Point....

BSN Required

Ed Note: *An editorial entitled the Tale of Two Elephants in the April-May-June, 2012 issue of the NH Nursing News (Vol 36:2, p.9) it was opined that there should be no new or expansion of pre-licensure programs (and that 12 hour shifts be restricted for new grads). Two prominent nurse leaders have since responded with their views on nursing education which we present here as POINT–COUNTERPOINT.*

Karen Tollick, RN, BSN

> "Based on the research is it evident that the time has come to end this debate. All nurses must attain a BSN as the minimum entry level into nursing practice."

Nursing originated in ancient times as an art. It consisted of tending to the sick and infirm in their homes. To nurse was to tend to personal needs such as hygiene and feeding. There was no formal education or training, instead nursing was learned by the passing down of information orally to those who either sought to nurse or those who were chosen to nurse (Egenes, 2009, p.2). The common health problems were infections, fever and childbirth and the treatments were few and simple–herbs, water, and poultices. Complex for the time, simple compared to the present day. Over the years the nature of nursing changed to meet the challenges of the times. Hospitals and almshouses were the setting for the sick and the types of illnesses and injuries requiring care were different. Nursing was now an entity, based in science, but still there was no formal education in place. It wasn't until the mid-1800s when the work of nurse Florence Nightingale clearly proved that nursing as an art and a science needed to be taught in the classroom setting, that learning by watching was not enough (Egenes, 2009, p. 6). Fast forward to the present where nurses are facing rapid advances in science and technology, an aging population, and rising numbers of people with chronic health conditions (Institute of Medicine, 2010). In addition are the complexities of the health care environment in the United States not in existence until the last few decades. The population is more knowledgeable about their own health. They have immediate access to health care information that is unprecedented thanks to the internet. They demand the best care available. One must also take into account the Affordable Healthcare Act of 2010 which, as currently written, will shift the manner and settings of health care delivery from managing acute illnesses and injuries in hospitals to focusing on health prevention, promotion and maintenance in the community. These changes and challenges have implications for nursing practice which, in turn, has implications for nursing education. Consider the following as written by Benner et al (2009):

> "Nurses maintain patient safety while managing multiple intrusive technologies where the margin of error is extremely narrow, and they do so in increasingly complex, hazardous work environments." (p. 1)

These are daunting words but this is the reality of nursing in the 21st century. It is clear that in order to provide patients with safe, evidence-based, quality care, the nurse of today and the future must be highly educated. Nursing education must not only include nursing science, it must expand to cover the humanities and social sciences (Benner et al, 2009, p. 2). At the core of the education process must be the development of critical thinking skills leading to sound clinical reasoning. The attainment of these abilities will provide the nurse with the competencies needed for practice. Currently there are two main education pathways to enter nursing practice–the associate degree in nursing (ADN) and the baccalaureate degree in nursing (BSN). Are both options capable of meeting the nursing education requirements for practice in the current healthcare environment? Each entity believes they are. It is this clash of beliefs about nursing preparation as well as the position taken by a number of leading nurse organizations calling for baccalaureate-only programs that has led to the debate that has gone on for nearly 50 years. In order to meet the evolving demands of healthcare and achieve satisfactory patient outcomes, the BSN must be the minimum entry level into nursing practice.

Essential to understanding what has led nursing to its present state of disunity over the education pathways, one must have an awareness of the development of nursing education. The first formal nursing education programs were hospital-based. They served two purposes: 1) they provided the hospitals with much needed staff for patient care; and 2) they provided training to nurses at no cost to themselves with the attainment of a diploma upon completion (Scheckel, 2009, p.33). This apprenticeship approach developed a capable nursing workforce for the time. The early 1900s saw a rapid growth in science knowledge, especially in areas affecting medicine and nursing (Egenes, 2009, p. 10). According to Smith (2009) these advancements led to concern about the nursing profession and its education process which, in turn, led to the establishment of two professional nursing organizations. The American Nurses Association (ANA) was founded to create rules and regulations as well as licensure for nursing practice. The National League for Nursing Education (NLNE, now the NLN) was founded to oversee nursing education through the creation of standards which included establishing a uniform curriculum for schools of nursing. Endeavoring to comply with these new standards and regulations, nursing leaders and educators began to discuss new approaches to providing nursing education. By 1909 the first baccalaureate degree nursing program was founded and come the 1960s this entry level into practice was firmly established (Scheckel, 2009, pp. 38-39). Diploma programs were still a popular choice for most seeking a nursing career, but not there was another option.

It was a different kind of change that led to a third entry level into nursing practice. World War II and the years immediately following saw a severe shortage in the number of nurses available for practice. At the same time there was an increase in the number of students who wanted to obtain a college degree (Egenes, 2009, p. 19). This shortage, coupled with the greater interest in a college education, led to the establishment of ADN programs. According to Montag (1951), offering such degrees in community colleges "could prepare registered nurses as semi-professionals" (as cited in Scheckel, 2009, p. 36). Nurse could be educated in a college and ready for practice in only 2 years versus the 3 and 4 years required of the diploma and BSN programs respectively. A reasonable solution for the needs of that era was in place and those seeking a nursing education had three options for entry into practice. Still it wasn't enough. According to Smith (2009), the U. S. Surgeon General's Consultant Group on Nursing reported in 1963 that the country was facing another nursing shortage. Other recommendations within the report led to federal legislation–the Comprehensive Nurse Training Act of 1964–which impacted nursing education, propelling it towards a professional model and away from the training model. The ANA reviewed this report and responded to the 1964 act by organizing a committee to "study nursing education, practice, and scope of responsibilities" (Smith, 2009). The end result was publication of the 1965 document "Education Preparation for Nurse Practitioners and Assistants to Nurses" now known as the ANA position paper. While this committee made a number of recommendations, only one created a rift among nurses at all levels of practice–"...minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing" (as cited in Starr, 2010, p. 129). It is this statement that has spurred the debate that will soon reach its 50th year without resolution.

Each time a change in healthcare needs or knowledge or advancements in technology has occurred, the response has been a change in education, practice, and responsibilities. The time for radical change has come again. The IOM report of 2010 laid out in detail the need for highly educated nurses. It cited the aging population, the increasing numbers of people living with chronic conditions and demographic changes in the population such as cultures, socioeconomics and ethnicity as the driving forces requiring a change in nursing education. These health care challenges have given rise to a different set of competencies that must be achieved by the nurse today. No longer is it adequate to know how to change a dressing, administer medications or auscultate a blood pressure. Today's nurse must assess, diagnose, intervene and evaluate. Today's nurse must understand health policy, be a leader at the bedside, deliver evidence-based care and know how to research and interpret that evidence. Finally, today's nurse must be able to communicate on multiple levels, using multiple technologies, in order to coordinate care and collaborate with the healthcare team (IOM, 2010). These competencies are only achievable through higher education, the baccalaureate level being the launching point.

Throughout the literature support for mandating the BSN as the only entry level into nursing practice is strong. According to the National Advisory Council on Nurse Education and Practice (NACNEP), the BSN pathway is best equipped to provide the sciences, communication and analytical knowledge needed to nurse the health of the people today (as cited in AACN, April, 2012). Lane and Kohlenberg (2010) expressed in an article that leadership, professionalism, and critical thinking are only delivered at the baccalaureate level. The American Association of Colleges of Nursing (AACN) lists multiple organizations that require a BSN for either employment or promotion or both (as cited in Lane and Kohlenberg, 2010, p. 219). They include all branches of the Armed Forces and the Veteran's Administration. Multiple state legislatures–Oregon, New York, New Jersey, North Carolina and North Dakota–are working on bills that propose advancing the entry into nursing practice to the baccalaureate level (Lane and Kohlenberg, 2010, p. 218-219). The public view of nursing also deserves consideration. Nursing is a service-based profession and as such has a duty to respect public opinion. According to the ANA (2009), nursing has consistently ranked as a most trusted profession in surveys for 8 consecutive years (as cited in Lane and Kohlenberg, 2010, p. 221). This is well deserved but the public also wants an educated, professional nurse. Also reported by Lane and Kohlenberg (2010), a 2005 AACN survey of public opinion on nurses and nursing found that 76% of respondents thought nurses should have a BSN or higher.

Strong opposition to the mandatory BSN entry level into practice comes from those connected with ADN programs–the nurse educators, deans, presidents, currently enrolled students and graduates of community college nursing programs. They put forth reasonable arguments. The large number of nursing programs available along with the shorter education time eases the burden of nursing shortages. Fraher et al (2008) report that ADN graduates are more apt to work in rural or underserved communities than BSN graduates and that ADN nurses are more likely to remain in the communities in which they were educated leading to reduced turnover rates and vacancies–costly problems for healthcare facilities (as cited in Starr, 2010, p. 130). Perhaps the strongest argument in favor or retaining this entry level for nursing practice is that these programs produce safe, competent nurses based on the fact that they pass the same NCLEX licensure exam as BSN nurse.

Counter to these arguments are several irrefutable facts. First, the NCLEX exam is a minimal competency exam. Passing it signifies that the nurse is merely safe to enter nursing practice. Success in this exam does not take into account the complex issues in healthcare or validate the competencies required to address them. Second, there are a number of studies conducted by nurse researchers and published between 2001 and 2008 that lend credence to the BSN mandate. Summarized in AACN's "Impact of Education on Nursing Practice" fact sheet (April, 2012), their findings were similar: patient outcomes and safety, as well as the quality of care, were improved when that care was delivered by a baccalaureate-prepared nurse. Specifically, these studies either demonstrated reduced patient mortality rates when care is provided by BSN nurses or they found that nurses educated at the associate degree level made more medication and procedure-related errors than baccalaureate-prepared nurses. Third is the point that ADNs are more likely to practice in underserved communities, the counterpoint can be made that this will soon change based on the 2010 AHA mandates and the 2010 IOM recommendations for nursing education and practice. Both recognize the need to move healthcare from its primary setting of hospitals to the communities.

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Community college programs currently have no or minimal focus on community health and nursing. It is unlikely that will change as their curriculum is filled to meet basic entry requirements. Baccalaureate programs have strong community courses, both didactic and practicums, but it is acknowledged that these will need strengthening to meet the new competencies.

As for the final stance that community college nursing programs positively impact the nursing shortage, there is no dispute. Graduating nurses in 2 years puts them into practice sooner, but are they the ready for practice as it stands today? The facts say no.

One can also point out that despite the number of ADN programs and the numbers that they graduate, nursing continually cycles through shortages and in all likelihood will continue to do so.

Community college nursing programs put forth other valid reasons for continuation: they are more affordable and more accessible. One cannot disagree with affordability. Preparation at the 4 year level is extremely expensive and out of reach for many. As for accessibility there are two levels, the number of programs and the opportunity for admission to those who would not meet the criteria for acceptance into 4 year programs. One can disagree with this argument. The number of BSN programs is rising and the advent of on-line nursing programs opens an avenue to many who could not attend a "traditional" college for any number of reasons. The difficulties in being accepted to a 4 year program because of being an older student, a minority, or nontraditional student are no longer valid. According to Fagin and Lynaugh (1992), "with appropriate guidance and adequate financial aid, students from traditionally disadvantaged groups can and do attain true professional mobility through baccalaureate education" (as cited in Nelson, 2002).

Finally, those who support the ADN entry level as a viable one argue that their programs offer similar nursing studies to those offered in the BSN programs. Already noted was the lack of community nursing in associate degree programs. A further, nonscientific comparison of courses offered in each program identifies other differences in nursing preparation. Courses such as Nursing Leadership, Clinical Decision Making Nursing Theory, and Professional Transitions exist at all baccalaureate programs (some under other names), but are non-existent at the associate degree level. The two year programs were not designed to educate to this higher level. They are task-oriented in their approach which is their maximum capacity relatable to the time frame for program completion. Community colleges also face challenges in the recruitment of faculty, space for nursing labs and other expensive resources required by nursing programs.

Mandating the BSN as the minimum entry level into nursing practice is key to solving the current nurse faculty shortage. According to Lane and Kohlenberg (2010), the number of students being denied entrance into nursing programs is directly related to a lack of nurse educators adequately educated to teach. The AACN (2007) reported that "30,709 qualified nursing applicants were turned away from baccalaureate programs in 2007 because of the shortage of nurse faculty" (as cited in Lane and Kohlenberg, 2010, p. 222). Requiring a BSN for entry into practice paves the way for nurses to continue on to higher education, creating a greater pool of nurses available for educator positions. Not to be ignored is the fact that if those 30,000 plus applicants were able to enroll in a program, it would not only increase the number of BSN nurses in practice, it would go a long way towards reducing the general nursing shortage. The ADN programs proffer the argument that they are a stepping stone to attainment of a baccalaureate in nursing. However the numbers do not support this. Spratley et al (2001) reported that only about 16% of ADN graduate go on to BSN education (as cited in Megginson, 2008, p. 48-49).

There is one other group opposed to a mandate for entry into nursing practice–the front-line nurses currently working and educated to the ADN or diploma levels. They argue that their employers do not provide monetary compensation based on degrees held and that there is no discernible difference in practice roles and responsibilities (NLN, 2011). Support of their assertions is found in a small, qualitative study published in 2008. Megginson questioned the participants about the barriers and incentives to pursuing a BSN. The findings with regards to the barriers aligned with the anecdotal comments above (Megginson, 2008, pp. 52-53). One cannot refute what these nurses experience and know to be true. However, a lack of understanding concerning the need for a single, higher entry level also contributes to the lack of resolution for the debate. To date, much of the discourse has been at upper levels, among nurse leaders, educators and policy makers. According to Smith (2009), part of the failure to resolve the issue is found at the grass roots level and is directly attributable to the paucity of information for these nurses detailing the issue and its implications for them and their patients.

Based on the research is it evident that the time has come to end this debate. All nurses must attain a BSN as the minimum entry level into nursing practice. Agreements among the stakeholders must be reached and steps towards implementation must be taken now. There are several actions needed to achieve this goal. First there must be active education of the nursing community, the public and the legislators on the facts (Smith, 2009). Better and wider dissemination of the 2010 IOM report and the results of the 2009 Carnegie Foundation for the Advancement of Teaching nursing study along with their implications for nursing education and practice arms the nurses with the power to make the needed changes in their nursing education and their practice. Engaging the public and legislature in the process presents a unified front and garners more support. According to Smith (2009), "if...the public perceives a true sense of unity and dedication to a cause (policy), it will most likely be more supportive of that cause." Building on this support, nursing organizations and nurse educators then must work with states' legislatures to change the entry level education requirements.

Consideration needs to be given to those nurses who do not currently hold a BSN but are currently in practice. Proposed solutions to accommodate these nurses include 3 strategies set out by the ANA in 2008. They are: 1) support for legislative proposals mandating attainment of the baccalaureate degree within 10 years of licensure as an RN, 2) encourage collaboration between schools of nursing, and 3) advocacy at the legislative level for financial support for educational advancement (as cited in Lane and Kohlenberg, 2010, p,. 224). While the final goal is a BSN–only entry level, it is impractical and unlikely that community colleges will simply close their nursing programs at once. Instead it is more feasible to deny the addition of any new ADN programs and to allow the remaining programs to close due to attrition as BSN programs become the requirement. There must be a transition plan in place until that occurs. The best plan, already in action in a number of states, is for collaboration between the 2 programs to create a seamless articulation agreement allowing continuation from an associate degree program directly into a baccalaureate program. Several ways this can be accomplished are co-development of the 2 programs' curricula as well as "enhanced transferability and credit distribution, and guaranteeing that 30 nursing credit hours of ADN studies be applied towards the BSN degree" (Lane and Kohlenber, 2010, p. 223). These collaborative programs must stipulate that licensure would not be allowed until completion of the BSN studies.

Higher education is expensive and not all ADN graduates or those seeking a career in nursing have the financial ability to pursue their endeavors. Resources must be made available to assist them. Federal and state funding must be available and employers of nurses must recognize their role in financially supporting the advanced education of their nursing workforce. Tuition reimbursement and, loan forgiveness programs as well as scholarships and grants would help offset the costs to the individual.

The road to resolution has been long and winding and nursing education and practice has not yet reached its desired destination. The reasons to change are compelling and the solutions are achievable. It is time for nurses to truly become a profession as their compatriots in New Zealand, Australia, the UK, Canada, and other European countries have done. As the largest number of healthcare providers and the ones with the most contact with patients, nurses have a duty and a responsibility to serve them to the best of their ability. Unless and until the nursing education level changes, the profession will not be able to meet the demands and challenges of the future.

Karen Tollick RN BSN is a clinical educator at Southern New Hampshire Medical Center and is currently completing a Master's degree at the University of Phoenix.

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NHNA is also developing a technology relationship with other states and the American Nurses Association (ANA) to allow us to be a more streamlined office that offers more efficient and accessible communications for members anywhere across the state. The utilization of a higher tech office will reduce operating costs and enable NHNA to redirect resources to programs, services and advocacy. This means that NHNA members will have easy and ready access to interface with their areas of interest in practice issues, policymaking, professional development, and much more. We have already reorganized our Board of Directors, reducing the number of directors to allow us to make important decisions quickly and efficiently. We are also considering more ad hoc commitments to the organization–we will be offering you opportunities that will be as brief or as long as you are able to contribute.

The NHNA stands ready to welcome every nurse prepared to play a part, whether only paying dues and supporting your profession financially or being active in short term or long term roles. No matter the role you want to play, you have to join to play: become a member of the NHNA. The benefits of membership in the NHNA are many, but for those who participate, the greatest benefit is being a part of the effort and a part of the change.

A final note: Immediate Past President of the American Nurses Association, Becky Patton, visited NH a couple of years ago. She ended her presentation to us with the following words of wisdom: "If you are not at the table [when important decisions are made about the profession], you are lunch." I, for one, do not wish to be on the menu.

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