Nursing Scope of Practice

Nursing Scope of Practice

Douglas Long, RN, MBA, PhD

Universal-Publishers
Irvine • Boca Raton

Nursing Scope of Practice

Universal Publishers, Inc.
Irvine • Boca Raton
USA • 2021
www.Universal-Publishers.com

ISBN: 978-1-62734-334-5 (pbk.)
ISBN: 978-1-62734-344-2 (ebk.)

Typeset by Medlar Publishing Solutions Pvt Ltd, India
Cover design by Ivan Popov

Library of Congress Cataloging-in-Publication Data

Names: Long, Douglas, 1965- author.
Title: Nursing scope of practice / Douglas Long, RN, MBA, PhD.
Description: Irvine : Universal Publishers, 2021. | Includes bibliographical references and index.
Identifiers: LCCN 2021019395 (print) | LCCN 2021019396 (ebook) | ISBN 9781627343435 (paperback) | ISBN 9781627343442 (ebook)
Subjects: LCSH: Nursing--Practice. | Nursing--Standards. | Nursing--Political aspects.
Classification: LCC RT86.7 .L66 2021 (print) | LCC RT86.7 (ebook) | DDC 610.73--dc23
LC record available at https://lccn.loc.gov/2021019395
LC ebook record available at https://lccn.loc.gov/2021019396

Table of Contents

Preface

The nursing profession is growing, professionalizing, and taking on more responsibility with every passing year. As I argued in my previous book *Nursing: Moving Forward,* though, there are some major disconnects that are not being addressed. My point was that nurses are overworked and taking on more responsibility without the authority to make their new role doable. The end result is burnout, bullying, and dishonesty.

Nurses are taking on almost limitless responsibility. Even if a problem arises that is beyond the realm of nursing and outside of our scope, we are still expected—*somehow*—to do something to address the matter. For example, even if a problem is the physician's responsibility to address, the nurse can be blamed for not recognizing that and contacting him fast enough.

Our scope of practice is a major part of this story. By stating all that a nurse is allowed to do, the scope of practice is essentially a statement of what nursing *is*. Do something outside of that scope, and you can jeopardize the patient's safety, lose your license, or worse.

It would seem that something so important would have an entire library of publications. Not so. There are books from professional associations, particularly the American Nurses Association (ANA), that include their official statements of what, in their view, constitutes the nursing scope of practice.[1] But Amazon.com lists not a single book published that takes an independent view on scope

of practice, critiquing the nursing boards and professional associations and their take on the issue.

So, I set out to fill that gap. I began with a literature review, reading everything I could find related to scope of practice—mostly in nursing, but also in other healthcare professions. I interviewed nurses and other subject matter experts about their experiences and opinions. Part of my objective has been to put a human face to the scope of practice, to show how individuals are affected and how, in turn, they react and perhaps seek change.

In the course of my work, I synthesized the information I had gleaned, aiming to provide a clear and simple explanation of the nurse scope of practice, why it matters, and the major issues that arise in carrying out our work as nurses. I even developed some recommendations for where we can take our nursing profession moving forward.

My research, and this book that summarizes its findings, is an attempt to look at the nurse scope of practice from different angles, *independently*, see how the issues, problems, and opportunities come together, show a need for clearer regulations, and discuss expanding the scope so nurses can work at the full extent of their abilities. My unabashed conclusion after studying the issue is that nurses are capable of working at a higher level, our patients would benefit from our doing so, and forces opposing this expansion are holding us back. To make the case for an expanded scope, we need to begin from a thorough understanding.

I am not a full-time nurse scholar or researcher. I work as a direct patient care nurse, and have studied the issue of scope of practice as I work, in real time. I also studied it as part of my doctoral research at the University of California, San Francisco (UCSF), and as part of the work that went into writing my last book. The first draft of *Nursing: Moving Forward*, had an entire chapter on scope of practice that ended up being used here instead. I've also studied nursing regulators extensively, on my own—including through visits to nursing boards in half the U.S states and about 40 other countries.

In short, I bring to the table the perspective of a nurse working on the front lines of patient care, along with about 14 years of

actively thinking about and studying our scope of practice. Working in direct patient care keeps me continually thinking about how these "academic concepts" look when you have a living, breathing patient in front of you. I self-fund my research, which gives me the freedom to critique publications, ideas, and even people, concerned only with the quality of my scholarship. This manuscript was not peer reviewed, but was offered to subject matter experts—including every U.S. state nursing board and every state chapter of the American Nurses Association, authors of publications I cited, and major nursing associations/organizations. Some revisions were made according to their feedback.

Backdrop to Writing

I began drafting this book once *Nursing: Moving Forward* was published in January 2020. As the Covid-19 pandemic progressed, travel and in-person meetings came to a halt, but my regular work as a nurse changed dramatically and took on a new urgency. Then, on June 17, 2020, I began to feel body aches. I had a slight cough, but no shortness of breath and no fever. It took my healthcare providers a few days to get me swabbed, and another day to get the results.

I still remember the missed phone call and the message that said, "Please call us immediately." The person who had called turned out to be an ophthalmologist sidelined in the pandemic from her regular duties. Her job was now to inform people of their positive test results. I had Covid-19. It came as no surprise. At work, I was surrounded by coronavirus-positive patients. There was no way I was *not* going to catch it, eventually. Now I had crossed that line.

It was not clear how serious it might be to my health. I live with my 85-year-old mother, who counts on me for her daily caregiving, and it was too late for me to isolate myself for her. She was already exposed and, given her age, contracting Covid-19 would probably be a death sentence.

Healthcare is complicated. Lives are at stake. This was all playing out in my work and at home.

For five days, the body aches kept me mostly awake, except for short bouts of sleep here and there. It was an exercise in sleep deprivation. After those five days, I felt lousy, but still no fever or shortness of breath. My healthcare provider said I could return to work after 10 days from symptom onset, and after 72 hours from the last symptoms (defined as fever or any respiratory symptoms). So 11 days after my symptoms started, I was back at work, into a viral outbreak the likes of which none of us had ever encountered. That kept me busy for the next month, non-stop. Then I was able to resume researching and writing this book.

My mother never got sick.

Also playing out during 2020—and continuing into the new year—was a battle for truth. We have a political war going on in this country, one in which lying and dishonesty have become normalized. Whether its "birtherism" or calls to defund the police, from the left or the right, I watch in horror as our society faces what appears to be existential crisis. Truth is not just a "narrative." Facts are not partisan.

In many ways, a similar "war" is taking place in nursing, with truth and facts also the "weapons." The nursing community treats evidence-based practice like a slogan used to support one's ideas, and discards it when it becomes inconvenient. If you don't want politicians to reject science, then you cannot treat evidence-based practice as if it's just a fashion.

Given my personal experience with Covid-19 and the battle for truth and honesty, my outlook on healthcare and what it means to be a nurse will never be the same. The nursing scope of practice is not a theory. It's not an academic topic. And neither is the need to respect science, evidence-based practice and open discussion. It's about real people, patients that need care, and nurses doing their jobs.

Note

1. As of Fall 2020, the ANA was still rewriting *Nursing Scope and Standards of Practice*. I have some insight into what the new edition may contain, but the book has not been published.

Acknowledgments

I have received extensive assistance and advice throughout this project, from the research and travel to the writing of the manuscript, and my heartfelt gratitude goes to all who helped me. Limited space allows me to mention only a few names whose contributions must not go unrecognized.

Hamza AlDuraidi of the University of Jordan worked with me on the Arab Gulf research project. Mariela Gomez Achury of the University of California, San Francisco, and Ia Gelenidze, executive director of the Union of Nurses in the Republic of Georgia, also contributing to that project. The writing and editing of the manuscript were done under the guiding hand of Scott Cooper, based in Boston. Jeff Young of Universal-Publishers guided the manuscript through the publishing process. Bill Hernandez developed the illustrations, translating my sometimes vague notion of how to convey ideas into graphic representations. Kian Huat Kuan went to great lengths as a graphics professional to translate the subject matter into the cover illustration.

Many nurse leaders reviewed the manuscript. A few of them deserve special mention for their above-and-beyond efforts and keen insights. David Benton, executive director of the National Council of State Boards of Nursing, provided numerous pages of commentary and guidance that helped me create a better manuscript. Patty

Bartzak, who co-chaired the committee writing the 4th edition of the American Nurses Association's *Nursing Scope and Standards of Practice*, also shared her extensive experience and wisdom; despite her busy schedule, she still found time to answer my questions.

Todd Foster offered his perspective on working in a highly technical field of nursing in a San Francisco hospital. Jarrica Davis shared her experience in the multiple roles she has played in the healthcare field. Guy Vandenburg told me about working in San Francisco on the front lines of the Covid-19 pandemic.

Amy Vandenbroucke, executive director of NationalPOLST, sent me extensive comments and advice, leading to a major rewrite of the section on that topic. Chris Bettin provided his insights into the politics of APRNs versus physicians. Physicians Jorge Blanco, Aisha Parker, and Alex Keller all offered their views about how we can work together as healthcare team members. David Daniels, author of *Oh, Nurse!*, was always quick to answer my questions and share his experiences.

I received input from beyond the U.S. borders as well. Pawinee Phakpoom laid out the differences between the nursing scope in her native Thailand and that of the United States. From Colombia, Erika Ramirez Gonzalez, Carolina Prada Morena, and Maritza Barroso shared their views of nursing in their country.

Finally, I would like to thank the many individuals that have helped but who here go unnamed. Some took risks by discussing sensitive topics. Others gave me precious time from their busy schedules. My hope is that their contributions prove worthwhile.

Douglas Long
San Rafael, California
February 18, 2021

Introduction

The nursing scope of practice (SoP) is one of the fundamental concepts of the nursing profession. The SoP is essentially a statement of what nurses are legally allowed to do, but it also describes the nurse's role, and in doing so defines what nursing *is*. It is based on the nurse's training and experience, and is meant to protect the public from unsafe nurses. Every nurse has heard of it, and told she must adhere to it. Most nurses, though, struggle to explain their scope.

Given its importance, one would think it would be carefully thought out and clearly explained. In my research of nursing regulations and my travels to nursing boards across the United States and internationally, I have been amazed to discover that the reality is quite the opposite. In this United States, there is almost nothing in any of our laws that spell out the SoP. You will find nothing, for instance, on the website of my home state of California's Board of Registered Nursing website. The California Nurse Practice Act (NPA) does not articulate a scope of practice; in fact, those words are not even mentioned.

California's lack is no exception. The great majority of the U.S. states' nurse practice acts include little or nothing to help nurses understand their scope. The absence of this guidance has serious ramifications for our profession: nurses need to understand the SoP

precisely, including the skills[1] it allows us to perform, what it forbids us from doing, and where there is room for negotiation.

The SoP's importance is amplified by the fact that it is also area of conflict between our profession and that of physicians, with which we are engaged in a battle over the right to do, well, anything. The medical scope of practice has no limits. It was written by doctors for their own benefit, when the first healthcare laws were first made, and it should not be a surprise they took all legal authority for themselves. Any *other* legal right for non-physicians to practice healthcare is a slice of that overall pie that constitutes the medical scope of practice. Therefore, our current scope is, essentially, everything we have won over the past decades to do our job without a physician's oversight and control. That description should be incentive enough to have a clear and strong *stated* SoP that can be understood by all nurses and will help us grow our profession.

This book explains the SoP, how nurses can expand their scope, and the pitfalls the nursing profession encounters when trying to do so. I begin with an introduction to the concept of the SoP, which is essentially a concept analysis (see Appendix A, "Research Methods"). I explain the meaning of the term *scope of practice* and tease it apart to explore how the parts fit together. This matters because nursing is a diverse field, and the SoP varies depending on a nurse's particular specialty.

What published SoP laws exist are vague, so much so that there is nothing that can be legally enforced. And when nurses working in a clinical environment are called upon to perform a skill that makes them wonder whether it is within their scope, there ought to be resources they can turn to for answers. Again, there is mostly nothing.

Organization of this Book

What, then, is in the nurse's scope? That is the subject of chapter 1.

The nurse scope of practice begins with the law, typically the NPA. Every state has one, along with a state nursing board (in other countries, this is typically called a regulatory body or council).

Officially, nurses look to the law and follow it. The law, though, does not give nurses near enough information to do their jobs—even with the additional guidance regulatory bodies *may* provide.

In reality, we get our scope from common practice. The things nurses typically do in the course of our daily work is accepted as within our scope. Instead of the law telling us what we are allowed to do, the reality is that government regulators look to nurses to see what normal practice is. That is assumed to be within our scope.

There is, of course, a lot that nurses are forbidden from doing. Those are things beyond our SoP. Even if something is within the scope of nursing, the individual nurse must be knowledgeable to perform that skill. The restrictions exist in the interest of patient safety. RNs, for instance, are not allowed to diagnose, prescribe, or order diagnostic tests. If nurses violate these restrictions to our scope, we may be subjected to disciplinary actions by state board or even, in extreme cases, criminal and civil prosecution. Since disciplinary actions are rare, nurses rarely benefit from the guidance their outcomes would signal with respect to how to adhere to their scope.

Advanced practice RNs (APRNs), a group on the cutting edge of our profession, are allowed to perform skills beyond those of the RN. APRNs are the ones working the most to expand the nursing scope as they challenge the medical profession for the right to work independently. This plays out in hospitals, nursing schools, the halls of government, and in the courts.

The other major group of nurses, licensed practical nurses (LPNs, also known as vocational nurses). are almost always regulated by the same boards as RNs/APRNs, but their scope if fundamentally different. Their scope tends to be a dependent one—that is, they can only perform skills for which they have an order, protocol, or supervision from a higher-level healthcare provider. Many of the issues affecting RNs, such as the lack of coherent laws, also affect LPNs.

Having laid the groundwork for defining the nurse scope of practice and the major issues, chapter 2 compares the 50 states' regulations on SoP. Each state has its own NPA, and while there is

some variance between them, it is not a lot. The small differences, though, are interesting.

The typical state nursing board's website provides little useful guidance on the SoP. Only a few state NPAs even mention a *scope*. A few states do provide further guidance for their nurses, such as advisory opinions on specific nursing skills. The chapter provides an in-depth look at California's SoP; it is the one state with separate boards for vocational (i.e., practical) nurses and RNs. Nevertheless, California—like most other states—provides very little guidance to its nurses.

Chapter 3 explores the special relationship nurses have with physicians. Our profession, in fact, can only be understood fully in relationship with the medical profession. As with nursing, the medical scope of practice is vague and based on common practice. The nurse SoP is essentially that which the medical profession has allowed us to have, a cutout of the medical scope of practice. That is the terrain of the major battle that has been central to the entire discussion of scopes of practice.

The focus shifts in chapter 4 to how nurses can use scope of practice to understand our roles and our work better, protect our patients, and grow the nursing profession. To clarify the discussion, I identify several distinct areas in which nurses and nursing organizations can effect change: government regulation, professional standards, nursing management, nurse training, and patient control. The chapter also discusses the organizational levels: a nurse as an individual can do some things to promote her scope, while her department, the hospital, or professional associations can do other things based on where there they are on the organizational levels. Healthcare leaders need to contend with the SoP for many reasons. For example, nurses that violate their scope create liabilities for themselves and their employers. Hospitals need to provide clear guidance on what their nurses are and are not allowed to do. Also included are case studies of specific campaigns to expand the SoP.

Nurses often use their role to move into other realms, and we often use the SoP to go into wrong directions—the subject of

chapter 5. These hurt the nursing role, endanger patient safety, and undermine SoP. They include nursing diagnoses, complementary and alternative therapies (CAM), and the use of "intuition."

Nursing diagnoses such as the NANDA system began with the expectation that they would replace medical diagnoses. Instead, we have an unworkable system that lacks credibility. The nursing community does not take these diagnostic systems seriously, and eagerly ignores them when we get into advanced practice. Yet there has been almost no call for them to be abandoned. As I explain in the chapter, my suspicion is that institutional inertia is the only thing perpetuating nursing diagnoses.

CAM, including spirituality, is another wrong direction that violates our commitment to evidence-based practice and undermines the nursing role. I argue against the American Nurses Association, which goes so far as to have a different definition of *evidence-based practice* to accommodate these practices. They pose significant dangers to or patients, waste precious resources that would otherwise go to evidence-based practice, and undermine our integrity.

Then there is intuition, a concept for which the nursing profession seems to have a special affinity, suggesting that a good nurse can see things without consciously knowing. I argue that contrary to conventional nursing wisdom, intuition is of limited use, and much like CAM, presents dangers to patient care. As we expand our scope, we need to show we use our knowledge and skills, not intuition, to provide safe patient care.

In the concluding chapter 6, I provide recommendations on how we can address the concerns raised throughout this book. Our profession if full of talented nurses working everywhere in our communities and all across the world. What we learn from the problems currently plaguing the SoP can have a major impact on our work, on patient safety, and on the health of our communities. Many of the problems associated with our scope is that nurses cannot openly admit to doing things beyond our scope, which are done routinely and without endangering patient safety. Among my recommendations is that we empower nursing professional associations to take

the lead in determining the SoP and use that to expand our scope. We need to support labor unions, whose role is to protect nurses so they can advocate for themselves and for their patients.

No one rule or regulation, by itself, should be the deciding factor in any important matter. This runs contrary to the notion that a law, or a rule, needs to be followed absolutely. We should consider alternatives to the U.S. approach to the SoP. For example, other countries designate skills as being controlled, and thus requiring special training. The law does not designate who performs that skill, so it is not exclusive to either the medical scope or the nursing scope. Let's stop pretending our battle with physicians is about patient safety. It's a turf war. Nurses need to be more honest and open about why we want to expand our scope, and how to do it safely.

Finally, and most important, we need to stick to evidence-based practice. It is the core principle that made the nursing a *profession*. Evidence-based practice started with Florence Nightingale, and continues to this day, albeit with challenges all along the way. We are being pulled in all sorts of wrong directions as special interests try to use nurses to achieve their own goals. But if the nursing profession is going to continue on a path of growth, we need to stay strong and hold to our principles.

Note

1. My editor points out that a *skill* refers to artistic or creative acts, and the proper term I should use is *task*. However, the nursing community typically (although not always) refers to what we do as "skills." Therefore, when I refer to a task in this book, I mean an act simpler than a "skill" according to that typical use—that is, an act that does not require much specialized nursing knowledge.

1

What is the Nursing Scope of Practice?

Cynthia, a nurse manager of a large department in a city hospital in Middle America, was training a new nurse in the med-surg department and asked her how she should give the 118-milligrams (mg) of methadone the physician had ordered when it comes in a 120-milligram vial. The RN answered that she could put the entire vial in a syringe, and then squirt out a little bit, and that should amount to the difference of 2 milligrams. Cynthia did not like that answer.

Legally, the nurse had only two choices: give the dosage exactly as written, assuming it was safe and appropriate for the clinical situation, or contact the prescribing physician to adjust the order. My first answer would be this: go back to the physician to get the order changed. After some more thought, it occurred to me that the problem is not about how to resolve that small difference of dosage, but that it's about the nurse's scope of practice (SoP; I sometimes refer to it simply as "scope").

This is an example of how nurses are prevented from doing their jobs because of our scope of practice. An RN should simply be able to give the full 120mg dose. The vial comes in units of measure appropriate for that clinical environment, and a quick look at their references would show 120mg is a typical dosage. Also, the error factor

is less than 1 percent (in other words, the difference between 118mg and 120mg is less than 1%). Anyone with an understanding of pharmacokinetics knows the effect of a medicine on an adult patient is not so precise that this difference would be a safety problem. If it would be, that patient should be in the ICU. Finally, it should come as no surprise that the medication came in 120mg vials.

Nurses have better things to do that worry about than giving such an exact amount when it has little clinical significance. An RN needs to prioritize her time, and spending it trying to give such a specific amount just because of a physician's order is not a good use of her time. The physician's time is also valuable, and should not be wasted adjusting orders to accommodate such a limitation on the nurse's scope.

The nursing profession is rapidly growing, and technology is changing. Having a clearly stated legal mandate to do our jobs should be of the utmost importance. But we nurses have an odd relationship with our scope. We continue to work, day after day, thinking we are covered or constrained by some law that, in the end, doesn't actually exist—or, at least, it doesn't state what we think it does. Still, we get the job done. One of the most important ways for our profession to grow is to allow nurses to work at the full extent of the scope we currently have *and* expand our scope to allow us to make full use of our knowledge, skills, and abilities.

We are told from our first days in nursing school about the importance of knowing and following our scope. We're reminded throughout our careers. Our employers routinely remind us to stay within our scope—especially when mistakes occur. That does not seem to translate into better understanding. In every study I could find in which nurses where asked to explain their scope, they could provide no more than vague notions of what they are and are not allowed to do in their jobs. Nurse researchers Nelly Oelke and Debbie White did a qualitative study in which they asked nurses to identify the facilitators and barriers to working at their full scope, and even the experienced nurses admitted openly that they do not really know what is in their scope or how it works.[1] Still, these same

nurses could articulate what they felt helped them in their practice or held them back. In other words, not knowing a *formal* scope did not impede them from performing their duties day after day without major difficulties (the researchers don't mention whether anyone expressed concern over not knowing their formal scope). This ability of nurses to perform their job despite the lack of guidance is what I refer to as the paradox of the nursing scope of practice.

Even our experts and leaders seem ill informed when it comes to the SoP. I was in an island nation, not wealthy but not poor, meeting its Chief Nurse Officer (CNO). The country's nursing system as a whole impressed me, given its small size and modest economic wealth. I described my research project and how many U.S. states and countries have no laws specifying an SoP. She quickly stated that her country has a large body of nursing law that covers all aspects of the profession. But in mid-sentence, she hesitated.

As CNO, she was responsible for advising her nation in the development of these laws. I could see in her eyes what I already knew: her country's laws made no mention of scope of practice.

"But we need to have flexibility in some matters," she continued, "and that means leaving things up to other … uh … other processes." It was jarring.

Lack of Guidance

The nursing scope of practice is important for a lot of reasons, which is why it should be clearly stated in the law, easy to find, and easy to follow.

Go ahead and look for it on your state nursing board's website.

That's what I did as a new nurse. And again, in my graduate program, as part of an assignment. The second time searching for it, I figured all my experience and newfound knowledge would help me locate it online, and understand it at a deeper level. Not so. On the California Board of Registered Nursing (BRN) website, there's a multipage explanation of the state's regulation of the SoP, including an emphasis on the importance of following it strictly as

a way to avoid being disciplined. Consequences of not doing so may include losing one's job and nursing license, getting sued, and even being subjected to criminal prosecution. Every state, including California, has a nurse practice act (NPA) that is the main law relating to nursing. But the words "scope of practice" appear nowhere in California's NPA. To be clear, there are many laws related to scope, but one would think the NPA would address the issue.

California's nursing laws are not just an exception. Many states claim to have such laws when, in fact, there is little or nothing to be found.

The most common guidance I see in the nursing literature and from our state nursing boards (referred to in other countries as councils; henceforth, I refer to them as boards or Boards of Nursing, BoNs) is the admonition to "consult your supervisor" when a nurse has a question about what she is allowed to do. That is a non-answer.

When a nurse doesn't know what to do, it's because of a deficiency in her training and guidance. Her supervisor, or the facility in which she works, has the same deficiency—lack of guidance on the scope. It's missing from our laws. Many well-used nursing textbooks neglect to mention it. Cherry and Jacob's book on contemporary nursing issues doesn't mention SoP,[2] nor does Kozier and Erb's book—the top-selling basic textbook.[3] Even when scope is mentioned, the discussion is brief and unenlightening. I searched through my books on nursing documentation, nursing law, ethics, and other topics, and either there was no mention or it was a generic statement about its important and a suggestion to look at your licensing authority's website for more information.

This is not to say there are no statements on our scope. Quite the opposite. There are many, virtually all written either by professional associations or government entities. These are the basic laws for all RNs. Advanced practice nursing entails a different set of rules, which will be discussed shortly. But before a nurse gets to advanced practice, she still needs to be licensed and work as an RN. In my California example, there was mention of a scope but no real substance to the laws. Other states have published SoP laws or

rules, but with varying degrees of specificity. This is actually part of the problem. Having so many statements spelling out our scope adds to the confusion.

Scope of Practice Terminology

The terms used to describe the various forms of *guidance* provided from different quarters to establish or explain the nurse SoP can be confusing because of how synonymous they seem to be. The explanations here are aimed at clarifying their meaning.

Laws—enacted by governments; carry penalties for noncompliance; often difficult for the average person to understand because of centuries-old conventions regarding how laws are written. California's Nursing Practice Act is an example.

Rules and regulations—generally, laws rewritten to make more specific the actions they intend, but may also be written independent of any laws; typically carry penalties for noncompliance. In this book, *rule* is used to indicate both, and the act of *regulation* or *regulating* is used to indicate government implementation and enforcement of those rules. An example can be found in the California Code of Regulations. Its section "Title 16. Professional and Vocational Regulations, Division 14. Board of Registered Nursing, Article 7. Standardized Procedure Guidelines" explains specifically how to write a standardized procedure that gives a nurse her right to perform a given nursing skill.

Policies—issued by hospitals, companies, the government and in some cases even by individuals (e.g., a nurse manager in a given facility). Policies do not carry the weight of law, but may still include penalties for noncompliance (such as a bank charge for bouncing a check). A hospital in California may, for example, require its nurses to perform only those skills for which it has a standardized policy.

What Is a Scope?

What I have just done thus far is make the case that the nursing profession has a problem, in which we lack guidance and a proper

legal mandate to perform our jobs. To put it in a positive light, we have an opportunity to move the nursing profession forward by addressing this important issue.

What exactly is a nursing SoP, or any scope of practice for that matter? There is no short answer, and there is no gold-standard definition. A scope of practice, for any healthcare profession, does three things:[4] define the practice of profession; limit the practice to certain people; and restrict the use of titles and credentials to holders of a license. Barbara Safriet of Yale Law School, who wrote one of the most widely cited articles on the subject, describes the SoP as "legislatively-defined spheres of activity within which various types of health-care providers…are authorized to practice." We will see that the legislatures' involvement does not carry as much weight as has been credited to these bodies. Nurses tend to look to government regulators for the scope, but a major theme in this book is that we get our guidance from many other sources. Private entities play important roles in determining the scope. The American Nurses Association (ANA) notes that regulation refers to both public and private types. Certification may be used in lieu of government regulation, which results in the ANA fulfilling some of the roles that would otherwise be the purview of a BoN.[5]

It is instructive to see how the Federation of State Medical Boards definition of a scope of practice compares to what nurses have produced:

> Definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability.[6]

That's a pretty good statement of what, generically, any SoP is. It just doesn't tell us what nurses are allowed to do. Note the

difference between spelling out what a certain type of law is supposed to do and specifying what a specific law allows someone to do. At least we're narrowing things down, at least a bit. Patricia Baranak, in her report comparing SoP laws across Canada, concludes that there is no agreed-upon definition.[7]

History provides an explanation of our scope. Physicians dominate the healthcare professions. They were the first to have their profession written into law, including their scope. It should come as no surprise that they wrote the law to take everything within the field of health, broadly defined, as their scope. Since then, other professions have written their scopes into law, with the medical field taking precedence. The nursing profession is thus legally defined after medicine, both historically and practically. Our scope is a carveout of the medical scope. In fact, every healthcare profession's scope is a carveout from that of physicians. Since all healthcare is within the scope of medicine, nurses are therefore working within the scope of medicine. That should strike a chord with respect to the competition between nurses and physicians (see chapter 3).

The ANA's *Nursing: Scope and Standards of Practice* is arguably the single-most important book on the topic, so it needs to be considered at length. The first edition arrived in 1987, and was eight pages long.[8] By way of comparison, the current edition is about 250 pages.[9] The original edition begins by noting it applies to nurses with a bachelor's degree or higher. This is an important distinction because at the time, nurses mostly came from hospital training programs or vocational schools. What exactly is nurses' scope, according to the ANA?

> Here is one scope of clinical nursing practice. The core, or essence, of that practice is the nursing diagnosis and treatment of human response to health and to illness. This core of the clinical practice of nursing is dynamic, and evolves as patterns of human response amenable to nursing intervention are identified, nursing diagnoses are formulated