

ORIGINAL RESEARCH

Making the case for differentiation of registered nurse practice: Historical perspectives meet contemporary efforts

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Abstract

In recent years, the nursing profession in the United States (U.S.) has made new efforts to advance the education of registered nurses (RNs) who provide direct patient care to the baccalaureate degree in nursing (BSN). This renewed focus is partially due to current research noting that an RN's education is positively correlated with improved patient outcomes. In spite of the research and efforts, multiple educational pathways for entry into RN practice continue to thrive throughout the U.S. and around the globe. The purposes of this paper are to present three historical cases describing the original intent of the graduates' differentiated practice role for entry-level RN educational pathways in America and evaluate the current efforts to advance the education of RNs within the U.S. for practice differentiation by education. Lack of practice differentiation among differently prepared RNs has persisted in America for more than a century and until recently hospitals often disregarded the RN's education when hiring direct care nurses. Lack of practice differentiation by education has affected the quality of nursing care as shown by the recent research. The current efforts to advance the education of the RN do not differentiate the practice of the differently prepared RNs. The present context provides the nursing profession an opportunity to differentiate RN practice based on education. Thus, the clinical ladder program is proposed as a model to initiate differentiated RN practice at the institutional level. Clinical ladder programs can be revised to meet the needs of the individual regions around the globe.

Key Words: Entry-level nursing education, Registered nurse, Differentiated practice, Clinical ladder, Nursing history

1 Introduction

In recent years, the nursing profession in the United States (U.S.) has made new efforts to advance the level of education of registered nurses (RNs) who provide direct patient care to the baccalaureate degree in nursing (BSN). This renewed focus is due, in part, to research published in the past 12 years demonstrating improved patient outcomes, including mortality rates, when the nursing workforce includes a high percentage of BSN nurses.^[1-4] As a result of this research, state legislatures, the Institute of Medicine (IOM) Future of Nursing report, and the American Nurses Cre-

dentiaing Center (ANCC) Magnet Recognition Program all have called for an increased percentage of BSN RNs in the nursing workforce.^[5-8] However, in spite of these efforts, multiple educational pathways for entry into nursing continue to thrive and graduates with different entry-level educational preparation are eligible to be licensed and practice as RNs throughout the U.S. How the nursing profession should effectively utilize these differently prepared entry-level RNs in practice while addressing the call for an increased BSN RN workforce remains unclear. In order to address how to utilize these differently prepared RNs in practice, it is necessary to understand the original intent of the

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different educational pathways for entry-level RN practice. The purposes of this paper are to present three historical cases describing the original intent of the graduates' differentiated practice role of the entry-level RN educational pathways in America; evaluate the current efforts in the U.S. to advance the education of nurses for differentiation of practice among the diploma, associate degree (ADN), and BSN nurses; and propose the clinical ladder program as a model to initiate differentiated RN practice at the institutional level.

2 Historical case studies of entry-level RN education pathways

Using case study research on early diploma (1873), BSN (1916), and ADN (1952) programs the original intent for the graduates' differentiated practice role in the development of these different entry-level nursing education pathways were examined.^[9] The points in history when individuals decided to develop the diploma, BSN, and ADN pathways were first analyzed in separate case studies. Triangulation analysis of the case studies then yielded a multidimensional representation of the past and a pattern of events. The use of both primary and secondary sources yielded various perspectives and enhanced the study's rigor.

Table 1 provides the program or school studied in each case study as well as the archives of the primary source docu-

ments used for data collection. Primary sources, including board of trustees' and various committees' minutes and supporting documents, speeches, letters, annual reports, school announcements, and city charters, to name a few, were analyzed. Secondary sources, including historical and contemporary professional journal and newspaper articles, and analytical books on the subject, validated, enhanced, and confirmed findings. Through careful collection and inspection of the data, genuineness, authenticity, and significance were determined. Genuineness refers to validity or whether the document is real, while authenticity refers to the reliability or truthfulness of the content of a document.^[10,11] As the sole data collector, the author maintained control over the process of determining which data to include. Balancing conflict and controlling bias were accomplished through journaling, disclosure of thoughts and feelings with other nurse researchers, and frequent review of the research questions and purpose. Analysis of data was facilitated through identification of themes and continuous reorganization of data into a synthesized narrative.

The case studies demonstrate that each of these pathways was developed to differentiate a nursing practice role based on educational preparation and to specify an identity for the entry-level professional nurse. Despite the successes of developing the new educational pathways, the actual role of the differently prepared graduates lacked differentiation in nursing practice as originally intended.

Table 1: School/program and archive location by case study

Educational Pathway Case Study	Specific School or Program	Primary Source Archives
Diploma	Bellevue Hospital Training School for Nurses New York, New York 1873	Archives of the Foundation of the New York State Nurses Association, Bellevue Alumnae Center for Nursing History in Guilderland, New York.
BSN	University of Cincinnati School for Nursing and Health Cincinnati, Ohio 1916	Archive and Rare Books Library/Blegen Library, University of Cincinnati in Cincinnati, Ohio. Henry Winkler Center/College of Medicine, University of Cincinnati in Cincinnati, Ohio. Wedbush Centre/College of Nursing, University of Cincinnati in Cincinnati, Ohio. Genealogy and Local History, Cincinnati Public Library in Cincinnati, Ohio.
ADN	Orange County Community College Associate Degree Nursing program Middletown, New York 1952	Gottesman Libraries Archives at Teachers College, Columbia University in New York, New York.

2.1 Diploma pathway

The diploma pathway began with the infusion of the Nightingale model for training nurses in America. The Bellevue Hospital Training School for Nurses in New York, established in 1873 by benevolent women, serves as an ex-

ample. The intent of establishing Bellevue as a Nightingale-modeled school was to develop a secular trained nurse role for middle class women. The founders of Bellevue envisioned the school to "benefit not only Bellevue [in improving the care of the hospitalized patient], but all pub-

lic hospitals, and also to train nurses for the sick in private homes and for the work among the poor".^[12] Other similar schools using the Nightingale-model were established around the same time. The addition of this type of training school improved patient care in the hospital.^[13] Quickly, the physician-run hospitals recognized the benefit of staffing wards with the unpaid students who were enrolled in the training schools and the care of the patient became a priority over the students' training.^[13-15] Because these hospitals routinely used nursing students as unpaid labor to staff the wards, the trained nurses often were not hired after graduation to provide patient care in the hospitals. Instead, the trained nurse, unless hired as a superintendent of a training school, often entered private-duty nursing. During this time, physicians not only determined the nurse's role and scope of practice in the hospital setting but also in private-duty cases where they continued to use untrained nurses.^[14,15] This led to the trained nurse competing for private-duty nursing work with untrained nurses.^[15] This type of physician control, over student training, and hospital and private-duty nursing, challenged efforts to establish a differentiated practice role for the trained nurse. The lack of differentiated practice between trained nurses and untrained nurses challenged implementation of the trained nurse's intended practice role both in the hospital and private homes.

2.2 BSN pathway

A dual diploma/Bachelor of Science (BS) degree program was designed in the early 1900s to provide an entry-level educational pathway for public health nursing practice and served as a model for future BSN programs. Public health nurses needed a broader, liberal studies education to develop successful nurse-patient relationships and effectively organize, teach, and work with individuals and groups in the community.^[15,16] The hospital-based diploma programs did not provide the broader education needed for the public health nurse role. In 1916, the School for Nursing and Health of the Cincinnati General Hospital moved to a department within the College of Medicine at the University of Cincinnati to collaborate in the education and training of nurses.^[17] With this collaboration, a dual diploma/BS degree program was established providing a liberal studies undergraduate nursing education program, consistent with other professional programs offered at that time.^[18] In addition to being qualified to provide hospital-based and private-duty care, the nurses graduating from this program were prepared to assume a public health nurse role at entry into practice.^[19]

During this time in Ohio, nurse leaders focused efforts to secure a nurse practice act outlining minimum educational standards for registration of nurses. Such standards for registration established a professional identity for nurses who were trained in schools meeting the minimum educational standards and thus, distinct from untrained nurses and

nurses trained in lower grade schools.^[20] Yet despite the advanced education of the dual diploma/BS degree graduates, these graduates received the same type and level of registration as nurses trained in hospital-based, diploma schools which met the minimum educational standards. Furthermore, in spite of the success of establishing the nurse practice act in 1915, non-registered nurses were permitted to continue to practice as long they did not claim to be "registered nurses."^[20] A lack of practice differentiation based on education among untrained nurses, registered and non-registered nurses trained in hospital-based programs of varying quality, and now, nurses educated in liberal studies continued.

2.3 ADN pathway

The ADN educational pathway^[14] was developed in 1952 to differentiate technical and professional entry-level RN roles. Mildred Montag (1908-2004), a doctoral student and part-time faculty member at Teachers College, Columbia University in New York believed that nursing functions could be differentiated in practice and specified by educational preparation. Montag proposed a two-year program in junior and community colleges that would produce graduates with associate degrees in nursing. The associate degree nurse would be more educated than the untrained nurse, now called practical nurse, and the diploma nurse from a hospital-based program. The associate degree nurse would also qualify to test for RN licensure and enter practice as a technical nurse.^[21] Montag's differentiated practice model included the professional RN, the technical RN, and the nurse aide.

Montag's differentiated practice model did not include the diploma and practical nurse and therefore failed to differentiate nursing practice for all the differently prepared nurses who were practicing at the time. However, she clearly defined the professional nurse as a nurse with a BSN and the technical nurse as a nurse with an ADN from a junior or community college. The technical nurse practice role was restricted to repetitive and routine situations in bedside care that required skilled techniques and exercise of judgment; thus, it was more limited in scope than the professional nurse practice role. Montag proposed that the technical nurse would provide nursing care under the supervision of a physician or a BSN RN.^[21]

Montag's research provided the framework for the experimental programs of the Cooperative Research Project in Junior and Community College Education for Nursing.^[22] Following the pilot experimental programs, ADN programs grew rapidly resulting in a decrease, though not elimination, of diploma programs. However, Montag's model of differentiation in the practice setting was never widely implemented. Instead, hospitals defined the role and functions of the RN based on licensure and not educational preparation, and therefore, the practice of diploma, ADN, and BSN

RNs was not differentiated.^[23] This lack of practice differentiation based on the education of the entry-level RN continues today.

3 Summary of case studies

As illustrated in the case studies, a lack of differentiated practice based on educational preparation for the entry-level RN has persisted for more than a century. Until recently, hospitals often disregarded the nurse's education when hiring direct care RNs. The RN license, rather than the education of the nurse, has predominately determined the direct care practice role of the RN. This lack of differentiated practice based on education has affected the quality of nursing care as shown by recent research noting that the education of the nurse is positively correlated with improved patient outcomes.^[1-4] This research, in part, has prompted the movement to advance the education of RNs to a minimum of a BSN degree; however, approximately 40% of RNs in the U.S. are currently practicing with a diploma or ADN education.^[24]

4 Contemporary paradigm shift provides opportunity

American nursing is moving forward on the journey to define the BSN as the minimum educational preparation for professional RN practice. State legislative proposals, the IOM Future of Nursing report, and the ANCC Magnet Recognition Program serve as examples of a paradigm shift toward support for BSN education of the entry-level RN. Institutions that have high percentages of BSN RNs have better patient outcomes. In the outcomes-driven health care system, this evidence provides the nursing profession an opportunity to also consider differentiation of RN practice based on education as a means to ensure quality patient care.

The state legislative proposals often referred to as the "BSN in 10" mandate advancement of education for diploma and ADN RNs to the BSN within 10 years of obtaining initial RN licensure.^[7,8] The "BSN in 10" supports advancing RN education but lacks differentiation based on education upon entry into practice and for up to 10 years of practice. Instead, the "BSN in 10" proposals support continuation of diploma and ADN programs as a means for RNs to enter practice with no differentiation in the practice role. The goal is that these nurses will obtain their BSN within 10 years of entry into practice. Lack of practice differentiation among the diploma, ADN, and BSN practice roles means that diploma and ADN RNs are practicing for up to 10 years after licensure in roles in which the BSN preparation is preferred. This approach discounts the research evidence illustrating the importance of the RN's education level for positive patient outcomes.

The IOM Future of Nursing report Recommendation #4

calls for an increase in the proportion of BSN RNs to 80% by 2020 (80 by '20).^[6] However, the 80 by '20 recommendation fails to differentiate anticipated practice roles between the projected 80% of BSN RNs and the remaining 20% of diploma and ADN RNs. Nevertheless, details in the IOM report support the BSN educational pathway to serve as the sole entry-level educational pathway to RN practice^[6] suggesting an eventual reduction or phasing out of diploma and ADN programs. The IOM report further acknowledges the difficulty of achieving a 100% entry-level BSN RN workforce, and therefore, the recommendation calls for an increase to only 80%.^[6] The recommendation to increase the proportion of BSN RNs to 80%, rather than 100%, coincides with the recent research which suggests that "increasing the proportion of nurses who have a baccalaureate degree" improves patient outcomes.^[3] However, no studies have suggested that a 100% BSN RN workforce is required to improve patient outcomes. While the IOM 80 by '20 supports an RN workforce that favors BSN nurses, it fails to discuss mechanisms for continuing to employ differently prepared RNs, especially as a potential nursing workforce shortage looms in the health care system in the U.S.^[25]

The ANCC Magnet Recognition Program serves as a "national leader in promoting education progression" of nurses in the U.S.^[26] Healthcare facilities that seek Magnet Recognition must employ a greater percentage of BSN RNs providing direct care.^[5] However, as with the IOM report, the ANCC Magnet Recognition Program supports BSN education for entry-level practice, but it does not provide guidelines to differentiate the direct care practice role of RNs based on education.

The "BSN in 10" legislative proposals, IOM 80 by '20 recommendation, and Magnet Recognition Program all serve as examples of current efforts to advance the education of the entry-level RN to the BSN. They also illustrate that despite support for advancing the education of RNs, differentiation of RN practice based on education remains an unrecognized opportunity in these current efforts to transform the nursing workforce for improved patient outcomes.

5 Why differentiate RN practice?

Why is it necessary to differentiate RN practice when the ultimate goal seems to be to reach a 100% BSN workforce? The answer lies in the numbers. According to the 2013 National Workforce Survey of Registered Nurses, 18% of the current nursing workforce entered RN practice with a diploma, 39% with an ADN, and 34% with a BSN.^[27] Considering these percentages and with the current and predicted nursing shortage,^[25] it is unrealistic, and most likely undesirable, to eliminate the ADN as an entry-level educational pathway into RN practice. Since development, ADN programs have been instrumental in increasing numbers and diversity in the nursing workforce.^[28-30] ADN programs al-

low individuals to enter nursing who are unable to attend a BSN program because of “lack of enrollment capacity, distance, or cost.”^[6] With continued preparation of non-BSN RNs to support the needs of the nursing workforce, differentiation of practice is necessary in order to successfully manage the practice of all RNs while maintaining the goal of improving patient outcomes.

Of the BSN RNs who completed the 2013 National Workforce Survey of Registered Nurses, 1 in 5 entered nursing practice as either a diploma RN (7%) or ADN RN (13%) indicating that non-BSN RNs are returning to school to earn a BSN.^[27] RNs who do not currently hold a BSN are getting the message that they need to advance their education for career advancement. The number of RNs enrolling in RN-BS programs was nearing 100,000 in 2012, compared to a mere 35,000 in 2004.^[31] This further indicates that diploma and ADN programs provide a resource pool for future BSN RNs.^[32] The strength and value of the ADN programs cannot be denied in efforts to maintain a nursing workforce and achieve a high percentage of BSN RNs. However, because of the research evidence illustrating the influence of the nurses’ education on patient outcomes, the need to define the RN practice roles based on the education should be an important consideration.

Using educational preparation as a method for differentiation of RN practice in the care setting would allow continuation of the current educational pathways to build the nursing workforce and provide opportunities for developing a diverse nursing workforce. Also, consistent with the research evidence showing that the education of the RN makes a difference, differentiation of practice has the potential to foster positive patient outcomes. Furthermore, differentiation would provide RNs a more clearly defined practice role based on education, which in turn will provide a map for the RN’s education and promotion in practice.

6 Differentiation using clinical ladder programs

The task of successfully differentiating RN practice based on education appears impossible when viewed on a grand scale, but differentiation is possible, even promising, if approached at the institutional level. Change in licensure to reflect differentiated practice roles for the diploma, ADN, and BSN RNs would clearly differentiate practice but this approach has proven unrealistic in the past.^[33–36] Moreover, efforts to differentiate practice through change in licensure may be unnecessary and even detrimental in some geographic regions. A more appropriate strategy would be for nurse leaders to implement staffing models in the institutional setting where the practice roles of RNs could be based on levels of education and corresponding competencies. The nurse leaders should be familiar with the needs of the institution, community, and region, and implement

strategies accordingly. For example, the availability of BSN RNs and the immediate health care needs of the community may not support immediate adoption of a differentiated practice model. These and other factors must drive the speed of differentiation efforts.

The American Association of Colleges of Nursing (AACN),^[37] *The Essentials of Baccalaureate Education for Professional Nursing Practice*, and the National League for Nursing (NLN),^[38] *Outcomes and Competencies for Graduates of Practical/Vocational, Diploma, Associate Degree, Baccalaureate, Master’s, Practice Doctorate, and Research Doctorate Programs* provide competencies for entry-level RNs based on educational preparation and provide guidance on how to differentiate practice without changing licensure. For example the level of competence for nursing judgment varies between the ADN/diploma RN and the BSN RN in that the former “integrate[s] nursing science in the provision of safe, quality care” and the latter “synthesize[s] nursing science and knowledge from other disciplines in the provision of safe, quality care.”^[38] The level of involvement for the RN in committees and decision-making regarding research and policy would vary based on the nurse’s education. The NLN competencies serve as an academic model yet can be translated for a practice model within varying institutions. These documents provide an evidence-based blueprint to evaluate the current nursing workforce and create a plan to differentiate based on education and competencies. Nursing leadership can use the competencies to make employment and staffing decisions that recognize the value of the differently prepared RNs while maintaining quality nursing care and improving patient outcomes. The research evidence supports the need to make hiring and staffing decisions based on nurses’ education and resulting competencies. Considering only licensure reverts back to the traditional ways when the educational preparation of the nurse was disregarded.

One way that nurse leaders could implement differentiation in practice based on education is through mandatory participation of all RNs in a clinical ladder program. Clinical ladder programs are most commonly developed for the following reasons: retention of bedside nurses, improving quality care, and having a means to differentiate levels of competency among nurses.^[39] A clinical ladder program based on educational level and associated competencies seems to be a perfect fit to encourage non-BSN RNs to return to school to advance their education while remaining at the bedside to provide quality patient care. This type of program would also ensure that nurses are functioning in a practice role with associated functions based on level of competency and educational preparation. Clinical ladder programs that include practice competencies based on education provide the institution guidance in hiring and staffing RNs, and provide the nurses with a clearly defined practice role, an incentive to advance their education, and a plan for promotion. Dif-

ferentiation does not require removing direct care responsibilities or limiting the scope of practice of the RN. Rather, differentiation should focus on the different competencies of RNs prepared through different levels of education. Aspects of the practice role related to leadership and involvement in policy, research, or management of care serve as examples. Additionally, clinical ladder programs can be uniquely developed to reflect the culture and style of the organization;^[40] therefore, providing a degree of flexibility to correlate with the local context of the institution. As the percentage of BSN RNs increases in the nursing workforce, clinical ladder programs and differentiated practice roles of differently prepared RNs can be refined to best match the AACN essentials and NLN competencies, and fit with the local context of the institution.

7 Summary

The lack of differentiation of RN practice by educational preparation has persisted in American nursing for more than a century. Despite the successes of developing new entry-level RN educational pathways to meet the changing needs of society, the actual practice role of the RN has lacked differentiation based on education. The RN license, rather than the educational preparation of the nurse, has predominately determined the practice role of the RN, even though the different diploma, BSN, and ADN pathways were originally developed to differentiate the practice roles of the nurse. The lack of a uniform educational requirement for the RN exists within and across most countries around the globe. According to the Global Knowledge Exchange Network on Healthcare,^[41] only Canada and Australia require a BSN for entry to RN practice; therefore, differently prepared nurses are practicing under the same RN title around the world.

Until recently, hospitals often disregarded the RN's education when hiring direct care RNs. The lack of practice differ-

entiation influences patient outcomes as illustrated in the research evidence showing that the education of the RN makes a difference. In part because of this research, the nursing profession in America is experiencing strong and successful efforts to advance the education of nurses and increase the percentage of BSN RNs providing direct care. These efforts do not outline how to manage the RNs in practice who have different levels of nursing education; therefore, this is left to the discretion of the institutions. The contemporary paradigm shift resulting from research evidence places new value on the education of the RN and provides institutions an opportunity to differentiate RN practice based on education. Nurse leaders can accomplish differentiation of RN practice with the use of mandatory clinical ladder programs that include documented competencies based on the education of the RN. Such clinical ladder programs will provide institutions guidance in making hiring and staffing decisions, and provide nurses a clearly defined practice role, an incentive to advance their education, and a plan for promotion. Differentiation of RN practice based on the education of the RN provides an opportunity to foster quality nursing care and positive patient outcomes.

The U.S. can take the lead on how to utilize differently prepared RNs by differentiating the practice role by education to not only sustain the multiple educational pathways which help to supply a sufficient workforce to meet changing health care needs, but also to improve patient outcomes. Differentiated practice within institutions through the use of clinical ladder programs could be a global strategy adopted and revised to address the different types of nursing educational pathways and nursing workforce needs within each country or region.

Conflicts of Interest Disclosure

The author declares that there is no conflict of interest statement.

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