Ethical Decision Making in the Clinical Setting: Nurses’ Rights and Responsibilities

Position

AWHONN supports the protection of an individual nurse’s right to choose to participate in any reproductive health care service or research activity. Nurses have the right under federal law to refuse to assist in the performance of any health care procedure, in keeping with their personal moral, ethical or religious beliefs. The refusal should not jeopardize a nurse’s employment, nor should nurses be subjected to harassment due to such a refusal.

Federal Law Protects Nurses Rights

Title VII of the Civil Rights Act of 1964 protects workers from employment discrimination—for both applicants and employees—based on their race, color, religion, sex, national origin or protected activity. With respect to religious protections, Title VII applies to most American employers. It also requires reasonable accommodation of employees’ religious beliefs, observances, and practices when requested, unless accommodation would impose an undue hardship on business operations.\(^1\)

These protections do and should continue to apply to nurses and other health care professionals. For example, a nurse should retain the right to practice in his or her area of expertise following a refusal to participate in an abortion, sterilization or any other procedure. In addition, one’s moral and ethical beliefs should not be used as criteria for employment, unless they preclude the nurse from fulfilling essential job functions.

AWHONN believes that these rights should be protected through written institutional policies that address reasonable accommodations for the nurse and describe the institution’s terms of notice to avoid patient abandonment.

Nurses Responsibilities to Protect Patients’ Rights

AWHONN considers access to affordable and acceptable health care services a basic human right.\(^2\) With regard to the nurse’s role in meeting the health care needs of his or her patients, AWHONN advocates that nurses adhere to the following principles:

- Nurses have the professional responsibility to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referrals.
- Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situations, regardless of the nurses’ personal beliefs.
- Nurses have a professional obligation to inform their employers, at the time of employment, of any attitudes and beliefs that may interfere with essential job functions.

Gender Bias in Women’s Health, Obstetric, and Neonatal Nursing

Position
All women, newborns, and their families have the right to quality care provided by a clinically competent, professional nurse. The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) maintains that nurses, regardless of gender, should be employed in nursing based on their ability to provide such care.

Background
Findings from the most recent National Sample Survey of Registered Nurses indicated that men represent only 7% of the registered nurse (RN) workforce (Budden, Zhong, Moulton, & Cimiotti, 2013). However, in the past several decades, the enrollment of men in nursing schools and the number of men who practice in the profession have increased dramatically. Of those nurses who were licensed before 2000, 5% were male; for those licensed between 2010 and 2013, 11% were male (Budden et al., 2013). As a result of this increase, more male nurses are seeking careers in all specialties, including women’s health, obstetric, and neonatal nursing.

Gender is not a qualification to practice as a nurse, and gender discrimination in employment is unlawful. In addition to legal requirements that bar discrimination, there is no evidence that female nurses provide superior care to male nurses in the areas of women’s health, obstetric, or neonatal nursing.

REFERENCES
Health Information Technology for the Perinatal Setting

Position
The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) recognizes the vital role of health information technology (HIT) in the health care delivery system of the United States. Because AWHONN members primarily provide care to women and infants, AWHONN is especially interested in HIT and data collection in the perinatal setting. AWHONN supports standard data collection across the perinatal setting, regardless of the format of the patient’s record (electronic or paper). Additionally, AWHONN recognizes the critical need for interoperability and archiving in data collection systems. Hospital and institution-wide HIT systems should incorporate specialty specific data (e.g., neonatal intensive care unit [NICU] and obstetric outpatient records) into patient records. To accomplish the efficient use of HIT in the perinatal setting, nurses must be involved in the product selection, development, implementation, evaluation and improvement of information systems.

Interoperability
Interoperability is the capability of a system to function and interact with other systems without any access or implementation restrictions. The interface capability of systems is critically important within a health care organization and between health care organizations. Interoperability is particularly important in the obstetric environment because the patient changes venues for care as she progresses through pregnancy, intrapartum, and postpartum. Many hospital information systems, such as admission, discharge, transfer (ADT), laboratory, pharmacy, critical care, and the emergency room, must efficiently interface.

Electronic perinatal systems were some of the first electronic systems developed in the health care setting; some are quite mature. Enterprise-wide systems developed more recently may not include perinatal content, which can make integration with other hospital systems challenging. Due to inadequate system integration, perinatal nurses must frequently document in different types of electronic systems simultaneously. This can create frustration and confusion, reduce the time available to provide direct patient care, and increase the potential for lost data and documentation errors. The ability to provide quality care safely and efficiently becomes compromised as the perinatal nurse navigates through multiple discordant systems. Additionally, important information from the patient’s prenatal record may not populate her intrapartum and postpartum records or the newborn’s record, further adding to inefficiency, fragmentation, and potential for error.

Another concern in the perinatal setting relates to fetal monitoring records. Many enterprise-wide HIT systems do not currently provide capabilities for electronic fetal monitoring (EFM) documentation and archival. Therefore, the obstetric provider must work with a system that may not interface with the hospital enterprise-wide HIT system. As a result, these providers may continue to document on and archive paper fetal monitoring tracings (also known...
as strips). Doing so fragments the EHR and increases the possibility for lost or unreadable fetal monitoring tracings over time. At the very least, without an interface, double documentation becomes necessary as notations made on the tracing do not populate the electronic obstetric record.

Archiving

Each institution should determine policies and procedures regarding maintenance, storage, archiving, and retrieval of the EHR. Each institution should also determine policies and procedures regarding maintenance, storage, archiving, and retrieval of the all forms, paper and electronic, of the fetal heart monitoring (FHM) record with special attention to the tracing itself. It is essential that these policies and procedures also include system back up implementation and emergency disaster planning. Currently, the health record may be archived electronically but not the FHM tracing or vice versa. Whatever method is used, clarity regarding the procedure for storage and retrieval of all essential elements of the maternal/newborn medical record is key.

Electronic archiving capability that ensures proper security, storage, and retrievability for both EHR and EFM documentation must be cost effective. With the national emphasis on EHR implementation, work needs to continue on standardization of terminology and interoperability within the obstetric specialty. It is also imperative that educational efforts continue for providers to ensure competency in electronic documentation.

Obstetric information should be available to all health care providers across the continuum of a woman’s life. Because of some of the challenges related to archiving and interoperability, pregnancy related information is often kept separate from other health information. Yet this information can be critically important long after pregnancy, labor and birth. For example, evidence suggests that women who have preeclampsia are more likely to have cardiovascular disease later in life (Smith et al., 2009). In addition, the presence of gestational diabetes puts women and their children at higher risk for obesity and type 2 diabetes (National Institute of Child Health and Human Development [NICHD], 2008). A number of similar risk factors associated with pregnancy should be considered by providers as they assess a woman’s health needs later in her life.

Given the acute care nature of the perinatal environment and the need for medical information generated during the childbearing period to be available to a woman and her newborn throughout the lifespan, perinatal providers must advocate for a high level of interoperability and determine archival policies. Also crucial is the need to advocate for standardization of terminology wherever possible to facilitate data sharing across organizations. Data sharing and organizational comparison are important elements for quality measurement and process improvement.

Essential Elements

In an effort to increase positive patient outcomes, limit duplicative work, and lower costs, each institution should gather the same data and follow certain standards related to data collection, reporting and maintenance. Common data elements require universal agreement on definitions, which will lead to better measurement of outcomes in the future. Further, the use of standardized language will move the obstetric field further toward interoperability across settings and align with national efforts to create a standardized EHR.

AWHONN supports federal and state incentives for the adoption of EHRs, such as those created in the Health Information Technology for Economic and Clinical Health (HITECH) Act. The goal of “meaningful use” of EHRs to significantly improve care (Blumenthal & Tavenner, 2010) is also important.

Essential data elements from the perinatal setting include the following:

- Nationally recognized terms for fetal monitoring developed by the NICHD and jointly reaffirmed and redefined by NICHD, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine in 2008
  (Macones, Hankins, Spong, Hauth, & Moore, 2008)
- National patient safety goals
- Pregnancy history
- Elements of the delivery record
- Prenatal record elements

The Role of the Nurse

Integrating HIT into the health care field is necessary and in some institutions long overdue. Realizing the success of any electronic record is dependent upon its users, and senior leadership must advocate for systems that complement the workflow of the perinatal nurse. At a 2010 roundtable discussion, nurse leaders captured this concept succinctly when stating, “Nurses drive
practice and decisions. IT experts support and complement the process” (American Nurse Today, 2010, p. 19). Nurses must lead the process for a patient centered system.

In addition to taking part in the selection, design, and implementation process, nurses must be diligent and provide continuous feedback while using these systems at the patient’s bedside. A nurse representative should attend hospital-wide informatics councils to share information and feedback regarding unit concerns. On some obstetric units, nurses are designated to patient data management systems. This position is beneficial as it allows a clinician to advocate for change while providing real time assistance as a technical issue surfaces. The bedside nurse should avoid “workarounds,” an alternative approach to override the system and accomplish the desired task (McCartney, 2006).

Technology can promote a safe environment for nursing practice by reducing negative exposure to risk and liability (McCartney, 2006). Safety reporting systems should be utilized whereby nurses report all near misses. Reports highlighting nursing outcomes along with performance improvement projects will reinforce the vital importance of a successful HIT system.

Electronic documentation enhances the opportunity for data maintenance and reporting and reduces error, which helps to improve care for patients. A great deal of work needs to continue to improve design and effectiveness of hardware and software that are cost effective. Analysis of the effectiveness of the technology needs to continue as we strive for a patient centered system that is available across the continuum of care across the lifespan.

REFERENCES
Position

Nurses are ideally positioned to screen, identify, care for, provide referral services for, and support victims of human trafficking. Therefore, the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) supports improved education and awareness for nurses regarding human trafficking. Patients should be screened for human trafficking in private, safe, health care settings. If there is a language barrier, professional interpreter services are imperative.

To protect the safety of women who have been trafficked, AWHONN opposes laws and other policies that require nurses to report the results of screening to law enforcement or other regulatory agencies without the consent of the woman who experiences the human trafficking. However, nurses and other health care professionals should be familiar with laws for mandatory reporting in their states, especially for minors, and comply as applicable.

Background

Human trafficking, a modern form of slavery, is generally divided into several categories: forced sexual exploitation, forced labor, and domestic servitude. Victims of forced sexual exploitation may have to work in a variety of settings, including but not limited to prostitution, exotic dancing, pornography, and/or as mail order brides (Richards, 2014). Victims of forced labor work for little or no money, often for long hours, and without appropriate safety measures or compensation. Female victims of forced labor are also often sexually exploited (U.S. Department of State, 2005).

Human trafficking is a global problem present in all countries, including the United States. Within the United States, sex trafficking of U.S. citizens is more common than labor trafficking; labor trafficking is more prevalent among foreign nationals (Sabella, 2011). Trafficking victims in the United States come from all over the world, but not all of these victims originate from other countries; many are U.S. citizens.

While there is no single profile for those who have been trafficked, certain individuals may be more vulnerable to being victimized: runaways; homeless and orphaned adolescents; foreign nationals; individuals with histories of trauma or violence; females; and lesbian, gay, bisexual, and transgender individuals (Greenbaum, 2014; Institute of Medicine, 2013; National Human Trafficking Resource Center, n.d.).

While the exact number of trafficking victims is unknown, it is estimated that 80% of the victims are women and girls (U.S. Department of State, 2005). As such, they are at increased risk for gynecologic and obstetric problems, including persistent or untreated sexually transmitted infections, unintended pregnancies, repetitive abortions or miscarriages, trauma to the rectum or vagina, and infertility. Further, basic primary health care services are rarely provided to this population. As a result, they often have untreated medical problems, including but not limited to physical injuries associated with abuse and torture (e.g., burns, lacerations, missing or broken teeth), malnutrition, dehydration, substance use disorders, depression, anxiety, and posttraumatic stress disorder (Deshpande & Nour, 2013; Grace, Ahn, & Macias Konstantopoulos, 2014; Richards, 2014).

The Role of the Nurse

One of the most challenging issues associated with human trafficking for nurses and other clinicians is the identification of victims (American College of Obstetricians and Gynecologists, 2011). In a survey of trafficking survivors, 28% came into contact with health care workers during the trafficking situation but were not recognized as victims (Family Violence Prevention Fund, 2005). Victims may not have the language or maturity to disclose their trafficking status and/or may fear what will happen if they do disclose.

Nurses are some of the few professionals who may interact with trafficked women and girls while they are still in captivity (Dovydaitis, 2011); thus, they should be aware of the warning signs.
(physical and emotional) associated with trafficking in women and girls. The National Human Trafficking Resources Center (2012) identified a number of these warning signs:

- Presence of cotton or debris in vagina and/or rectum,
- Problems with jaw or neck,
- Inability to keep appointments,
- No identification,
- Tattoos or branding,
- Accompanied by a person who does not allow her to speak or does not want to leave her alone during interview and/or care,
- Inconsistent stories (conflicting stories or misinformation),
- May not speak English, and
- Lack of documentation of age appropriate immunizations and health care encounters.

Interviewing a woman who has been trafficked poses safety concerns for the woman, others close to her, and the interviewer. For this reason, the interview technique must be specific to the situation in order to avoid the potential for causing harm (World Health Organization, 2003). Nurses should be specifically trained about the safety needs of this vulnerable population, including how to phrase conversations, the availability of appropriate resources for immediate and follow-up care, and the various cultural aspects and norms of care. Education should also extend to the implications for anonymity, confidentiality, and informed consent as appropriate, such as in the case of specific traumas.

As part of the educational process, nurses should examine their own perceptions of human trafficking so they do not inadvertently impose those perceptions and leave the individual feeling more victimized and/or criticized. Respect and nonjudgment are key components of the interview and care encounter (International Organization for Migration, 2007). Nurses must also be aware of the range of risks involved for the victim, including immigration violations, labor laws, and other legal implications. Victims may also experience physical harm or death for revealing the situation, and their families may punish or banish them as well (World Health Organization, 2003).

Nurses also support and participate in safety planning for victims and are encouraged to be aware of follow-up resources. Delays or inappropriate referrals can result in harm and/or increased risk for the victim. These resources may include local organizations specializing in working with trafficked women; free health services (general practice, reproductive health, hospital, and mental health); sources of advice on housing and other social services; legal aid/immigration advice services; local churches/community support organizations; language training centers; and nongovernmental organizations in the women’s home country (World Health Organization, 2003).

Nurses should be aware of the need to establish boundaries as appropriate to maintain their personal safety. It is not unusual for care providers of victims of abuse (in this case human trafficking) to experience emotional distress themselves; therefore, nurses should be aware of professional resources for debriefing and counseling (International Organization for Migration, 2007). Nurses are uniquely situated as trusted professionals that provide support and empathetic care. The perception of the victim that the nurse can be trusted can facilitate honest communication and a willingness to share the situation.

Recommendations
AWHONN supports research and policy initiatives to improve care and support for victims of human trafficking. Such initiatives may include the following:

- Development of a validated, brief, screening tool to better identify victims of human trafficking in clinical settings.
- Mechanisms to support continuity of care, especially when warning signs of human trafficking are present.
- Advancement of research focused on the long-term health implications for victims of human trafficking.
- Development of educational opportunities in relation to interdisciplinary and multidisciplinary interviews and ongoing care.
- Development of validated lists for legal, health care, mental health, safe housing, and culturally appropriate resources. One such resource is the National Human Trafficking Resource Center, which maintains a crisis hotline.
- Enhancement of multi-sector collaboration and coordination in order to support information sharing.
Public health campaigns to raise awareness of human trafficking particularly targeted to at-risk populations.

Support for legislative efforts that seek to penalize traffickers and fund support services for victims.

Nurses should take leadership roles in these initiatives. Improvements in screening, identification, and treatment will ultimately lead to safer, healthier women.

REFERENCES


Midwifery

Position

The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) supports midwives as independent providers of health care services for women and newborns. AWHONN supports a woman’s right to choose and have access to a full range of providers and settings for pregnancy, birth, and women’s health care.

What Is Midwifery?

Midwifery practice, as defined by the American College of Nurse-Midwives (ACNM), includes health care for women from adolescence through menopause (2011). Midwives provide primary care; gynecologic, family planning, and preconception care; care during pregnancy, childbirth, and the postpartum period; care of the normal newborn during the first 28 days of life; and treatment of male partners for sexually transmitted infections (ACNM, 2011). Midwives provide care in a number of settings, including the home, birthing center, clinic, office, and hospital.

Midwifery practice facilitates natural processes with an emphasis on the holistic care of women within the context of their families and communities. Midwives partner with women to provide evidence-based, individualized care (ACNM, n.d.). The midwife collaborates with appropriate health care professionals and refers the woman and/or newborn to specialists as needed if complications arise beyond the midwife’s scope of practice.

In much of the world, midwives and nurses form the majority of the clinical health workforce that attends women during labor and birth (World Health Organization, 2013). In fact, in many countries, the role of the midwife and the role of the obstetric nurse in the hospital setting are the same, although the midwife’s responsibilities and relationship with a collaborative physician vary by country. Through the Nursing & Midwifery Programme, the World Health Organization and partner organizations have committed to invest in the development and implementation of high-quality nursing and midwifery education and practice to promote more equitable access to health care worldwide (World Health Organization, 2013).

Basis for Midwifery Practice

AWHONN supports the Essential Competencies for Basic Midwifery Practice and Global Standards for Midwifery Education defined by the International Confederation of Midwives (ICM, 2013a, 2013b), which have been endorsed by ACNM (2014) and the American College of Obstetricians and Gynecologists (2014) as the minimum requirements for practicing midwives in the United States. The ICM defines a midwife as a person who has successfully completed a midwifery educational program that is recognized in the country in which the program is located and is based on the Essential Competencies and the framework of the Global Standards; has acquired the qualifications to be registered and/or legally licensed to practice midwifery and use the title midwife; and who demonstrates competency in the practice of midwifery (ICM, 2011). In the United States, these standards include the following:

- Education—completing a midwifery education program consistent with ICM’s Essential Competencies (2013a) and Global Standards (2013b). An important requirement of these programs is that they periodically undergo external accreditation review by an organization recognized by the U.S. Department of Education.
- Certification—passing a nationally recognized midwifery certification examination. Examinations are offered by the American Midwifery Certification Board and the North American Registry of Midwives (NARM).
- Licensure—completing requisite qualifications to be registered and/or legally licensed to practice midwifery in the jurisdiction in which the midwife practices (ACNM, 2014).

In the United States, differences exist in the education, certification, and licensure pathways for midwives. Certified nurse-midwives (CNMs) are
prepared at the graduate level and are educated in the two disciplines of nursing and midwifery. CNMs practice legally and hold prescriptive authority in all 50 states, U.S. territories, and the District of Columbia (ACNM, 2014). Certified midwives (CMs) also are educated at the graduate level, are authorized to practice in five states, and hold prescriptive authority in three states. CNMs and CMs are certified by the American Midwifery Certification Board and attend education programs accredited by the Accreditation Commission for Midwifery Education.

In 2013 in the United States, 94.6% of births attended by CNMs occurred in hospitals, 2.8% occurred in freestanding birth centers, and 2.6% occurred in homes. The percentage of midwife-attended births has grown every year since 1989; in 2013, CNMs/CMs attended 12% of all vaginal births or 8.2% of the total births in the United States (ACNM, 2015).

Certified professional midwives (CPMs) must hold high school diplomas or the equivalent and are educated through an apprenticeship model that meets NARM's standardized criteria or through the Midwifery Education Accreditation Council. CPMs are authorized to practice in 28 states through various mechanisms determined by the states and are certified by NARM. Most CPMs work in home or birth center settings in the United States, Canada, and Mexico (NARM, n.d.).

AWHONN recognizes the CNM as one of the four advanced practice registered nurse (APRN) categories defined by federal regulatory agencies (Federal Trade Commission, 2014). The education and scope of practice of CNMs and CMs prepares them to offer primary women's health care throughout a woman's lifespan. As health care needs increase, it is essential that CNMs/CMs are used to provide critical health care services to women and families.

Choice of Birth Providers and Settings
AWHONN supports a woman's right to choose and have access to a full range of providers and settings for pregnancy, birth, and women's health care. Women have a right to access fair, reliable, and unbiased information about care options so they can make well-informed choices best-suited to their individual and family needs. A woman's choice may be influenced by a number of factors, such as her health status; personal circumstances and preferences; and family, religious, or cultural values. Clinicians should respect a woman's choice of birth setting and provider.

Because women may choose different settings for birth (hospital, free-standing birth center, or home), it is important to develop policies and procedures that will ensure a smooth, efficient transition of the woman from one setting to another if the woman's clinical presentation requires a different type of care. Exemplary best practice guidelines have been developed for transfer from home or out of hospital birth settings to the hospital (Home Birth Summit, 2014; Maine Center for Disease Control and Prevention, 2014). These guidelines present the core elements for transfer policies in each setting and include actions to promote respectful, interdisciplinary collaboration; ongoing communication; and compassionate, family-centered care.

Policies, procedures, and guidelines should also support and facilitate effective communication and teamwork among nurses, midwives, physicians, social workers, and other professionals involved in obstetric care. Researchers suggested that successful teamwork “depends on a willingness to cooperate, coordinate, and communicate while remaining focused on a shared goal of achieving optimal outcomes for all patients” (King et al., 2008, para. 5). Researchers also found that key sources of conflict among health care professionals related to planned home birth were differing beliefs about patient autonomy and risk; lack of fluency with each other's scopes, roles, and responsibilities; and unclear expectations around communication (Vedam et al., 2014). Such mismatched beliefs and expectations can complicate the transition from home to hospital. Effective communication between all types of health care professionals is essential to provide safe and effective care of women and newborns and is especially critical when the woman's care occurs in more than one setting.

The Role of the Nurse
Nurses are the frontline health care providers in hospital birth settings. Nurses interface with the woman, her family, other health care providers, and ancillary personnel. They often coordinate communication among the members of the health care team and advocate for the woman within that team. Nurses are often the first professionals to
receive a woman who is transferred from an out of hospital birth setting to the hospital, to assess her and the fetus or neonate, and to orient her and her family to the hospital setting (Vedam et al., 2014). The nurse can best advocate for the woman and promote safe and effective team communication in the following ways:

- Support a woman’s access to reliable and unbiased information about care options.
- Understand the factors that influence a woman’s choice of birth providers and settings.
- Respect a woman’s choice of birth setting and facilitate care in a new birth setting if the clinical condition of the woman or fetus necessitates transfer.
- Facilitate efficient and respectful transitions of care when a woman in labor changes from one care setting to another.
- Incorporate principles of effective communication into policies and procedures regarding interaction among interdisciplinary team members.
- Recognize and respect the scope of practice and state licensure parameters of each collegial health care professional.

The Institute of Medicine (2010) urged nurses to achieve higher levels of education and training. AWHONN encourages the registered nurse to consider pursuing a career in midwifery as one pathway to further promote healthy childbirth practices. Midwifery can expand opportunities for a nurse to conduct research; assume leadership roles in hospitals, health systems, and the public health arena; and work in academia (AWHONN, 2014).

Public Policy Recommendations

AWHONN supports the availability of midwifery services as an option for all women and newborns. AWHONN supports policies and legislation to expand midwifery practice, specifically policies and legislation to

- Recognize and utilize midwives in private and public health care plans.
- Ensure access to hospital privileges and allow full participation on the medical staff for midwives.
- Provide for equitable, third-party reimbursement, including reimbursement under Medicaid fee-for-service and managed care programs, for professional services of the midwife. Currently, Medicare reimburses CNMs at the same rate as physicians. However, parity does not exist in the Medicaid programs of all states.
- Extend full practice and prescriptive authority to midwives, i.e., the ability to practice to the full extent of licensure and training without a requirement that the midwife enter into a formal supervisory or written collaborative agreement with a physician.
- Ensure that licensure requirements applicable to midwives reflect the minimal standards of the ICM with acknowledgment that midwifery is regulated at the state level, not the federal level, in the United States.
- Recognize the CM credential in all states.

REFERENCES


The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) supports the requirement of a baccalaureate degree in nursing as the minimum educational preparation for entry into professional nursing practice. All academic nursing programs should incorporate didactic content in maternal, newborn, and child health along with guided clinical experience. AWHONN also encourages nurses to pursue higher levels of education and training beyond a baccalaureate degree as a means of career development and growth. All nurses should practice to the full extent of their education and training.

**Baccalaureate Degree as Entry into Practice**

Unlike other health professions, nursing is unique in that there are several basic educational pathways to entry-level professional practice (American Association of Colleges of Nursing [AACN], 2012). While identifying the optimal educational pathway for entry into practice has long been debated, research suggests that there is link between patient outcomes and nursing education. For example, patients experience lower rates of mortality and failure-to-rescue (deaths following a major complication) in hospitals with higher proportions of registered nurses educated at the baccalaureate level (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Friese, Lake, Aiken, Silber, & Sochalski, 2008; McHugh et al., 2013). In an effort to reduce adverse outcomes for patients, the Institute of Medicine (IOM) and many policy experts recommend moving to a nursing workforce in which a higher proportion of registered nurses are required to have at least a baccalaureate-level education (IOM, 2010).

Professional nursing practice encompasses a wide variety of populations, settings, and skills. Baccalaureate nursing programs include all of the course work taught in associate degree and diploma programs as well as additional and more comprehensive content related to leadership, nursing research, evidence-based practice, population health, disease prevention, interprofessional communication and collaboration, and the humanities (IOM, 2010). This information is essential for nurses to effectively navigate an increasingly complex healthcare environment.

The social, cultural, developmental, and economic context of patients’ lives can make providing individualized, high-quality nursing care challenging. In addition, science and technology in the healthcare setting are rapidly evolving, and new developments in areas such as health information technology, stem cell research, and genomics require nurses to acquire new knowledge and skills at a similar pace. Baccalaureate nursing programs instill the analytical and critical thinking skills required to appropriately respond to these changes.

In order to achieve the goal of amassing more registered nurses educated at the baccalaureate level, AWHONN encourages academic institutions to establish systems that allow seamless academic progression for nurses who choose to pursue higher levels of education (IOM, 2010).

**Maternal and Newborn Content**

Maternal and newborn nursing education is necessary for entry-level competency. Childbirth is the primary reason for hospitalization in the United States (Russo, Wier, & Steiner, 2009). The majority of women in the United States become pregnant at some point in their lives, and providing high quality, safe care for these women and their families before, during, and after pregnancy is crucial to the overall health of the nation.

Further, women of childbearing age, pregnant women, breastfeeding mothers, and newborns routinely require care in venues outside of maternal/newborn specific areas. Such settings may include emergency rooms, medical-surgical units, psychiatric care environments, operating rooms, ambulatory care units, and community or public health-based venues. Registered nurses who do not work in the perinatal setting but who provide care for women elsewhere should be aware of the implications that diseases,
physical and psychosocial trauma, medications, and other medical-surgical management can have on women of childbearing age and on the health of a fetus or newborn. Because women and newborns receive care in various settings, all nurses need at least basic didactic and clinical preparation in maternal and newborn nursing to appropriately care for them.

**Graduate Nursing Education**

AWHONN recognizes that masters and doctoral programs in nursing bring unique value to nursing practice and the science that informs that practice. Graduate nursing education often provides more opportunities for nurses to conduct research, work in nursing administration or health systems leadership, work in academia or informatics, and provide higher levels of direct patient care.

Four roles are available for registered nurses who choose to become advanced practice registered nurses (APRNs): nurse practitioner, certified nurse-midwife, clinical nurse specialist, and certified registered nurse anesthetist. In order for an individual to practice in an APRN role, she/he must complete an accredited graduate program, pass a certification examination (when required by state law), and obtain a license or registration in one of the four APRN roles.

The four types of APRNs may also pursue a clinically-focused doctoral degree in nursing practice (DNP). AWHONN supports the range of doctoral nursing programs (PhD, DNP, DNSc) but does not believe that a DNP should be required for entry into practice for APRNs. Substantial empirical evidence demonstrating that DNP prepared nurses provide higher quality, more cost effective care than their master’s prepared counterparts should exist before such a change is made.

**Scope of Practice**

Regardless of their levels of education, baccalaureate, master’s or doctoral preparation, nurses should practice to the full extent of their education and training. Laws and regulations guiding a nurses’ scope of practice are defined at the state level. As a result, what a nurse may do in a clinical setting is not entirely dependent on education or training but instead on geographic location and the political climate of the state. Because of the variations in state regulations related to scope of practice, states are encouraged to evaluate and expand their scope of practice laws to permit all nurses to practice to the full extent of their education and training.

Further, the federal government can play a key role in helping to eliminate certain scope of practice barriers through reimbursement policies that include all APRNs. Additionally Centers for Medicare and Medicaid Services (CMS) can provide opportunities for the implementation of demonstration projects utilizing evidence-based APRN services that support quality and cost effective outcomes. This evidence may expand the support for maximizing the scope of practice of the ARPN and improve reimbursement policies for APRNs in the public and private sectors.

**REFERENCES**


The Role of Unlicensed Assistive Personnel (Nursing Assistive Personnel) in the Care of Women and Newborns

Position
The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) recognizes that unlicensed assistive personnel (UAP) also known as nursing assistive personnel (NAP) can function as supportive members of the health care team under the direction of the professional registered nurse (AWHONN, 2010). The professional registered nurse is ultimately responsible for the coordination and delivery of nursing care to women and newborns.

Background
A health care system that delivers optimal care for women and newborns is dependent on a high degree of collaboration among registered nurses and other members of the health care team, including UAPs/NAPs. Characteristics that distinguish the professional registered nurse from UAPs/NAPs include but are not limited to the type and amount of education, depth of knowledge, and critical thinking skills. The knowledge base and clinical skills of the professional registered nurse provide the foundation for nursing assessment and diagnosis, critical thinking and decision making, outcome identification, planning, implementation, and evaluation that are requisite for high quality outcomes for women and newborns.

When UAPs/NAPs participate in direct care, parameters for the education and supervision of these nursing support personnel must be in place and should include the following:

- Define UAPs/NAPs as unlicensed personnel who are not professional registered nurses but who are accountable to and work under the direct supervision of a professional registered nurse to implement specifically delegated patient care activities.
- Evaluate the individual state’s current nurse practice act to ensure that UAP/NAP job descriptions and delegated activities are consistent with established rules, regulations and statutes.
- Provide written job descriptions that clearly delineate duties, responsibilities, qualifications, skills, and supervision of UAPs/NAPs.
- Ensure that UAPs/NAPs are readily identifiable by the patient as non-licensed.
- Establish competence-based performance expectations and systems for ongoing performance appraisals.
- Provide orientation and education for UAPs/NAPs, including didactic content as needed and appropriate for the clinical setting, evaluation of knowledge, and verification of clinical skills consistent with performance expectations and role responsibilities.
- Clearly define parameters in writing to ensure that all UAPs/NAPs are supervised directly by and responsible to professional registered nurses.
- Monitor and evaluate adherence of UAPs/NAPs to patient care guidelines and their effect on patient outcomes.

The Role of the Nurse
The professional registered nurse is responsible and accountable for the delegation of certain tasks to and the supervision of the UAP/NAP. More specifically, the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) define these responsibilities as follows:

- Accountability: Being responsible and answerable for actions and inactions of self or others in the context of delegation.
- Delegation: Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. Responsibilities related to making nursing judgments may not be delegated to UAP/NAP.
Supervision: The provision of guidance or direction, evaluation and follow-up by the professional registered nurse for accomplishment of a nursing task delegated to UAPs/NAPs (ANA & NCSBN, 2006).

When the professional registered nurse decides to delegate, consideration should be given to the likely effects and consequences of delegation on patient well-being. The following factors should be assessed prior to delegating tasks to UAPs/NAPs:

- Potential for harm,
- Complexity of task,
- Problem solving and critical thinking required,
- Unpredictability of outcome,
- Level of care giver-patient interaction, and

Practice settings can include the inpatient setting, freestanding birthing center, surgery center, ambulatory care center, community health clinic, primary health care provider’s office, and home care agency and/or home care environment (ANA, 2012). The level of preparation, education, and competence of the person to whom the tasks are being delegated and how much supervision the professional registered nurse can and will be able to provide are important considerations in the delegation process.

It is not appropriate to delegate nursing activities that comprise the core of the nursing process and require specialized knowledge, judgment, competence, and skill (ANA, 2012). Assessment and evaluation of the effect of interventions on care cannot be delegated (NCSBN, 2005). These activities include but are not limited to performing initial and ongoing patient assessments, establishing diagnoses, working with patients and families to identify outcomes and an appropriate plan of care, implementing the plan, and evaluating the patient’s progress or lack of progress toward achieving care goals. In addition, it is inappropriate to delegate any subsequent assessments or nursing interventions that require professional knowledge, judgment, and skill (ANA & NCSBN, 2006).

Some examples of nursing activities for women and newborns that should not be delegated include the following:

- Telephone triage,
- Triage of women and their fetus(es) who present for care,
- Initial and ongoing assessments of women and newborns,
- Application of electronic fetal heart monitoring components,
- Initial and ongoing assessment of maternal-fetal status, including auscultation and interpretation of electronic fetal heart rate pattern,
- Ongoing assessment of
  - Women receiving oxytocin infusion,
  - Pain management needs of women and newborns,
  - Women receiving regional analgesia/ anesthesia,
  - Women who have complications of pregnancy,
  - Progress of labor,
- Management of the second stage of labor,
- Circulator responsibilities for vaginal or cesarean birth,
- Initial assessment during the postpartum period after vaginal or cesarean birth,
- Assessments required for discharge from post-anesthesia care units,
- Initial assessment of women and newborns during post-surgical care,
- Assigning Apgar scores,
- Newborn identification (e.g., assigning security device, placing identification bracelet),
- Newborn assessment during the transition to extrauterine life,
- Determining the plan of care based on nurse assessment,
- Nursing interventions that require specialized knowledge, judgment, competence and skill,
- Discharge planning,
- Patient education,
- Parent education, and
- Evaluation of the outcome of nursing interventions.

When nursing activities or tasks are delegated to UAPs/NAPs, professional registered nurses remain responsible and accountable for overall nursing care. Thus, assessment and diagnosis of patients, evaluation of outcomes, establishment and implementation of plans of care, and appropriate delegation and supervision of tasks all remain the responsibility of the professional registered nurse. It is appropriate to delegate the following activities to UAPs/NAPs:

- Assigning Apgar scores,
- Newborn identification (e.g., assigning security device, placing identification bracelet),
- Newborn assessment during the transition to extrauterine life,
- Determining the plan of care based on nurse assessment,
- Nursing interventions that require specialized knowledge, judgment, competence and skill,
- Discharge planning,
- Patient education,
- Parent education, and
- Evaluation of the outcome of nursing interventions.
- Clerical duties,
- Selected care tasks such as assistance with ambulation, feeding, mouth care, and bathing (activities of daily living), and
- Gathering of data such as intake and output and vital signs.

The professional registered nurse is responsible for determining the competence of UAPs/NAPs who will perform delegated tasks and for evaluating each patient's clinical situation. Delegated activities should be limited to clearly defined and thoroughly described repetitive tasks that do not require the professional judgment of a registered nurse. Federal regulations, state nurse practice acts, rules and regulations of boards of nursing, and institutional guidelines must be followed any time nursing activities are delegated.

REFERENCES


