

CREDENTIALING: SETTING STANDARDS FOR ADVANCED NURSING PRACTICE

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Abstract

While the document Framework, Guidelines and Competencies for Post-Registration Nursing Education (Nursing Council of New Zealand, 1999) provides for approval of programmes preparing nurses for advanced practice, the related credentialing and titling of individual nurses in advanced practice has not been addressed. This article examines professional regulation with particular reference to advanced practice. As well as providing an overview of credentialing and other aspects of professional regulation, including licensure, certification, registration, and titling, the question of how much regulation, and by whom, will be explored. The paper has been prepared independently of the Nursing Council, and may not necessarily reflect the Council's views.

Key words: Credentialing, advanced nursing practice, professional regulation

Introduction

The issue of credentialing related to specialty and advanced nursing practice is gaining in significance and momentum as nurses come to appreciate both opportunities and barriers to developing their practice, as is well illustrated in the following quotation:

...nursing strains to release its potential, to assert its values and capabilities, and to increase its voice and stature in the scheme of things. Regulation is central to this transformation. On the one hand it brings order to the movement, and on the other hand it provides social sanction for its objectives (Styles, cited in NZNO, 1998, p.5).

The Ministerial Taskforce on Nursing (1998) urged the development of a

framework for nursing specialist competencies, "linked to nationally consistent titles, so that all nurses using a particular title can be recognised as having particular competencies" (p.39). One of the key points of discussion in the College of Nurses initiated workshop on advanced nursing practice in March 1999 related to such credentialing. It was agreed "there should be one protected title related to advanced practice nursing, regulated by the Nursing Council of New Zealand. Nursing Council should co-ordinate and manage the credentialing process with the professional organisations" (College of Nurses, Aotearoa (N.Z.), 1999, p.15).

At a Nursing Council Forum later in the year, the issue of credentialing was a major concern among those attending. However, there was evident

confusion about the nature, purpose and implications of credentialing.

How does credentialing relate to professional regulation?

In its web page on regulation, the International Council of Nurses (ICN) states that the means of setting standards includes “credentialing (licensing and certification) of nurses..., approval of schools, and accreditation of nursing services in hospitals and other settings” (ICN, 1999, p.1). Thus credentialing is a broad term which refers to “those activities aimed at determining and maintaining specific standards to ensure safety of the public” (Doheny, Cook, & Stopper, 1997, p.235). Credentialing is a form of occupational/professional regulation. “Regulation,” however, denotes control and authority, while “credentialing” connotes a more affirming process. Therein lies a source of some confusion, as well as intraprofessional discord, a point which will be taken up later in the paper.

Stewart (1996, p.1) defines occupational regulation as “any institutional action which has, or may have, the effect of limiting the ability of a practitioner to offer services to a potential customer”. Such regulation may protect the public on the one hand, but on the other may set up barriers to the provision of services. This dichotomy is brought into sharp relief by a comparison of nurses’ concerns about unregulated caregivers, with the belief held by many nurses that there are functions currently regulated as “physician-only” which, if they could be performed by nurses would bring about more accessible, timely, and effective care. Stewart (1996, p.1)

outlines the range of mechanisms which, singly or in combination may be used to effect occupational regulation:

- 1) *Legislation:* requirements defined by Act of Parliament or through establishment of a statutory body;
- 2) *Statutory regulation:* requirements defined through government regulations promulgated under statutory authority;
- 3) *Professional self-regulation:* requirements established by professional organisations, and accepted as norms by the profession at large;
- 4) *Industrial regulation:* limitations on employee selection or deployment resulting from employer policies or employment contract conditions;
- 5) *Immigration law:* residency and work permit requirements which may restrict entry of foreign professionals into the New Zealand workforce;
- 6) *Entitlement to third party payment:* restriction of eligibility to claim subsidies for the provision of specified services (may be imposed either by governmental or private agencies);
- 7) *Qualification granting bodies:* such bodies may effectively determine the knowledge and competencies required by potential entrants to a specific occupational group, and thus indirectly define the practice boundaries for that group.

Generally one through four, and seven above, relate to credentialing, although credentialing may impact on other categories as well.

Credentialing: Designation, registration, certification, licensure

In the USA the National Council of State Boards of Nursing (NCSBN) notes that there are four tiers to credentialing. The higher tiers are considered to be required where the occupational “activities are complex, require specialised knowledge and skill and independent decision-making” and where the potential risk of harm for the consumer is high (NCSBN, 1996, p.7).

The first level, and least restrictive approach, is **designation/recognition**. This recognises special formal or informal qualifications/expertise. It does not limit the right of anyone to practice, or to use the designation, nor does it involve statutory inquiry into competence (NCSBN, 1996). Recognition by the New Zealand Nurses Organisation as a “nurse consultant” is a type of designation, as is membership as a Fellow of the College of Nurses, Aotearoa (N.Z.).

Registration is the second level of credentialing. It may be voluntary or statutory. Persons apply to have their names added to an official roster or register of individuals who provide certain services. Voluntary registration exists where a private organisation, representing a particular group decides to restrict membership to people who meet certain requirements, such as passing an examination, having certain education qualifications, and who are considered to be of good professional standing. However individuals who are not

registered may still provide the service.

Statutory registration is where the government, through a statutory body is “empowered to restrict any person from engaging in the relevant occupation, or from carrying out particular activities, or imposes specific obligations on such people” (New Zealand Business Roundtable, 1997, p.2). Often the scope of practice is not defined in registration. This is true for nursing in New Zealand, where the Nurses Act 1977 provides for statutory registration, but does not define nursing, or the scope of nursing practice. It is worth noting here, as we approach the 100th anniversary of statutory registration in New Zealand, that while efforts to achieve protection of the public through statutory registration of nurses began in England, New Zealand was the first country to enact a registration law in 1901 (Burgess, 1984; NCSBN, 1999).

The third level of credentialing is **certification**. Applicants for certification meet specific requirements, generally pertaining to education and training, qualifications, and good character (Stewart, 1996). A certification process usually includes restrictions on the use of a title, the performance of certain tasks, and to third party payments (insurers).

Certification may be carried out by an institution, a statutory body, or professional body. Institutional certification is common in New Zealand, particularly for specific tasks, such as intravenous cannulation or epidural medication. The development of the neonatal

nurse practitioners' programme described by Jones (1999) provides a clear model of institutional certification for an expanded role. The programme, which commenced in 1992 at Waikato Hospital, developed the neonatal nurse practitioner (NNP) role similar to that of the neonatal registrar, and included such responsibilities as chest tube insertion, intubation, peripheral arterial line placement, resuscitation and initiation of treatment. This development in New Zealand mirrors the earlier development of expanded roles in the USA and Canada, including the initial support from medical colleagues (Jacobs, 1998; Jones, 1999).

While the NNP programme is now affiliated with tertiary education providers, graduates from it can only be institutionally certified for their role. Thus they have no title protection, nor can they legally carry out their role in another hospital without first gaining that institution's certification. Institutional certification, and the lack of national recognition and portability is at the heart of the credentialing issue for many nurses.

However, perhaps the more compelling issue is whether the NNPs are carrying out delegated medical practice, or expanded or advanced nursing practice. Where the nurse is accountable to a medical practitioner with no statutory sanction for her expanded scope of practice, this surely reinforces nursing as a medical-practitioner-dependent occupation, and curtails the ability of NNPs to delineate and affirm the nursing practice inherent in their role.

Certification by a professional body occurs extensively in the USA, where certification is "a voluntary, professional form of recognition and professional achievement that validates advanced knowledge and skills of nurses in specific areas of practice" (Doheny et al., 1997, p.238). In New Zealand, the term certification is used to mean credentialing which "registers competent practitioners, protects titles... and makes it an offence for anybody to hold themselves out as being able, entitled, or qualified to practice the occupation ..." (Ministry of Health, 1997, p.3). New Zealand combines statutory registration and certification in that an annual practising certificate is required. Thus, "a certification regime... (may be) little different from a licensing regime" (Stewart, 1996, p.2).

The fourth level, **licensure** is a statutory process "by which an agency of the state grants permission to an individual to engage in a given profession upon finding that the applicant has attained the minimal degree of competency necessary to perform a *unique scope of practice*" (NCSBN, 1996, p.7). Licensure is reserved for those circumstances in which the practice of the profession is defined in an Act; thus "its effect is to prevent other health sector professionals from using any of the defined aspects of practice when undertaking their occupation" (Ministry of Health, 1997, p.2). If the legal changes come into force enabling the implementation of competency-based annual practising certificates, then New Zealand nursing regulation

will come closer to a licensure process. The inclusion of a legal definition of the scope of professional nursing practice would complete all requirements for a full licensure process for entry to the profession. The proposed regulatory framework for nurse-prescribing will require the nurse to be registered, certified, and then licensed as a nurse-prescriber within a specific scope of practice. That raises questions about other areas of advanced nursing practice, and whether they, too, require some form of regulation.

Post-registration credentialing in the USA: Should we draw on their experience?

We are in the throws of a love affair with (credentialing) in this country, and virtually every RN has a string of possibly inexplicable initials following her signature ...certification has become a powerful card in the competition for jobs (Barnum, 1997, p.4).

As the United States has the longest history of advanced nursing practice, we may be able to draw on their experience. In 1974, the American Nurses' Association (ANA) initiated a national certification programme "in response to a proliferation of specialties in nursing, and a growing emphasis on quality care in the health professions, ..." (Porcher, 1996, p.182). ANA certification required that the nurse pass specific certifying examinations, among other quality assurance requirements. By 1979, there were thirteen generalist and specialty certifications available; and

by 1993 there were 24 certification categories, consisting of 21 clinical specialties, two administrative areas, and one staff development area.

Certification versus licensure

In 1986, the National Council of State Boards of Nursing in the USA adopted a Position Paper on Advanced Clinical Nursing Practice. At that time the NCSBN acknowledged that there were differing interpretations and regulation of advanced nursing practice. The position paper affirmed the "educational preparation to be at least a master's degree in nursing, and concluded that the preferable way of regulating advanced nursing was designation/recognition" through the certification process (NCSBN, 1993, p.1). This model was favoured because historically, nursing has shadowed physician specialisation and credentialing. Physicians are licensed to practice medicine without regard to specialty, but may seek certification from specialty boards established by private professional organisations. Thus, a similar model was proposed for nurses. This appears similar to that which the New Zealand Nurses' Organisation favours (NZNO, 1998).

However, by 1993, the NCSBN had made a major shift, one we should consider. This revised position paper noted that with the economic, legislative and policy changes affecting health care, alternative approaches to health care delivery had grown. Furthermore, it was noted that with the increasing body of nursing knowledge, and the multiple levels of nursing practice, there was increasing

recognition of the overlap between medical practice and that of other providers, such as advanced nurse practitioners. The NCSBN concluded that:

the evolution of advanced nursing has produced an expanded scope of practice and a high level of autonomy based upon advanced knowledge, skills and abilities. Safe and competent advanced nursing practice requires licensure as the method of regulation necessary to protect the public. An identifiable and unique scope of practice is a key element of licensure (1996, p.7).

Credentialing in New Zealand: How much and by whom?

Barnum (1997) notes that issues in American post-registration credentialing primarily involve quality control and who has the right to credential in a particular area. Credentialing for post-registration nursing can be provided by health agencies, professional organisations and the statutory body. But which one is appropriate in which instance? These same issues and questions are being raised currently in New Zealand.

Some credentialing such as for single tasks may be appropriately left at institutional level. However, this is a time-consuming and expensive process. Furthermore, it is a practice predicated on nursing as a task-oriented workforce, rather than on nurses as accountable professionals. Revision of the Nurses Act could go some way to addressing this matter if it includes a sufficiently broad

definition of nursing.

How, and who should credential advanced nurse practitioners is a matter of dispute within the profession. Earlier it was noted that professional regulation by statute denoted control, while credentialing connoted something more affirming. There are ideologically based views on professional body domain versus the domain of the statutory authority. The draft Ministry of Health paper on health sector occupational regulation (1997) noted that most submissions supported the Nursing Council being able to endorse advanced qualifications, and to designate specialist registration areas in the Act. Statutory regulation of advanced nursing practice is particularly important because of the issues associated with expanded nursing practice, who has dominion over that practice - the nurse or the physician, and matters of consumer knowledge and protection of the public (Ministerial Taskforce on Nursing, 1998; NCSBN, 1993; Porcher, 1996).

On the other hand, the New Zealand Nurses' Organisation (1998) in their response to the Report of the Ministerial Taskforce on Nursing, advocated professional credentialing for specialist and advanced practice. They proposed that "the regulation of nurse specialists should be conducted by the professional association and its branches" (p.6). This reflects the difficulty in differentiating the specialist from the advanced practitioner, and also presupposes there is one professional organisation. Delineating attributes of expert, specialist and advanced practice,

Christensen (1999) suggests that “one approach to clarifying this issue is to suggest that specialisation is an inherent component of the performance of every qualified nurse, and therefore every nursing role” (p.4). She goes on to note

...there could be a process of credentialing for advanced practice which would include some form of licensure (by the statutory body) related to the attributes of advanced nursing practice, as well as certification for a specific role configuration by a professional group. However it is inconceivable that there would be a certifying group for every possible advanced practice role, and the requirement for this may hinder much needed innovation in nursing practice (p.8).

Rolfe and Fulbrook (1998) tease out some of the difficulties in relation to the regulation of advanced nursing practice. One set of tensions arises in the push and pull of the development process. Rolfe and Fulbrook wonder whether “developments of this sort can and should be imposed from above in a planned and rational exercise” (1998, p.xiii), or whether they emerge from the discourse of the community of practitioners and academics. They go on to suggest that:

By redescribing the world as we would like it to be, we establish language patterns that facilitate the existence of that world.... Only when practitioners start to use the new *language* of advanced practice

does the *reality* of advanced practice become a possibility (p. xiii).

While we have a most useful Nursing Council framework (1998) and a growing body of New Zealand literature on advanced nursing practice, Christensen (1999, p.9) cautions that “tomorrow’s advanced practice roles are yet to be determined”.

Conclusion

This article has examined a range of approaches to professional credentialing with emphasis on credentialing for advanced practice. Some of the issues of advanced practice credentialing have been explored. Sheets Cook (1999, p.2), commenting on the advanced nursing practice workshop, reminds us that “focused and unified efforts are more likely to be successful in accomplishing the overall goal of improving health for New Zealanders”. Examination of the New Zealand nursing literature of the 1960s -1970s reveals a profession unified in its efforts to move nursing education into mainstream tertiary education. That same strong common purpose is needed again now. Let us draw on Litchfield’s (1998, p.23) suggestion for a re-vitalised “view of who we are as a professional community” and actively engage in dialogue, respectfully seeking to understand our points of difference in order to agree on how we can go ahead together. “Without this dialogue we will remain invisible and reactive to the whims of others shaping health care” (Litchfield, 1998, p.23).

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