. Researches show that patients, nurses and doctors agreed that the General practitioner was ultimately responsible for a patient's care in the general practice. While this view could appear to be reasonably justified, today's healthcare environment demands that every person charged with the care of patients is ultimately answerable for their own practice.

Nursing Workforce Development

In US, ***since the introduction of university-based education for nurses, newly qualified registered nurses typically enter the workforce through a transition to practice program.*** At present, there is a surplus of new graduate nurses resulting in limited placements. Therefore, the addition of a transition program for new graduate nurses into PHC will increase employment opportunities, and may inevitably increase current and predicted nursing shortages in the future.

Similarly, new graduate nurses specifically recruited to work in a general practice setting, would also require the support provided by a transition program - to access specific education and develop the necessary skills to work effectively in this field. However, there is a paucity of information on transition programs for graduate nurses entering general practice settings. Therefore, this innovation would require the development and evaluation of a transition to practice program specifically for graduate nurses entering the nursing profession in a general practice setting. [3, Rank 2]

Factors Hindering the Success of a Nursing Workforce in General Practice

The capacity of general practice support the employment of new nurse graduates, in addition to current nursing staff, will be important to ascertain in the initial needs assessment. ***Physical size constraints of practices have been reported to impact on the number of nurses employed in general practices.*** Investigating the optimal size and work environments of general practices, will be important in developing recruitment protocols as part of a program implementation plan.

The confidence of new graduates may be affected negatively by inexperienced or poorly motivated preceptors. It will be important that a selection criteria is developed for engaging experienced and motivated nurses into the role of a preceptor and that they are in addition provided with sufficient education and training in transition theory and the needs of new graduate nurses, as well as being provided with support and feedback by the coordinators of the program. Investigating other incentives such as business case studies to encourage general practices to collaboratively engage and support the program will be important. ***Linking the transition to practice program to obtaining credit points associated with gaining a formal post-graduate tertiary qualification in specialties may increase the interest of pre-registration students in taking part in the program and partially remove barriers associated with completion of post-graduate studies.***

In addition, ***securing funding to support ongoing program implementation and evaluation will be paramount. Development of the program in partnership with key stakeholders will be paramount in ensuring sustainability.*** An initial priority in program inception will be to undertake a national needs assessment of staff within general practices and final year pre-registration nurses to provide critical information related to attitudes, knowledge, skills and support needs to inform program design and delivery.

Postgraduate training support models for general practice such as the Prevocational General Practice Placement (PGPP) or the US General Practice Training programs could be expanded or modified to include nurses.

This might be justified on the provision of financial assistance to allow practices to offset the cost and time spent by the specialty nurses and the potential supernumerary time of the new nurse graduates.

An integral component of a transition to the role of practitioner will be comprehensive, formative and summative evaluations, including cost-effectiveness studies. To support evaluations, key performance indicators and targeted outcome measures should be defined and evaluated.

These indicators at a minimum should focus on the level of competency and confidence obtained by the new graduates and their intention to stay in the nursing workforce and in the field of general practice in the future. Evaluations should also include the impact of engagement with the program on the existing nurse workforce and the service delivery of general practices. [2, Rank 4]

> "Transition to practice programs acknowledge that new nursing graduates require additional education preparation and consolidation of skills to support the evolution from student nurse to a practising professional"

Ethics in Nursing Practice

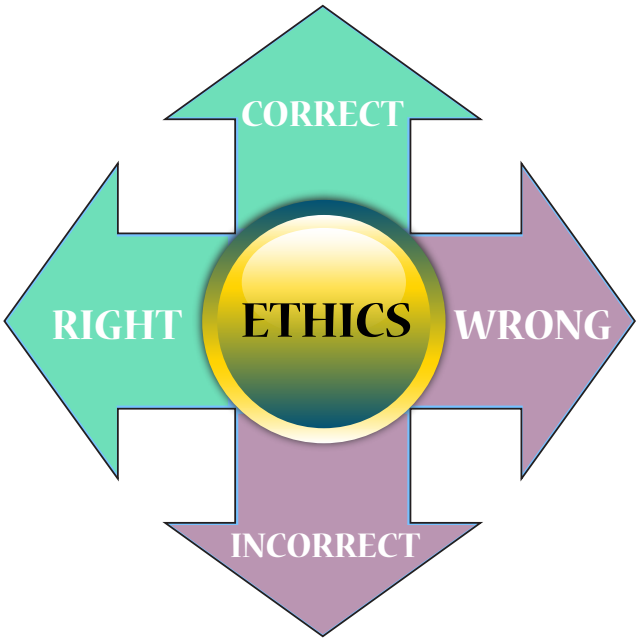

Figure 26: Ethics in Nursing

The most important ethical principles (as shown in Figure 27) ***that should be considered in nursing profession are:***

1. Respecting the patient/client and pre serving human dignity
2. Altruism and sympathy
3. Devotion to professional obligations
4. Accountability, responsibility and con science. Accountability is accepting responsibility for one's own actions.
5. Justice (fairness) in services
6. Beneficence - doing good and the right thing for the patient
7. Commitment to honesty and loyalty
8. Non maleficence - doing no harm
9. Fidelity - keeping one's promises
10. Maintaining patient's privacy, and commitment to confidentiality, and trust
11. Continuous improvement of scientific and practical competence
12. Veracity - being completely truthful with patients
13. Promote the awareness of professional rules and ethical guidelines, and respecting them
14. Mutual respect and appropriate com munication with other health care providers
15. Respecting autonomy and self-determi nation of the patient/client
16. Compassion and kindness [10, Rank 3]

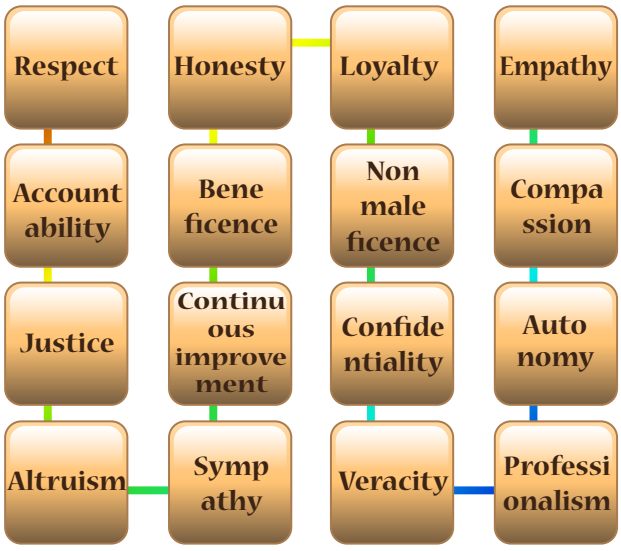

Figure 27: General Ethical Principles in Nursing

Factors Affecting Professional Ethics in Nursing

Nursing mission is to provide high quality healthcare and maintaining and improving community health. Ethics is considered as an essential element of all healthcare professions including nursing. Thus, it has a central role in nurses' moral behavior toward patients, which strongly influences on patients' health improvement. Professional ethics constitutes legitimate norms or standards that govern professional behavior of both client and non-client. Indeed, professional ethics addresses obligations of a profession towards people who are served.

An inherent part of nursing is to respect human values, rights and dignity. From a clinical point of view, nursing has three basic principles of caring, namely ethics, clinical judgment, and care. Research points to five elements that are epistemological and fundamental to nursing, which include the following: knowledge of nursing, art of nursing, individual knowledge, ethics of nursing, and sociopolitical knowledge. From moral and philosophical perspective, nursing ethics incorporates using of critical thinking and logical reasoning in clinical practice on the basis of values.

Ethics are highly interwoven with clinical practices that cannot be alienated from them. Ethical commitment to care is an integral part of nursing practice in nurse-patient relationship.

Nowadays, health care settings are changing rapidly. Thus, nurses are facing ethical challenges in healthcare that put them at risk of ethical conflict. Although meeting the requirements of professional ethics in patients' care is essential, studies revealed that standards of professional ethics are not observed in nursing practices. Indeed, standards and criteria of professional ethics are not considered based on patients' preferences and culture. According to previously conducted studies, nurses had poor attachment to professional ethics. Nursing awareness and application of ethical principles in patient's care and clinical decisions were not desirable.

Additionally, nurses were not interested in applying ethical knowledge in their work. Safe medication administration by nurses was significantly poor and lacked adherence to the professional ethics. A comparative study on nurses' perceptions of ethical problems in China and Switzerland revealed that there were differences in some ethical concepts including culture and faith. Chinese nurses were more nervous, sad and dissatisfied during and after the work compared to nurses from Switzerland. However, both groups experienced ethical problems of poor communication with patients due to heavy workload. Another study reported that nurses might confront with various problems during their works. Thus, ethical issues should be taken seriously as a basic requirement. On the other hand, the most comprehensive and

complete approach to observe ethical standards is qualitative approach in which participants share their experiences. Such information helps administrators promote professional ethics.

The research findings have shown that both internal and external factors affect professional ethics in clinical practice. Therefore, professional ethics is not limited to the internal factors. External factors including instructors, administrators, health care providers, education, and culture can be applied in workplace in order to assist nurses in moral development. [7, Rank 5]

Factors effecting professional ethics in nursing practice have been identified. (as shown in Figure 28

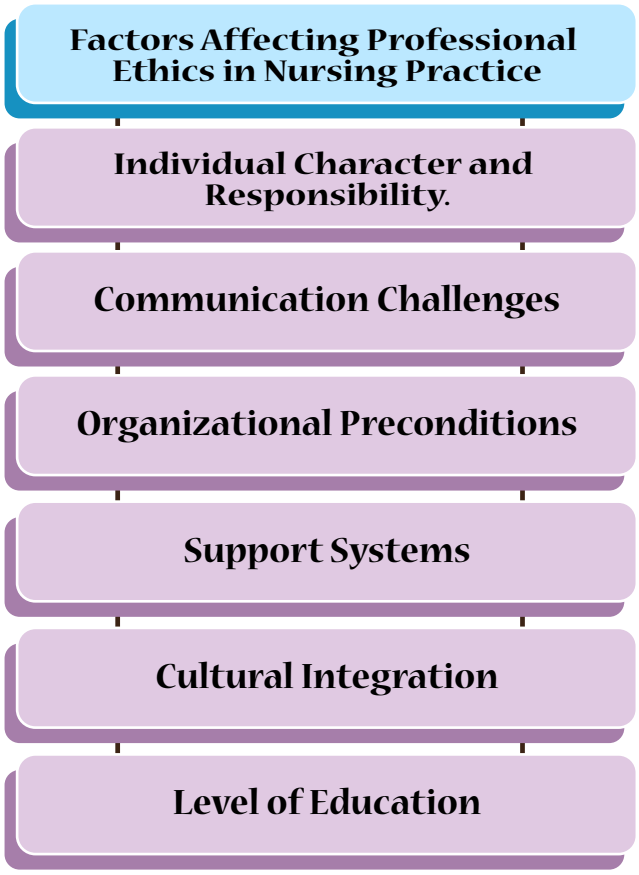

Figure 28: Factors Affects Professional Ethics

Individual Character and Responsibility.

The first main category of the findings was focused on the individual character and responsibility. ***It was emphasized on developing a sense of responsibility in nurses as a significant factor that influences professional behavior.*** Also, nursing literature indicated that creating professional commitment should be regarded as a necessary quality for nursing practice; nurses should be accountable for their decisions and outcomes. Such characteristics lead to better observance of professional ethics by nurses. Indeed, ***most nurses believed that individual character and responsibility play an important role in sensitivity to the professional ethics compliance and moral development.*** Students who desire to enter into nursing profession should be checked for metacognitive features (e. g. personality) and be coordinated with nursing profession.

Communication Challenges

The second category is communication challenges among health care members. The participants highlighted effective relationship as the element of professional ethics. The researchers also believe that effective nursing is highly related to developing proper relationships among members of the health care system. In the absence of

such attitudes, patient care will be adversely affected.

This study also indicates ***that patient's assessment is one of the important measures in establishing rapport between nurse and patient.*** In recent years, it has been emphasized on professionalism in nursing. Thus, health care system requires nurses who are able to develop relationships with the multidisciplinary professionals as well as patients and their families. Nurses do not work solely. In other words, they should try to expand connections with other health care teams in order to enhance patients' quality care.

In addition, ***interpersonal relationship is a vital factor in ethical sensitivity,*** and ignoring it may decrease the sensitivity. Also, participating students in another study expressed poor interpersonal communication as one of the barriers in achieving professional ethics. Poor communication between doctors and nurses and patients is a main part of the most raised ethical problems, which could lead to the violation of patients' rights.

Organizational Preconditions

Organizational preconditions are the third category affecting professional ethics. ***Organizational structure should be compatible with nursing professional knowledge.*** When there are inappropriate organizational structures in health care systems, nurses cannot use professional knowledge properly. In fact, ***it is a reasonable expectation that in an environment, which is consistent with organized standard of care, basic ethical working conditions are met.***

Although patient care is important for nurses, deficiency of clinical standards negatively affects nurses' performance. This study showed that the effects of environmental factors including facilities and equipment on professional ethics have not been widely reported in the literature. Based on the participants' perspective, another important aspect in compliance of professional ethics is the existence of human resources. Both time and staff shortage and/or in some cases the presence of too many patients are major barriers that challenge nurses in using research evidence and observance of professional ethics in health care.

Nurses have in close contact with patients and have a good situation to support them; however, such a role is ignored in Greek hospitals due to staff shortage, lack of enough time and proper training regarding these subjects. Participants In a study mentioned that excessive work and staff shortage are two important factors that reduce the quality of care and ethical issues. They also stressed that even if the nurses wish to do so, it is not possible to provide adequate ethical nursing care.

Support Systems

Studies showed that elements of supportive environment in nursing contain an appropriate team work, accepting sense of personal identity, freedom to ask questions, and having a suitable working relationship. These factors can enhance professionalism and autonomy in nursing. From practical point of view, however, most nurses have not experienced such a supportive working environment; too much effort is needed to get support. In other studies, inappropriate feedback and insufficient support from both managers and organizations were mentioned by the participants as factors that decrease ethical sensitivity.

In this regard, ***inadequate support systems were major causes of moral sensibility reduction.*** Participants of this study believed that when a person was sensitive to an issue, receiving support from others could compensate the inabilities and deficiencies and empower this sensitivity, while inadequate support could suppress this sensitivity. Inadequate support shared among the managers and colleagues can cause decreased job satisfaction resulting in decreased ethical sensitivity and increased moral distress.

Cultural Integration

Experts have explained that establishing bonds of commitment to nursing profession depends on cultural considerations. This, in turn, will lead to the enhancement of professional ethics in clinical practices. In doing so, the need for cultural understanding and establishing effective relationships with patients is widely expected to be inserted in the curriculums designed for nursing. Another external factor influencing professional ethics as reported by participants of this study was their desire for an efficient educational system.

Nurses, as significant agents of human resources in health care services, play a major role in health promotion of society. Therefore, training programs of nursing should contain materials that incorporate boarder needs of society. Also such programs should be modified according to the changes and advancements in the medical care. Teachers who have theoretical and professional knowledge in the field of ethics can be considered as role models; in fact, they

"Professional ethics refers to the use of logical and consistent communication, knowledge, clinical skills, emotions and values in nursing practice."

could assist the development of professional ethics. Although the role of instructors as role models in creation of student's ethical behavior is important, student's philosophical readiness and knowledge development in ethical field are the responsibilities of nursing instructors.

Educational Levels

A wide range of studies are emphasized the effects of education on increasing compliance and ethical sensitivity. In a conducted review study education and training methods could effect on ethical sensitivity. Doctors and nurses were not able to properly make an ethical decision and follow a consistent pattern, mainly due to their lack of education in ethical issues. In addition, ethics education improves student's awareness from ethical issues and their application in the workplace is effective.

Moreover, students attending ethics courses were more able in decision making for ethical issues compare to those who did not attend such courses. Curriculum is an effective factor in shaping peoples' attitude and increasing their knowledge, and also a framework to discuss and criticize the ethical issues. Furthermore, he claims that ethical knowledge is an important issue in nursing. In fact, including ethical issues in the curriculum is an appropriate way to be assured of increased ability in solving the ethical dilemmas as well as improved ethical judgment.

Knowledge and Performance of Nursing Ethics Code

In a study which investigated knowledge and performance of nursing ethic codes from nurses' and patients' perspective in teaching hospitals and the effect of demographic characteristics on the levels of nurses' knowledge and performance was conducted. Findings showed, nurses were aware of ethic codes, had job satisfaction and no ethical complaints. Nurses, who work at night, were aware of ethic codes more than the others. Nurses in surgical ward act more ethically. Older nurses are also increased their ethical performance. The result of this study showed that 86.4% of nurses were aware of nursing ethic codes and 91.9% of nurses and 41.8% of patients stated that nurses act ethically. There was significant difference between patients' and nurses' perspective about this matter. Unlike patients, nurses believed that they always act based on nursing ethics codes.

Against this study, one study revealed that 11% of nurses daily and more than 35% of nurses faced with ethical dilemmas every week that a quarter of them were not aware of nursing ethic codes. 34% of nurses did not know the codes. 29% of physicians and 37% of nurses had no knowledge of any

hospital ethics committee. Doctors had a stronger opinion than nurses regarding ethical performance and more than half of Participants were aware of ethics and law from multiple sources.

Nurses acquired their knowledge of ethics and law during training. More than 70% of doctors and nurses acquired their knowledge of ethics during work. In the present study, the 79.1% of nurses acquired their knowledge of ethics in nursing school, and 53.6% of them acquired their knowledge of ethics during work also 40.5% of nurses stated that nursing ethic codes is formally given them. According to one study, three common problems in nursing ethic codes are; Lack of effectiveness in daily clinical practice, the difference between the moral code and realities of clinical and actually, some of the nurses are not aware of the content of ethical codes.

Findings of another study showed that ***nurses deal with ethical problems not always based on ICN code for nurses.*** In addition they are informed by local ethical performances related to some institutional and cultural environment in Ghana. Nurses face ethical issues were affected by the conflict and nurses worked with local ethical performance and attitudes. Also concern about ethical competence of nurses is rising. In fact, nurses' application of available ethic codes in research has revealed that their knowledge about and their use of ethic codes was incomplete. ***Only half of the nurses used ANA code of ethics or some other ethical frameworks for their performance and stated there is a definite need for continuing education about ethical issues that enable nurses to use ANA code of ethics as a framework for action.***

The result of another study showed that 8% of social workers versus, 23% of nurses had no ethics training and only 57% of participants had ethics training in their professional education programs. Those with professional ethics training or in-service or continuous education were more confident in their moral judgment, use ethics resources to act ethically. Social workers, who were trained in ethics dimension, had higher confidence and moral action scores and use ethics resources, more than nurses.

These differences between the results of these studies can be due to lack of nursing ethics codes of these countries, their different cultures, environments, method and measurement tools. In different countries and even different parts of one country academic education programs and in-service or continuous education in nursing ethics codes may vary. According to findings of this present study, the effect of existence

ethic codes on nurses' knowledge and performance is evident and differences can indicate weakness in moral education in schools and hospitals or weakness in writing and promoting nursing ethic codes.

Although, some nursing ethic codes has been written in accordance with Islamic culture, differences between nurses' and patients' perspective about nurses' performance of ethic codes, need more attention to ethics education of students and promotion or supervisory programs for nurses performances. However, it cannot be claimed nurses knowledge and performances will be upgraded by only a course or training. Perhaps, patients may not have sufficient knowledge or reasonable expectations of the areas of nurses' ethical performance. [8, Rank 4]

Ethical Violations in Clinical Setting

Professional guidelines and integrity were compromised through the use of student nurses as adjunct staff. Nursing students' involvement in such jobs may have consequences for their training as they are unable to adequately train during their student years due to the responsibilities of staff duties, and this also forces error-making in the workplace due to inadequate knowledge.

Although, ideally, medical policies and local laws aim to guarantee nurse safety and integrity in the clinical setting, our findings reveal that ***nurses reported experiencing high levels of verbal and physical violence during role delivery.***

Figure 29: Sources of Work Place Violence

Nurses have to manage violence from many sources: co-workers and trainers, patients, and multiple family attendants etc. ***Social acceptance of the low status of nurses and fears of violence from multiple sources leads to nurses adopting coping strategies such as non-disclosure and withdrawal of treatment from patients.***

Patients are reluctant or unwilling to receive treatment from nurses, due to the inferior status of nurses and a negative nurse identity in the community. The reluctance of patients to receive treatment from nurses is known to have a negative impact on patient safety due to delayed treatment in

the absence of a doctor, and even to cause patient mortality. Previous research confirms that ***patients from developing and patriarchal regions prefer medical administration to be performed by doctors, while preferring nurse duties to be reserved for tasks like body-sponging and bed-linen changing.*** Reasons for patient reluctance to receive treatment from nurses includes the general belief that nurses are medically incompetent, a lack of nurse training in dealing with different languages, customs and sectarian beliefs, and patients witnessing the general attitude of doctors in treating nurses as inferior colleagues.

Patient informed consent is being seriously violated, according to a study's findings. All participants confirmed that there is a near-absence of consent taking from patients for most non-surgical medical procedures and an absence of patient consent taking for receiving treatment from student nurses. Discussions revealed that this was mainly due to time constraints, and the difficulties of having to communicate with populations that are largely illiterate.

In Asian societies, there is a lot of pressure to take informed consent from multiple family members, due to family autonomy taking precedence over individual autonomy, and thus medical practitioners prefer to take swift decisions autonomously. However, research shows that the ***lack of consent taking or discussion of treatment options with patients contributes in the long run to patient hostility, distrust and feelings of lack of control.*** In addition, the absence of consent taking also weighs heavily on nurse practitioners' professional ethics and becomes a burden on them psychologically; consequently, this influences their commitment to work.

Patient rights were found to be breached through the withdrawal of treatment. Firstly, hospital service delivery and the allocation of staffing and resources were being distributed according to a patient's socio-demographic characteristics. The poor, the illiterate and populations of lower socio-economic status, who usually visited public-sector hospitals, were being deprived of optimal care provision, in comparison to richer populations and those of upper socio-economic status. This is consistent with previous research, which found that confounding problems of staffing and resource shortages, role burden, difficulties in dealing with illiterate patients, and pressure from VIP society (which control promotion and the retention of medical practitioners) contribute to the practice of patient discrimination in public health services.

Nurses were practising withdrawal of treatment from patients out of concern for

> **"Cultural tendencies towards violence against women, especially in patriarchal societies, tend to cross over into professional relations, especially in nursing. Nurses also experience violence from patients and family members due to shortages of staffing, being overburdened in their duties and the practice of reserving better services for patients of elite socio-economic status."**

their own safety and fears of facing violence. As a consequence, nurse communication, cultural competency, emotional relief and care provision for patients were limited. The absence of care provision and inadequate role delivery by the nurse practitioner is of grave concern due to the negative consequences on patient safety, and also on the job satisfaction and job commitment of the nursing professional.

Co-worker coordination for competency, learning and patient safety is an integral component of nursing ethics. Clinical trainers are instrumental in teaching ethics and creating a culture of learning and sharing; which consequently promotes ethical compliance and error reporting. These findings, however, show that nurses are training in a non-learning and hierarchical culture, where knowledge-sharing and competency development is dangerously limited. Barriers to learning and sharing are created through informal social laws that sanction outspoken and enquiring juniors through character defamation. Other studies have highlighted that non-learning cultures are common in hospital settings when there is a shortage of staff, a heavy workload and hierarchical cultures.

Doctors and surgeons shift blame onto nurses as a norm, specifically when nurses attempt to report or share errors in the workplace. Fears of losing their job or lack of promotional opportunities create disincentives amongst nurses to report errors. ***Character defamation for female members of society is not a minor problem, as it causes family dishonour,*** social ostracism, and lack of arranged marriage prospects, and fear of these major consequences limits nurse resistance to the status quo. Other research has also evidenced that ***whistle-blowing in the hospital setting is frowned upon and ethical violations are underreported due to the pressures of a hierarchical culture and the fear of dismissal.*** Healthcare sector suffers from an absence of formal systems for tracking and reporting errors and also from an absence of the culture of error reporting and error sharing; both of which are harmful to patient safety and optimal healthcare coordination and planning. [7, Rank 3]

Nurses' Reaction During Patient Aggression

Patient aggression toward health professionals is a serious global concern. ***Health professionals taking care of persons with mental disturbances are often exposed to patient aggression.*** Patient aggression in these settings is associated with healthcare workers' wellbeing. Being the target of patient aggression has been found to be associated with anxiety, fear, guilt, sleep disturbances, burnout, poor self-rated health or dissatisfaction toward work. Furthermore, longitudinal studies have shown that the relationship between workplace aggression and the wellbeing of employees seems bidirectional; those who experience aggression are more likely to report occupational stress, and those who report occupational stress are at a higher risk of workplace aggression.

Staff members working in mental health settings are at a higher risk of being assaulted by patients. For example, a systematic review showed that the rate of physical violence varied considerably across settings, the highest being in psychiatry (55%). The risk for aggression may be greater among inpatients, persons with substance abuse disorder and those who have severe mental disorders. Working in psychiatry also includes greater odds for diagnosed depression, antidepressant medication use and sick leave due to depression and mental disorders. On the other hand, staff working in emergency care units is at an elevated risk of experiencing physical aggression, although the risk is lower than for staff working in psychiatric settings. The risk of experiencing physical aggression is significantly lower in medical and surgical specialties.

To prevent a serious shortage of nurses in the coming years and nurses leaving the field because of increased stress as a result of patient aggression, more knowledge about the association between patient aggression and nurses' wellbeing is needed. [1, Rank 5]

Facts on Aggression Experience	
1.	More nurses working in psychiatric settings experience patient aggression than nurses in non-psychiatric settings.
2.	Nurses working in psychiatric settings have poorer self-rated health, more sleep disturbances and psychological distress, and reduced work ability compared to nurses in non-psychiatric settings.
3.	Nurses who experience patient aggression while working in psychiatric settings are more likely to experience poor self-rated health, sleep disturbances, psychological distress and reduced work ability compared to their counterparts in non-psychiatric units

Table 3: Facts on Aggression Experience Among Nurses

Physical Violence and Mental Abuse in Healthcare Setting

> " Aggression can be defined as a range of behaviors or actions that has the potential to harm, hurt or injure another person, either physically or verbally, regardless of whether or not harm is actually sustained or the intention is clear. "

More nurses in psychiatric settings experienced patient aggression compared to nurses who worked in medical and surgical settings. However, physical aggression and mental abuse were more common in emergency settings, compared to psychiatric settings. The finding regarding physical aggression is not totally in line with previous studies, although earlier research has reported emergency settings as having a high risk for experiencing physical aggression. On the other hand, some studies have found a higher occurrence of non-physical aggression in emergency settings, compared to psychiatric settings. Nevertheless, the finding regarding the high occurrence of patient aggression in psychiatric settings is worrying because working in psychiatry includes higher odds for diagnosed depression, antidepressant medication use and sick leave due to depression and mental disorders.

Nurses working in medical and surgical settings suffer from psychological distress and sleep disturbances more often than nurses in psychiatric settings, whereas they did not detect any significant differences in these indicators regarding emergency settings. Nurses in psychiatric settings are merely more likely to seek help for psychological disturbances because they can more easily recognize factors related to psychiatric wellbeing and have more positive attitudes toward mental health problems than those working in medical and surgical settings. This might also indicate that psychiatric organizations and those providing emergency services have better tools to manage stressful work environments.

The fact that psychiatric nurses are more likely to recognize these issues might also reflect on our finding of poor self-rated health among psychiatric staff, a finding that has emerged in previous studies, too. Furthermore, certain types of violence such as bullying by staff members, which has been associated with employees' wellbeing, might be more common in non-psychiatric settings compared to psychiatric settings when comparing occurrences found in separate studies. This situation might explain why nurses in medical and surgical settings suffer from psychological distress and sleep disturbances more often than nurses in psychiatric settings. However, the differences between

the mean values of these wellbeing scores in psychiatric and non-psychiatric settings were small, as were the effect sizes.

Nurses working outside the psychiatric field are more likely to experience psychological distress and sleep disturbances in cases of patient aggression. Nurses working in psychiatric settings may be better educated on how to manage patient aggressive behavior or they may have better coping mechanisms in these events. On the other hand, nurses working in psychiatric settings may be more hardened toward less severe forms of patient aggression, and therefore their psychological reactions are less severe than those of their counterparts. Our earlier studies have already shown that psychiatric nurses have reported in interviews that verbal assaults are not always recognized as violence, and patient aggression is rather unavoidable in their job.

On the other hand, a study conducted in Italy found that the association between experiences of verbal aggression and psychological problems were stronger among student nurses than among professional nurses, which might indicate that less experienced nurses have less resilience to workplace violence. When comparing occurrences in separate studies, nurses in non-psychiatric settings experience lower rates of, for example, patient-initiated verbal abuse compared to psychiatric nurses.

It has been suggested that in non-psychiatric settings, perpetrators are mainly visitors, caregivers or relatives, whereas in psychiatric settings the perpetrators are mainly patients. Therefore, non-psychiatric nurses might be less experienced than psychiatric nurses in managing this type of patient aggression and its consequences, which might explain the results that they are more likely to experience psychological distress and sleep disturbances in cases of patient aggression. However, this still raises the question of why nurses working in emergency settings are more likely to suffer from sleep disturbances in cases of physical assaults and armed threats. Although certain types of aggression are more prevalent in emergency departments, education in the management of aggression and its consequences is lacking compared to that in psychiatric settings.

We need to ask whether poorer self-rated health and reduced perceived work ability among nurses working in psychiatric settings are signs of a serious hidden problem among staff in health services, which should urgently be considered. If nurses' silent concerns cannot be identified, they may result in depression and medication use, something that has been found in our previous studies. On the other hand, we need to ask whether nurses working outside psychiatric settings, who face aggressive events, are in more serious danger to suffer from poor psychiatric

wellbeing and sleep disturbances. More research on this should be conducted. In any case, both problems identified in this study need to seriously be taken into account to ensure occupational safety and support the wellbeing of staff in their work.

The cross-sectional nature of the study does not allow us to make definite causal conclusions about the results. The study relies on self-reported questionnaires, which include the possibility of common method variance, and misunderstanding or modifying answers in order to give a more socially desirable response. This is a case, especially in the retrospective evaluation of patient aggression during the 12 months prior to the measurement, which causes concerns due to recall bias or likelihood to underestimate the occurrence of aggression. More objective data collection, such as organizations' incident reports, could have been provided, although underreporting cannot be avoided in incident reports either.

The differences between the groups could have been affected by the large sample size, although the finding is not relevant in clinical practice. However, the sample size obtained in this study is representative, with a good response rate (72%) from various regions. This allows generalization of the results to Finnish healthcare services and abroad, keeping in mind the differences in the health systems. [2, Rank 5]

Clinical Ethical Support

Clinical ethical support from a bottom-up perspective might give healthcare professionals opportunities to think and reflect on issues they are facing in their everyday work. A dominant top-down perspective could be a less risky approach if, and only if, it removes ethical responsibility from the healthcare personnel. For example, if a consultant makes a decision, or gives advice or a recommendation that is not beneficial for either the patient or the personnel, but only beneficial from an economical perspective. If later on the consequences of that decision or advice/recommendation proved detrimental to the patient, the healthcare personnel involved could free themselves from guilt by placing the blame on the consultant. If a decision or recommendation was based on a bottom-up approach that involves the reflections of the healthcare personnel, they would need to assume greater ethical responsibility and perhaps wish to reflect more in such situations. Consequently, the status of a professional expert in ethics might lead to a risk, an undermining, or a challenge to the healthcare personnel's personal autonomy, e.g., a limitation on their autonomy when dealing with ethical issues. Professional practitioners are specialists that encounter certain types of situations again and again in their daily work. They

learn what to look for and how to respond to those particular types of situations. Even though many ethically difficult situations are unique, repeating patterns can be found. Therefore, the ethical responsibility and choice of what to do should remain with the healthcare personnel in clinical practice. To permit someone from the outside to make a decision or give a recommendation in a particular situation could be risky.

Conclusion

Nursing profession requires knowledge of ethics to guide performance. Nursing ethics is professional ethics of care. The nature of this profession necessitates ethical care more than routine care. Ethical concepts are one of the basic elements in this profession and the important indicator of its progress. Ethical performance is critical aspects of nursing care and development of moral competence, is essential for nursing practice in present and future. In this regard, any gaps in nursing ethics can affect the most scientific and the best nursing care. Promote the principles of professional practice by emphasizing ethical foundations are the only way to strengthen trusting on medical group. Today, worldwide definition of professional ethic codes has been done based on human and ethical issues in the communication between nurse and patient. In this regard, professional and international organizations, have written codes despite some apparent differences, their goal is accreditation of the nursing profession by providing good quality care to patients. [9, Rank 5]

***Important information for post-test is highlighted in red letters, boxes and diagrams.**

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