FAMILY NURSE PRACTITIONER'S SCOPE OF PRACTICE:

FOCUS ON THE STATE OF MONTANA

by

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ABSTRACT

Purpose: The purpose of this project was to educate current and future nurse practitioners by offering clarity about the components of scope of practice (SOP) for Family Nurse Practitioners (FNPs) in the state of Montana. Background: It is crucial for FNPs to know where to locate and understand each state's Boards of Nursing (BON) statutes, administrative rules, and Nurse Practice Acts (NPAs) in order to legally practice. Significant liability issues can result if one ventures outside of their scope of practice. The safety of patients is increased when a provider explicitly knows his or her limits. It is also critical that graduate educational programs clearly articulate SOP for Nurse Practitioners (NPs), so that once they begin in clinical practice, they are better informed about their role, SOP and related boundaries. Methods: A quantitative, quasi-experimental design with consecutive sampling was used. Neither randomization nor a control group was employed. The researcher designed and created an evidence-based, recorded YouTube education presentation regarding FNP SOP in Montana, along with pre and post-education questionnaires that were distributed to four cohorts of FNP students at Montana State University College of Nursing. Descriptive statistics and the paired t-test were used to analyze the demographic data and measure gain scores between the pre and post-education questionnaires in order to evaluate if knowledge increased. Results: Results indicate that the YouTube educational presentation is associated with higher post-education scores ($p < .001$). Seven students fully completed all components of the project for a participation and retention rate of 22%. Conclusions: The results of this study can help guide FNPs who need to clearly understand the components that define NP SOP within their population-focused specialties. It highlights the need for graduate educational programs to clearly articulate the population-focused and specialty NP roles.

FAMILY NURSE PRACTITIONER'S SCOPE OF PRACTICE

Nurse Practitioners (NPs) are part of a group of Advanced Practice Registered Nurses (APRNs) who are eligible to practice in a variety of settings. Some of these settings include, but are not limited to, family practice clinics, acute care facilities, physician practices, and urgent care walk-in clinics. Over the years, much has evolved in regards to the role of the NP and these settings in which the NP practices. Presently, NPs must graduate from an accredited formal education program specific for a population of interest, successfully pass a national certification examination for licensure that is based on the focus of the NP's formal educational program, and apply for advanced practice endorsement to their existing registered nurse (RN) state license (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). The state of Montana issues separate APRN licenses with one's specific APRN practice displayed as well as an endorsement for prescriptive authority, if the APRN holds it. Prior to employment, credentialing and privileging typically occur if the NP is going to work in the acute care setting. This process can be institution dependent for clinic sites. The focus of the NP's formal educational program is the foundation that defines an NP's scope of practice (SOP) (Kleinpell et al., 2012). "Despite the existence of a number of authoritative documents that outline SOP for NPs, uncertainty continues to exist about the essential components that define NP SOP" (Kleinpell et al., 2012, p. 11). Therefore, the purpose of this scholarly project is to offer clarity about the components that define NP SOP with an emphasis on Family Nurse Practitioners (FNPs).

In the United States, registered nurses do not enter practice with a specialist certification and their SOP is common throughout all regulatory jurisdictions (Hudspeth, 2009). However, this is not true for the nurse who moves into the advanced practice role of the NP (Hudspeth, 2009). “Instead, NPs enter the profession as specialists, certified to care for populations that fall within their area of certification” (Keough, Stevenson, Martinovich, Young, & Tanabe, 2011, p. 196). Nevertheless, there is variability in SOP among individual jurisdictions and lack of clarity by the NP regarding how they practice, which results in confusion (Hudspeth, 2009). To add to the existing confusion, the literature offers varying definitions of SOP for NPs, which range from very broad generalizability to slightly more specific delineations of what is permitted. Klein (2005) states “Scope of practice determines who you can see, who you can treat, and under what circumstances or guidance you can provide this care. Scope of practice also determines the limits and privileges of your licensure and certification as an advanced practice nurse” (p. 1). These descriptions and definitions may seem straightforward, but they are not as explicit as one might think.

There are a plethora of titles that reflect the specialization under which NPs function. Family Nurse Practitioner (FNP), Acute Care Nurse Practitioner (ACNP), and Psychiatric Mental Health Nurse Practitioner (PMHNP) are just a few examples. This composition of initials implies clarity of function for the NP’s diverse roles through a sense of core NP content (McCabe & Burman, 2006). But, the NP role has developed in a rather arbitrary fashion, and has been externally influenced by changes in the health care delivery models, which has added to the confusion regarding the actual duties performed

by any given NP (McCabe & Burman, 2006). Therefore, there may be confusion over the myriad of titles, but even more significant is the confusion that exists related to practice boundaries of the NP's specific roles and SOP associated with their titles.

Problem Statement

Confusion exists about what a nurse practitioner's SOP means and the implications this has for the nurse practitioner's job descriptions and responsibilities. Clarification across NP specialties is needed to create clear boundaries among the scopes of practice for nurse practitioners. McCabe and Burman (2006) make the point that there are many documents available that provide outlines of scope of practice. However, the individual NP is responsible to decipher the implications and applications this carries in their personal clinical practice. Although each state enacts nurse practice acts (NPAs) for the purpose of outlining SOP boundaries, these limits continue to remain unclear (Owsley, 2013). With blurred boundaries and lack of clear distinction of competencies among the population-focused NP roles, how is one to choose which educational program best fits their needs for practice? How does one choose the proper place of employment? How does the NP make clear distinctions of boundaries in regards to exceeding SOP in their population-focused specialty? Therefore, clarification of SOP is needed for FNPs.

Clinical Significance

Stakeholders impacted by this project include patients, employers, the Montana Board of Nursing (BON), individuals applying to NP graduate programs, current NP

students, and all practicing nurse practitioners, with an emphasis on FNPs. This project will increase the stakeholder's knowledge by offering clarity about the components of SOP for FNPs, which are multifactorial (e.g., boundaries and competencies). Two resources that the Montana BON utilizes are the 2008 APRN Consensus Model and the National Professional Organizations for APRNs that define SOP for each type of certification. It is crucial for FNPs to know where to locate and understand each state's BON statutes, administrative rules, and NPAs in order to practice legally. Significant liability issues can occur if one ventures outside of their scope (Klein, 2005). Additionally, the rationale for this project includes the potential to positively impact patients and their health care when clarification of SOP exists among providers. The safety of patients is enhanced when a provider explicitly knows his or her role, responsibilities and limits.

It is critical that graduate educational programs clearly articulate SOP for NPs. The reasons are two-fold. First, individuals applying to graduate school for NP education need to be informed about how the educational program will prepare them to practice within the SOP for the specific certification. Applicants will then be able to make an informed and educated decision about the program they desire to attend. Second, current NP students enrolled in a program are better informed about their SOP and boundaries once they begin in clinical practice. According to Hudspeth (2009), during the course of NP education, varying degrees of emphasis are placed on understanding SOP, the NPA, state-specific requirements for practice, and delegation, which, indeed, contributes to provider dilemma regarding SOP.

Clarifying how an NP's SOP serves as a guide in their role is significant to advanced practice nursing as a whole. How does an individual know which educational program to apply for based on the practice setting they desire to work in? How does SOP relate to each specific NP title? Does the NP understand how their SOP applies in their specific practice setting, and how does one clarify areas of overlapping scope? There are no easy methods for finding answers for many of the questions that NPs face in practice. As Hudspeth (2009) points out, "Seeking clarification about individual SOP is not always easy" (p. 367). In addition to this dilemma, basic assumptions that NPs practice within a specified population is not always the case. Some NPs who practice in a physician's practice are not necessarily population-focused settings (Keough et al., 2011). Regardless of the NP's certification, legal regulations do not exist that restrict the setting in which the NP chooses to practice (Keough et al., 2011). This only adds to the confusion in practice because patient's needs do not fall out as neatly and cleanly as the NP's SOP documents might suggest (McCabe & Burman, 2006). For example, if an FNP is working in the acute care setting, there are no lists of specific competencies that state what the FNP is allowed, or not allowed to do if he or she does not have a certification as an ACNP. Unfortunately, not every health care need among the U.S. population or the settings in which patients seek health care fit into these strictly defined categories (Keough et al., 2011).

Holistic patient care is a core value to the nursing profession, and one that has been a source of pride. Yet, in recent years, due to the proliferation of specialty certification practice, there is the implication of division among the NP's holistic care

requiring NPs to practice within their specialty areas (McCabe & Burman, 2006). In the tale of two personal NP stories, McCabe and Burman (2006) emphasize that in an NP's world of clinical practice "Patients do not necessarily compartmentalize their health in ways matched to our specialization or divided scopes of practice" (p. 6). The reality is in the practice world of multiple specialty certification titles, confusion and frustration exist about NP SOP. McCabe and Burman (2006) sum up the dilemmas that present to NPs in the real world of clinical practice: NPs face issues that impact their SOP on a daily basis. The truth of the matter is that there is limited consensus or distinction of boundaries between specialties, their unique scopes of practice, and what to do when faced with situations that may result in crossing those boundaries.

Tensions parallel these situations as NP knowledge continues to expand within current practice environments, limited healthcare resources, barriers to access, and all the while trying to discern the boundaries that demarcate SOP (McCabe & Burman, 2006). For example, chronic illnesses are increasing as are the costs that are associated with them (Rich & Adams, 2015). Studies have shown that the number of primary health care providers will not be sufficient for the number of health care needs in the near future (Newhouse et al., 2011). To compound the problem even further, many areas of the country are rural, including Montana, highlighting the geographic dilemma for individuals' access to health care (McCabe & Burman, 2006). As NPs' knowledge and experience expand with time, there is constantly a push to provide high-quality care and improve access by NPs (Fund & Swanson-Hill, 2014), despite the boundaries and confusion that exists among specialization and NP SOP (McCabe & Burman, 2006). This

confusion between specialties can create unnecessary frustration that leads to an increased need for the NP to explicitly understand their SOP.

Purpose of the Project

The purpose of this project was to educate current and future nurse practitioners by offering clarity about the components of scope of practice for FNPs in the state of Montana. The project was accomplished with three objectives:

1. A recorded YouTube educational presentation regarding FNP SOP in Montana was created and distributed to four cohorts of FNP students at Montana State University (MSU) College of Nursing. Pre and post education questionnaires were designed and distributed to evaluate for potential knowledge increase.

2. In order for this project to be sustainable in reaching current practicing FNPs, a presentation to the Montana BON occurred at their quarterly board meeting on October 19, 2016 that targeted the results of this scholarly project. The YouTube educational presentation was provided to the MT BON so they may archive the information and have it accessible when needed.

3. Incorporating clarification and clearer boundaries of FNP SOP into the educational curriculum at Montana State University will be executed through the NRSG 612 Ethics, Law, and Policy class.

LITERATURE REVIEW

Literature Search Strategy

In order to conduct a comprehensive review, a literature search was periodically completed which is presented in this chapter. The primary research databases that were utilized were Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and internet sources through Montana State University (MSU) library. The search terms included a combination of the following: APRN, hospital, acute care, family nurse practitioner, acute care nurse practitioner, outcomes, regulations, policy, scope of practice, hospitalists, and benefits. Only those articles with links to full text were used.

A significant amount of confusion exists regarding NP's SOP and understanding the components that delineate exactly who the NP can treat. This has created multifactorial dilemmas. The literature is laden with evidence of confusion and barriers that NPs encounter as a result of this uncertainty regarding SOP. As mentioned previously, in the United States, all NPs begin their professional career with an RN license and degree (Klein, 2005). As an RN, nurses do not enter practice with a specialist certification, giving them opportunities to gain experience and care for any population of their choosing. They are trained on the job to care for the population of their interest and have freedom to interchangeably care for differing populations of choice. However, what one did as an RN no longer counts legally under SOP as an NP (Klein, 2005). For example, the RN who has worked for ten years in the Intensive Care Unit (ICU) and goes on to acquire an FNP cannot work in the ICU using the expanded scope of practice of an

FNP, but must maintain the scope of practice of an RN (Haut & Madden, 2015; Kleinpell et al., 2012). This can often be a starting point of confusion for the NP.

Current Best Evidence

Unlike the Certified Registered Nurse Anesthetist (CRNA) and Certified Nurse Midwife (CNM) who have had a history of uniform accreditation and competency-based education, the NP role "evolved in a more fragmented fashion, and curriculum standardization and accreditation standards followed, rather than directed, education" (Klein, 2005, p. 1). Historically, NPs entered practice as providers based on the shortage of primary care physicians (Newhouse et al., 2011). This rapid need for primary care providers and emerging economic trends contributed to the lack of structured models of practice for NPs, and thereby, had a blurring effect on SOP (Percy & Sperhac, 2007). The literature suggests that current trends are continuing in the same fashion based on the rapid pace with which newly emerging NP roles are being adopted and the shortage of providers predicted persists, only contributing to the confusion of SOP (Gardner, Chang, & Duffield, 2007).

Barriers. In an Australian study, the literature suggests that clarity in advanced practice roles is needed due to the plethora of roles that exist under the umbrella term of APRN (Gardner et al., 2007). In order for nursing to be in an optimal position to influence best practice in patient care, providing a language that is more easily understood by non-nursing administrators is warranted (Gardner et al., 2007). The literature is replete with evidence that indicates that NPs are safe and effective providers

who provide high-quality care in a variety of settings (Cahill, Alexander, & Gross, 2014; Fund & Swanson-Hill, 2014; Newhouse et al., 2011). For NPs to continue to contribute to health care by producing outcomes of high-quality care and lead change by creating innovative health care system solutions, barriers must be removed in order for NPs to practice to the full extent of their SOP (American Academy of Nursing, 2014).

One key factor is to fully understand what SOP imposes on NPs. According to Hudspeth (2009) "SOP is extended to professionals by society through the legislative process whereby state legislatures enact laws, or statutes, that define what professionals can and cannot do within the parameters of their education and training" (p. 366). Essentially, NPAs are the laws which generate Administrative Rules (ARs) that regulate nursing practice (Owsley, 2013). However, it doesn't end here. There are a few methods that states utilize in denoting conditions and limitations of NP practice (Hudspeth, 2009). Within these methods where SOP statements are endorsed, further clarification can be created by additional practice statements within a statute, rule, position paper, or policy adding further clarification and guidance to practice limitations as long as they don't exceed what the law allows (Hudspeth, 2009). Removing barriers for easier access to this knowledge, along with clear-cut information concerning SOP is indispensable. This supports removing barriers of restriction of SOP by state legislation. Ultimately, the NP remains personally responsible to know their SOP boundaries within the jurisdiction of where they practice because when one violates the NPA by practicing outside their scope, disciplinary actions from the state BON may ensue (Hudspeth, 2009).

Regulatory boards, such as the BON, “are established to monitor professional activities with the primary purpose of safeguarding the public’s safety and welfare” (Hudspeth, 2009, p. 366). Hudspeth (2009) continues to report one of the four broad categories that complaints of NPs fall into at the BON is “exceeding or some breech in SOP” (p. 366). This study’s results stated a total of 34 boards of nursing reporting physicians being the main source of complaint in regards to NPs exceeding SOP, supporting the need for clarity of SOP among NP colleagues (Hudspeth, 2009). Although the purpose of keeping NPAs and SOP guidelines vague is to not limit the specific activities that can be performed by a nurse practitioner, or place unnecessary restrictions on them practicing to the full extent of their education and training, the vagueness can set forth a lack of fairness to the practitioner in aspects of the disciplinary process (Owsley, 2013). As currently enacted, NPAs present many barriers to the delivery of effective healthcare that are unfair to consumers and practitioners alike by offering vague definitions and guidance when it comes to SOP (Owsley, 2013). These vague definitions of NPAs do not provide clarity regarding overlap of practice among NP specialties (Owsley, 2013). Clearer and better definitions of SOP are needed to give guidance to NPs and to reduce disparities in enforcement (Owsley, 2013). In addition, making boards of nursing websites easier to navigate in order to find necessary supporting documents is key. Delineating the language of NPAs and ARs and incorporating more precise SOP boundaries will increase patient’s access to health care, ensure public safety, and offer clearer guidelines for regulators, payers, employers, and other pertinent stakeholders, including NPs (Haut & Madden, 2015).

Scope of Practice may strengthen the differentiation of NP roles, but does not specify hiring guidelines (Haut & Madden, 2015). It is crucial for all NPs to have clearly defined roles, SOP, and an identified population of patients in their job descriptions (Haut & Madden, 2015). The literature suggests that this may decrease the risk of practicing beyond one's scope (Kleinpell et al., 2012).

Further Investigation

One change that is needed in order to bring clarity to NP's SOP is uniformity across the United States' borders by removing state legislation restrictions of SOP; this would optimize NP contribution to health care (American Academy of Nursing, 2014). NPs are well prepared to provide high-quality care and reduce health care costs all while improving access to health care (American Academy of Nursing, 2014). But uniformity of SOP and clearer descriptions among NP specialties is warranted in order to optimize access to health care (American Academy of Nursing, 2014). Historically, although the APRN profession accredits itself through national criteria, each individual state has determined its regulation of NPs (Lugo, O'Grady, Hodnicki, & Hanson, 2010). Individual states' authority to regulate NPs was put in place by the United States federated system, but in doing so, it has unintentionally created a national patchwork of regulation of NPs, resulting in barriers for NPs practicing to their full capabilities (Lugo et al., 2010). Whether an NP practices in acute care settings, under physician supervision settings, or even military settings, the NP's SOP should be based on a health care system that is designed to address the health care needs of the citizens as opposed to addressing the state's regulations (American Academy of Nursing, 2014).

Addressing primary care shortages. It is predicted that shortages of health care providers will continue to increase in the following years, and this gap could be reduced through the full use of APRNs covering all populations of interest (American Academy of Nursing, 2014). There is a lot of work to be done in order to achieve this. One of the recommendations from the literature is sole regulation of NPs by state boards of nursing, without the involvement of other external professions, such as the Board of Medicine (Lugo et al., 2010). "It is not in the interests of public safety and consumers to have the economic and professional interests external to nursing dictate the rules and regulations for NP practice and consumer access to NPs and related services" (Lugo et al., 2010, p. 33). It stands to reason that each state BON is the most appropriate design for NP management (Lugo et al., 2010). However, there must be consensus among all the state Boards of Nursing in order for this plan to be executed to its full potential. Currently, no uniformity across all state lines exists for APRN practice, including the requirements for LACE--licensure, accreditation, certification, and education (Stanley, 2009). "These realities lead to potential confusion among the public, weakens the APRN position in the public policy arena and health care community, and limits access to APRNs across states and settings" (Stanley, 2009, p. 100).

Uniformity of SOP. Through several years of toiling, the 2008 APRN Consensus Model for Regulatory Language was developed in response to this growing concern and lack of uniformity across the country (Stanley, 2009). Recommendations in the literature include all states adopting the National Council of State Boards of Nursing (NCSBN) 2008 APRN Consensus Model for Regulatory Language (American Academy of

Nursing, 2014). Among the recommendations included is creating job descriptions and clearer language for defining the core content of NP SOP (American Academy of Nursing, 2014). Thus far, a total of 16 states have adopted 100% of the language from the 2008 APRN Consensus Model, and Montana is one of those states ("NCSBN's APRN Campaign," 2016).

LACE is the foundation of the consensus model which stemmed from the need for APRN's SOP to be effectively aligned while meeting patients' needs and being an integral part of the health care system (APRN Consensus Work Group, & National Council of State Boards of Nursing APRN Advisory Committee, 2008). Each element of LACE plays an essential part in the full implementation of the consensus model, including each NP is **licensed** and regulated solely by each state BON, and is considered an independent practitioner in at least one defined population-focus specialty, graduated from an **accredited** graduate-level **education** program that prepares them for their recognized professional role, and be **certified** by a formal professional organization who recognizes the knowledge, skills, SOP, and experience that has been identified by the NP profession (APRN Consensus Work Group, & National Council of State Boards of Nursing APRN Advisory Committee, 2008). Kleinpell et al. (2005) states there is continued "need to ensure that the educational preparation of NPs is appropriate for practice based on recognized scope and standards of practice for NP specialties" (p. 469). The literature states that SOP is not based on practice setting, but rather on the health care needs of the patient (Kleinpell et al., 2012). Therefore, further research is indicated on how educational programs will meet the demands of new accreditation requirements that

parallel consistent SOP for NPs throughout all jurisdictions (Melander, Kleinpell, & McLaughlin, 2007).

The findings from the literature review indicate that while documents and descriptions exist for NP SOP, simultaneously, confusion exists as a result of varying definitions of SOP, lack of uniformity across state jurisdictions, and the plethora of titles indicative of NP specialty. Professional organizations, such as the American Association of Nurse Practitioners (AANP) work to provide statements that outline SOP, however, confusion continues in areas of overlapping responsibilities where specialty nurse practitioners practice across the spectrum of patient care needs. McCabe and Burman (2006) discuss the blurred lines between the real world and written regulations. Nicely demarcated scopes of practice for NPs exist, all the while "in front of you sits the live embodiment of a holistic person who does not fit in those discrete categories, and asks for a full array of health care" (p. 7). For example, an FNP who works in the acute care setting may be very competent at treating urinary tract infections (UTI) in an office-clinic setting, according to their training. However, if a patient is under the FNP's care in the hospital and is admitted with a diagnosis of dehydration, diarrhea and acute renal failure and subsequently develops a UTI, this patient will need a different treatment approach than an ambulatory client with an episodic illness in which the FNP was trained for (Kleinpell et al., 2012). This can cause a dilemma for both the patient and the FNP. Therefore, there is work to be done.

Theoretical Framework

The theoretical framework that guided this project is the ACE Star Model of Knowledge Transformation (Stevens, 2012). The Model was born out of Steven's mission and goal of turning research into action, and improving health care and outcomes through evidence-based practice (EBP), research and education (Stevens, 2012). This Model consists of five stages of knowledge transformation: discovery, summary, translation, integration, and evaluation (Stevens, 2012). The structure of the ACE Star Model supports this project in that the discovery phase is the research that has been investigated for defining SOP for NPs. A comprehensive literature review was conducted to discover that confusion exists regarding components that define an NP's SOP. Second, summarization of the findings in the research needed to occur in order to define and discern that clarity and understanding of SOP is needed. Third, an educational presentation, along with pre and post questionnaires, were created based on the research (translational). The integration phase was the presentation of the evidence-based information to current and future FNPs. Finally, all questionnaires were evaluated to ascertain whether or not knowledge and understanding increased about SOP for FNPs.

METHODS

Project Design

The purpose of this quantitative project was to measure the knowledge and understanding of FNP SOP among current and future FNPs in the state of Montana. A quasi-experimental design using neither randomization nor a control group was ideally suited for this project. The comparison that was made was a before—after contrast with pre and post-education questionnaires. Participants were not aware of the validity of their responses in order to avoid a response bias. Test-retest reliability was used with both the pre and post-education questionnaires by using the exact same questions in order to determine if knowledge increased.

Sampling Method

Consecutive sampling was the method of choice for this project. According to Polit and Beck (2012), consecutive sampling "involves recruiting all of the people from an accessible population who meet the eligibility criteria over a specific time interval, or for a specified sample size" (p. 278). Participants were selected for this study if they were currently enrolled in the Family/Individual Doctorate of Nursing Practice Program at MSU, resided in the state of Montana, and were scheduled to graduate in the years 2016, 2017, and 2018. It should be noted that the invitation for participation included individuals who were attending MSU to obtain their doctorate degrees but were currently practicing as FNPs with a master's degree. The student cohorts were as follows: seven

full-time students graduating in 2016, six part-time and 10 full-time students graduating in 2017, and nine part-time students graduating in 2018. This came to a total of 32 students. Participants were selected based on meeting the criteria for the project and based on their willingness, interest, and availability to voluntarily participate. Due to this consecutive sampling method, a sample that can't yield inference to a larger population of DNP student cohorts, and a pre-determined sample size, a power analysis was not conducted for this project.

The first step in the recruitment process included contacting the Associate Dean of the Graduate Program of the College of Nursing at MSU who was the liaison to current DNP FNP student cohorts for reasons of confidentiality. The four cohorts of FNP students at Montana State University were contacted by e-mail from the Associate Dean's office on April 11, 2016 asking for voluntary participation. An independent third-party point of contact was appointed to assure the participant's anonymity from the researcher and to code the respondent's pre and post-education questionnaires. Throughout the 11 week data collection period, two email reminders were sent out to the four cohorts from the Associate Dean's office in hopes of gaining more participation. The first reminder was emailed on Monday, April 25, 2016 and the second reminder was emailed on Monday, June 13, 2016.

Prior to data collection, the project application request for designation of research as exempt was submitted to the Institutional Review Board (IRB) through Montana State University on April 5, 2016 and was approved (Appendix A).

Subjects

Demographics were collected on each voluntary participant. The demographic information included ethnicity, age, number of years in their current nursing profession, the year they were scheduled to graduate from MSU's DNP FNP program, and the number and type of degrees they held. Gender was not asked in order to decrease the potential for participant identity. Information regarding the number of degrees that the participant held was asked for the reason that more life experience in education may contribute to more baseline knowledge regarding SOP. Because of the nature of the targeted population, a clause was included at the beginning of the pre-education questionnaire that stated baseline knowledge was being gathered and, therefore, it was acceptable for participants to miss one or more questions. Additionally, a pledge statement was included for participants not to seek input from any outside sources in answering any of the questions.

Data Collection Tools

The first objective of this project was to create and distribute a pre-education presentation questionnaire to determine baseline knowledge. Due to time constraints of the project, there were no suitable participants readily available to perform a trial run with the pre and post-education questionnaires. The questionnaire contained 21 True/False, Yes/No questions, seven open-ended questions, one multiple choice question, and one short answer for a total of 30 questions (Appendix B). One of the questions asked was if the participants had taken the class NRSG 612-Ethics, Law, and Policy for

Advocacy in Healthcare, anticipating this class could contribute to increased baseline knowledge regarding FNP SOP. A consent cover letter was e-mailed with each pre-education questionnaire (Appendix C). Returning a completed pre-education questionnaire was considered granted consent of the participant. The evidence-based online educational presentation (YouTube recording) offering clarity of FNP SOP in the state of Montana was distributed as a link, via e-mail, to all participants once the pre-education questionnaire had been completed and returned. The length of the YouTube educational video was 21 minutes, and the most current evidence gathered from research was utilized in its formation. The participants could watch the educational video as many times as they deemed desirable or necessary. Once the participants notified the appointed contact person they had watched the education presentation, post-education questionnaires were distributed via e-mail, and evaluated to determine if knowledge increased regarding SOP for FNPs (Appendix D). Additionally, there was a section at the beginning of the post-education questionnaire asking participants to record the length of time between watching the YouTube presentation and completing the post-education questionnaire. The data collection period ended on June 27, 2016. In appreciation for their participation, once all components of the project were completed, the participants were entered into a raffle to win a $200 Visa gift card. The gift card was mailed via USPS to the winner on June 29, 2016 and remained anonymous from the researcher. All respondents were emailed an answer key to the questionnaires on June 29, 2016.

The second objective was to present the discoveries and results of this scholarly project to the Montana BON at their quarterly board meeting on October 19, 2016, as

well as provide the YouTube educational presentation for possible distribution to the board. The Board of Nursing can potentially archive the information and have it accessible when needed. The BON has a need for FNPs to know where to locate and understand the BON statutes and rules as they pertain to advanced practice. This information is included in the YouTube educational recording. Although each NP is individually responsible to know and understand their SOP and how it affects their clinical practice, offering clarity on these issues is invaluable due to the vast amount of confusion that exists regarding FNP SOP, in addition to the fact that the literature reports Boards of Nursing receiving complaints about NPs exceeding their SOP with boundary violations (Hudspeth, 2009).

In addition to these two objectives, incorporating clarification and clearer boundaries of FNP SOP into the NRSG 612 educational curriculum in the Doctorate of Nursing Practice program at the College of Nursing at Montana State University will be accomplished.

RESULTS

Description of the Sample

Out of the 32 students who were contacted via e-mail asking for voluntary participation, seven students fully completed all components of the project for a recruitment and retention rate of 22%. An additional seven students completed the pre-education questionnaire, but failed to fully complete the project, despite the two e-mail reminders that were sent out from the Associate Dean's office. Incomplete data from these additional seven students are not included in the analysis. Only one student participated from the 2018 cohort, and six students participated from the 2017 cohort, but no one from the 2016 cohort volunteered to participate. Four of the seven participants (57%) had earned more than one degree, and their number of years in the nursing profession ranged from a minimum of two years to 13 years of experience. Every participant pledged they had not used any outside sources of information for help in answering the questions on the pre-questionnaire. Although one participant did not report how many days in between watching the YouTube educational presentation and taking the post-education questionnaire, participants with the least time lapse tended to have higher gain scores. An overview of the demographics of the sample is provided in Table 1. Ultimately, there were no significant differences in demographic data among the sample.

Table 1. Demographic Overview of Sample

ID	Ethnicity	Age	Years in Nursing Profession	Graduation from MSU DNP	Education/Degrees	Length after watching YouTube Presentation
10	Caucasian	33	2	2018	BSN, Bach in Music Education	8 days
11	Caucasian	26	3	2017	BSN	1 day
12	White	51	13	2017	MSN	----
13	Caucasian	33	2	2017	BSN, BS Environmental Science	3 days
14	Caucasian	38	9	2017	Bachelor of Arts in Modern Language, BSN	1 day
15	Caucasian	26	5	2017	BSN	10 days I think
18	Caucasian	27	5	2017	BSN	5 days

Note. The dashes represent data that was not reported. Data reflected here was entered exactly as the participant recorded it.

Data Measurement and Analysis

The aim of this project was to determine whether knowledge increased regarding FNP SOP among the current and future FNP DNP student cohorts at MSU after watching the evidence-based YouTube educational presentation. After inputting the pre, post, and gain scores into Microsoft Excel, formal analysis of the data was completed using RStudio. Gain scores were calculated on 29 of the questions because question number 13 (regarding whether the student had taken NRSG 612) did not elicit a gain score.

Additionally, questions 11 and 18 (regarding comfort levels of participants in navigating the Montana BON and AANP websites) were scored as follows: 0 = Never Attempted; No = -1; Yes = 1. In general, participants could receive partial credit (0.5) on open-ended, multiple choice, and short answer questions. Before presenting a formal analysis of the data, it is helpful to summarize the pre, post, and gain scores using summary statistics. Each response to a question was treated as an observation which yields a total of 203 observations from the sample (n = 7). A summary of the counts of pre-education, post-education, and gain scores are reflected in Tables 2, 3, and 4, respectively.

Table 2. Counts of Pre-Education Scores

-1	0	0.5	1
6	84	11	102

Table 3. Counts of Post-Education Scores

-1	0	0.5	1
2	35	15	151

Table 4. Counts of Gain Scores

-1	-0.5	0	0.5	1	2
5	7	128	9	49	5

Although there are a large number of zeros for gain scores (see Table 4), it should be noted that the zeros are largely comprised of individuals who stayed at 0 or 1 after the educational presentation. Table 5 displays the breakdown of gain scores of zero even further. From the breakdown of the gain scores of zero, only 28 observations resulted in zero, meaning the participant answered the question incorrectly on both the pre and post-

education questionnaires. Furthermore, only 34 observations (points) had opportunity for improvement. This is largely due to the fact that participants already knew the material, which is reflected in the 94 observations that remained at a score of 1, before and after the education presentation.

Table 5. Subset of Zeros as Gain Scores

-1	0	0.5	1
1	28	5	94

However, it is helpful to see the counts of total correct scores before and after watching the YouTube educational presentation. The average gain score from the pre to post-education questionnaire was 7.86 points, and ultimately, all participants improved their scores after viewing the educational video. Table 6 provides this information.

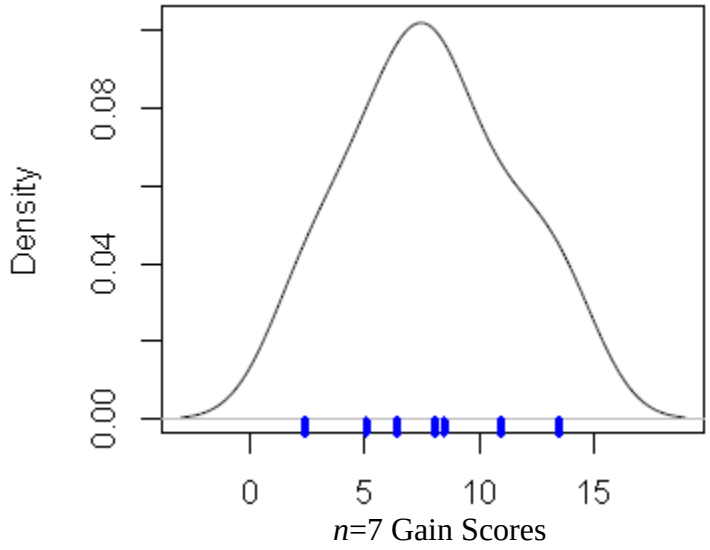
Table 6. Counts of Total Correct Scores

ID	Pre-score	Post-score
10	15	21.5
11	14.5	28
12	14	16.5
13	12	20
14	16	27
15	15	20
18	15	23.5

Although 203 individual responses were recorded, they certainly were not independent responses since the pre and post-educational questionnaires came from the same individual. Statistical analysis, using the paired *t*-test, was conducted, and therefore, it is necessary to assess the distribution of the pre, post, and gain scores due to the small

sample size (n = 7). A density plot superimposed on top of a jittered rug plot is helpful in revealing more information about the shape of the distribution of gain scores. This is displayed in Figure 1. If a sample size is small, it is desirable to have a relatively symmetric distribution which satisfies the distributional assumptions in order to conduct a paired *t*-test.

Figure 1. Distribution of Gain Scores

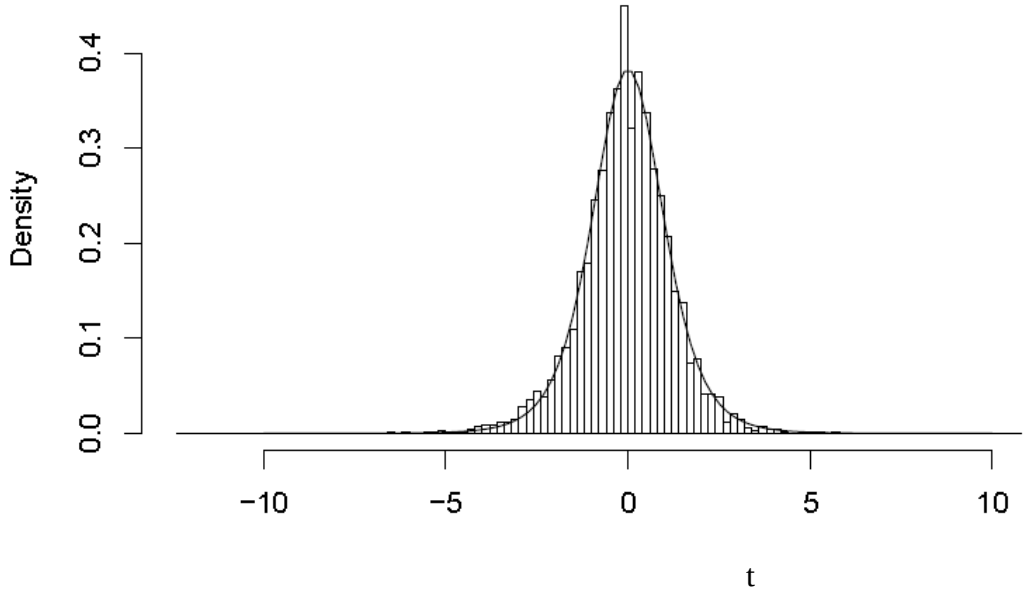


To test the null hypothesis that the YouTube educational presentation had no effect on questionnaire scores, a paired *t*-test was conducted on the sum of the gain scores for each participant. Testing the null hypothesis was done by comparing the *t*-statistic to a *t*-distribution with $df = 6$. The null and alternative hypotheses are denoted respectively: $H_0 : \mu \leq 0$; $H_a : \mu > 0$. The mean gain score per questionnaire is $\bar{x} = 7.86$, $SD = 3.67$. The results were statistically significant, which suggests that the null hypothesis is false ($t = 5.67$, $p < .001$). These data reflect a one-sided 95% CI that the true mean increase in questionnaire scores is greater than 5.16 points per questionnaire. It is worthy to note that

before the YouTube educational presentation the average questionnaire score was 14.5 points, whereas the average post-educational presentation score was 22.36 (see Table 6). This makes the average gain score per questionnaire to be 7.86 points.

Due to the small sample size, and in order to appeal to the central limit theorem, it may be helpful to view the option of conducting a non-parametric permutation test, although inferences will likely be the same due to the relatively symmetric distribution of scores that were displayed in Figure 1. Nonetheless, a permutation distribution under the null was built with 100,000 permutations. Figure 2 displays that the theoretical *t*-distribution matches the permutation distribution under the null.

Figure 2. Theoretical and Permutation Distribution Under the Null

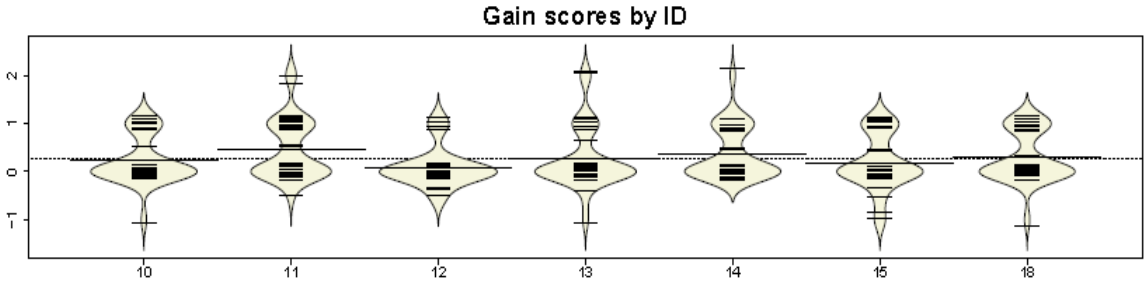


This histogram shows the null distribution of the test statistic under shifted and permuted re-sampling with the density of the theoretical *t*-distribution with $df = 6$ overlaid. As expected by the symmetry of data, there is little difference between the two null distributions indicating the theoretical *t*-test would be reasonable to use. Thus, the

inference made is that the YouTube educational presentation is associated with higher post-education presentation scores.

Finally, it is interesting to note that, in general, from all the questions offered on the questionnaires, on average questions 2, and 20 through 23 showed the most improvement overall. Likewise, the beanplot shown in Figure 3 displays the participants who showed the most improvement in their scores overall.

Figure 3. Gain Scores by ID



The beanplot above makes it possible to see that participants with IDs 11 and 14 showed the strongest improvement in their scores. It should also be noted that gain scores tended to be higher with less time in between taking the post-questionnaire and watching the YouTube education recording. Both participants with IDs 11 and 14 recorded taking the post-questionnaire only one day after watching the YouTube recording (see Table 1).

MTBON Presentation Summation

The results of this project were given in a presentation to the Montana Board of Nursing at their quarterly meeting on October 19, 2016. Emphasis was placed on the need for NP graduate educational programs to clearly articulate specific components

differentiating SOP among NP specialties and their population foci amid their academic and clinical curriculum. It was also recommended that the MTBON website be fashioned in a more user-friendly manner in order to locate specific documents and supporting statements that outline and provide SOP clarity for NPs. Specific questions from the questionnaires that were pertinent to the BON's mission to protect the health, safety and well-being of Montana citizens through the licensing of competent nursing professionals was shared with them in this presentation. All elements of the presentation were accepted with enthusiasm from the Board including the potential for creating access to the YouTube educational presentation for viewing within the BON website.

DISCUSSION

The aim of this project was to measure if knowledge increased regarding clarity about the components of SOP for FNPs in the state of Montana. The findings revealed that there is strong evidence against the null hypothesis that no difference between pre and post-education presentation scores existed after viewing the YouTube educational recording.

Kleinpell et al. (2012) report that inconsistencies in NP educational programs have existed and variation between states' SOP boundaries persist, despite the efforts of the NCSBN documents defining and supporting alignment of LACE. Because of the national goal to implement consistent SOP throughout all jurisdictions regarding NP SOP, there is a transition time for graduate educational programs to meet these new propositions set forth in the 2008 APRN Consensus Document recommendations (Kleinpell et al., 2012). This project is in agreement with this. Targeting graduate students enrolled in NP programs, and offering clearer distinctions of competencies between the population foci is recommended and was accomplished with this project. When given questions regarding specific components differentiating SOP among NP specialties, it was evident that uncertainty existed which highlights the need for ensuring congruency of NP practice based on LACE (Kleinpell et al., 2012). Certain information regarding NP SOP continues to be inaccurately conveyed denoting the need for continued specific clarification of SOP that supports NP practice based on LACE (Kleinpell et al., 2012). If more graduate educational programs incorporated specific components of population foci SOP into their curriculum, NPs will be better equipped to self-assess the

appropriateness of their educational preparation leading to their certification demonstrating their competency. This will support NPs in their ability in identifying the patient care needs of those they are seeking to treat (Kleinpell et al., 2012).

However, this project reveals that gaps in knowledge exist related to future FNP's levels of expertise regarding clarity of specific components that define SOP. This indicates the need for graduate educational programs to clearly articulate the population-focused and specialty NP roles, so as NPs enter clinical practice, they are clear about their practice boundaries. The literature shows there is a gap regarding SOP knowledge among current practicing NPs. Targeting populations of graduate students who are studying to become NPs allows one of the root causes of inconsistency in education, leading to confusion regarding SOP, to be addressed.

As NPs begin clinical practice, they will be able to better inform their colleagues, and set a standard and example by having clarity of boundaries in regards to SOP within their population-focused specialties.

There were limitations to this project. The number of participants was lower than anticipated. This could have been largely due to the demands of individuals' schedules while in graduate school, although the data collection period overlapped a break between semesters. Another limitation to the project was that the time available before data collection was short, and there were no readily available participants to conduct a trial run of the questionnaires prior to implementing data collection. If this process was able to be performed, higher gain scores may have been appreciated as a result. Lastly, this was

not a random sample of DNP FNP students from a larger population. Therefore, inferences of results can only be made to the population of participants in the study.

Conclusion

The results of this study can help guide the future for FNPs who need to clearly understand the components that define NP SOP within their population-focused specialties. The framework for this project could be expanded to include all NP specialties, not just FNPs. The results of the questionnaires show that there is lack of understanding regarding more specific components that define FNP SOP. Therefore, graduate education programs should be focusing on how to integrate specific components that target clear elements of population-focused SOP into their educational curriculum. With the utilization of these recommendations, there is potential for minimizing the confusion that exists related to practice boundaries of the NP's specific roles and SOP that is so prevalent. In turn, decreasing provider dilemma regarding SOP issues ultimately benefits the safety of patients, as well as all stakeholders impacted by this project: employers, Boards of Nursing, individuals applying to NP graduate programs, current NP students, and physician colleagues. Continued progress towards uniformity in LACE will contribute towards NPs functioning to their fullest capacity which will benefit the overall health of the nation.

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APPENDICES

APPENDIX A

IRB EXEMPTION/APPROVAL

MONTANA STATE UNIVERSITY

INSTITUTIONAL REVIEW BOARD

For the Protection of Human Subjects
FWA 00000165

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c/o Immunology & Infectious Diseases
Montana State University
Bozeman, MT 59718
Telephone: 406-994-6783
FAX: 406-994-4303
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Chair: Mark Quinn
406-994-5721
mquinn@montana.edu
Administrator:
Cheryl Johnson
406-994-6783
cherylj@montana.edu

MEMORANDUM

TO: Hannah Gilliland and Polly Petersen

FROM: Mark Quinn, Chair Mark Quinn CTJ

DATE: April 5, 2016

RE: *"Family Nurse Practitioner's Scope of Practice (SOP): Focus on the State of Montana" [HG040516-EX]*

The above research, described in your submission of April 5, 2016, is exempt from the requirement of review by the Institutional Review Board in accordance with the Code of Federal regulations, Part 46, section 101. The specific paragraph which applies to your research is:

____ (b) (1) Research conducted in established or commonly accepted educational settings, involving normal educational practices such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

_X_ (b) (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

____ (b) (3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

____ (b) (4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available, or if the information is recorded by the investigator in such a manner that the subjects cannot be identified, directly or through identifiers linked to the subjects.

____ (b) (5) Research and demonstration projects, which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

_____ (b) (6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed, or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the FDA, or approved by the EPA, or the Food Safety and Inspection Service of the USDA.

Although review by the Institutional Review Board is not required for the above research, the Committee will be glad to review it. If you wish a review and committee approval, please submit 3 copies of the usual application form and it will be processed by expedited review.

APPENDIX B

PRE-EDUCATION PRESENTATION QUESTIONNAIRE

Pre-Education Presentation Questionnaire

☐ **I pledge I am answering these questions on my own without input from other individuals or outside sources.**

The purpose of this pre-presentation questionnaire is to gather baseline knowledge. It is acceptable for participants to miss one or more questions.

Demographics

- Ethnicity:
- Age:
- Number of Years at Current Nursing Profession:
- What year are you scheduled to graduate from MSU's DNP FNP program?
- Education/Degrees:

Q1) What is the definition of the term 'scope of practice'?

Q2) What lays the foundation for an APRN's scope of practice?

Q3) Whose responsibility is it to know, understand, and enforce APRN scope of practice?

Q4) What is the purpose of a state's Board of Nursing?

Q5) What is a Statute?

Q6) What is an Administrative Rule?

Q7) What is a Nurse Practice Act?

Pre-Education Presentation Questionnaire

Q8) Do national professional organizations (NPOs) provide scope of practice documents for APRNs? **Yes** ☐ **No** ☐

Q9) Once becoming an APRN, do RN administrative rules still apply? **Yes** ☐ **No** ☐

Q10) Does an APRN need an active national certification in order to practice in the state of MT? **Yes** ☐ **No** ☐

Q11) Do you currently feel comfortable navigating the Montana Board of Nursing website in order to find necessary documents for APRN scope of practice? **Yes** ☐ **No** ☐ **Never Attempted** ☐

Q12) Does Montana issue temporary licenses for APRNs? **Yes** ☐ **No** ☐

Q13) Have you taken the class N612 (Ethics, Law, & Policy) yet? **Yes** ☐ **No** ☐

Q14) What does an NP's certification represent?

☐ a. Population focus
☐ b. National Professional Organization
☐ c. Certifying body

Q15) A: Is a nurse practitioner's certification indicative of the setting in which they must practice? **Yes** ☐ **No** ☐

B: Can an FNP work in the hospital setting? **Yes** ☐ **No** ☐

Q16) Is it considered 'standard of practice' for the FNP to participate in health policy activities at the local, state, national, and international levels? **Yes** ☐ **No** ☐

Q17) In MT, is regulation of APRN prescriptive authority solely regulated by the Board of Nursing? **True** ☐ **False** ☐

Q18) Do you currently feel comfortable navigating the American Association of Nurse Practitioner's website for necessary documents offering guidance for SOP? **Yes** ☐ **No** ☐ **Never Attempted** ☐

Q19) National certification is established for a specific population of interest (foci). Population is not only defined by diagnosis, gender, and age, but also by acuity and type of care needed. **True** ☐ **False** ☐

Q20) What are considered to be the two broad categories of NP preparation?

Pre-Education Presentation Questionnaire

Q21) Per the MT BON, the FNP is required to maintain an individualized quality assurance plan within their SOP and population foci. Do you understand what this entails? **Yes** ☐ **No** ☐ **If yes, please offer a brief description.**

Q22) Is an FNP allowed to expand scope to a different specialty without completing a basic NP program in that specialty? **Yes** ☐ **No** ☐

Q23) Can an FNP work as an in-patient provider caring for individuals who are critically ill or unstable? **Yes** ☐ **No** ☐

Q24) The FNP can only provide health care services for which competency has been established and maintained? **True** ☐ **False** ☐

Q25) It is the expectation of the FNP to utilize appropriate judgment to determine if a specific role or procedure within a patient care situation is within the SOP that he or she is prepared to provide from their formal education? **True** ☐ **False** ☐

Q26) According to the literature regarding SOP, experience as an RN and the personal comfort of the FNP are not sound basis for accepting an assignment or role beyond the FNP's SOP. **True** ☐ **False** ☐

Q27) Is there such a thing as overlapping SOP between specialties? **Yes** ☐ **No** ☐

Q28) Is it within the SOP of an FNP to work and solely provide psych care in a setting caring for psychiatric mental health patient populations? **Yes** ☐ **No** ☐

Q29) In the state of MT, an APRN with prescriptive authority may not prescribe controlled substances for self or members of the APRN's immediate family. **True** ☐ **False** ☐

Q30) In the state of MT, an FNP is required to maintain competency development within the relevant role, scope of practice, population focus, and practice setting? **True** ☐ **False** ☐

APPENDIX C

CONSENT COVER LETTER

Consent Cover Letter

Family Nurse Practitioner's Scope of Practice: Focus on the state of Montana

Dear Graduate Student:

I am currently enrolled in the Family/Individual Doctorate of Nursing Practice program at Montana State University and am in the process of completing my scholarly project. I am conducting a study to measure knowledge levels regarding scope of practice for family nurse practitioners. The purpose of this study is to offer clarity that defines a nurse practitioner's scope of practice and to better inform current and future family nurse practitioners regarding boundaries and limitations to their scope of practice. I am asking for your participation.

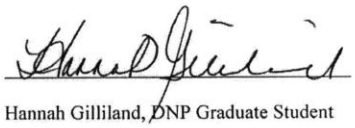
You have been selected for this study because you are currently enrolled in the Family/Individual Doctorate of Nursing Practice program at Montana State University and reside in the state of Montana. Participation is anonymous. Therefore, I hope that you will be comfortable giving your honest thoughts and answers. If you prefer not to answer any particular question, feel free to leave it blank.

Please complete the attached pre-education presentation questionnaire. Once completed, please email it to (scopeofpracticeresponses@gmail.com), an independent third-party point of contact to assure your privacy. Upon completion, you will receive a recorded YouTube presentation via email. It is approximately x amount of minutes. Please listen, in full, to this presentation—you may listen as many times as you feel necessary--and then email scopeofpracticeresponses@gmail.com with notification that the presentation portion has been completed. You will then receive the post-presentation questionnaire via email. Please complete the post-presentation questionnaire and email it to scopeofpracticeresponses@gmail.com. If you have any comments or concerns about any part of this project, please feel free to contact me by email (hpiano@hotmail.com) or by phone (406-370-0504). You may also contact the Institutional Review Board (IRB) Chair, Mark Quinn, at Montana State University if you have any questions regarding your rights as a research participant. Mr. Quinn can be reached at mquinn@montana.edu or (406-994-4707).

In appreciation for your participation, you will be entered into a raffle to win a $200 Visa gift card. Simply complete each component of the project--pre-questionnaire, recorded presentation, and post-questionnaire--and email it back to scopeofpracticeresponses@gmail.com. To be included in the raffle, your pre and post-presentation questionnaires must be completed and returned by Monday June 27, 2016. The raffle winner will be notified by July 7, 2016, and remain anonymous from the researcher.

Your participation in the study is completely voluntary. By returning your completed pre-education presentation questionnaire, you will be granting your consent to participate in the study. Thank you in advance for your assistance.

Sincerely,



Hannah Gilliland, DNP Graduate Student



APPENDIX D

POST-EDUCATION QUESTIONNAIRE

Post-Education Presentation Questionnaire

How long has it been since you have watched the YouTube educational presentation?

Q1) What is the definition of the term 'scope of practice'?

Q2) What lays the foundation for an APRN's scope of practice?

Q3) Whose responsibility is it to know, understand, and enforce APRN scope of practice?

Q4) What is the purpose of a state's Board of Nursing?

Q5) What is a Statute?

Q6) What is an Administrative Rule?

Q7) What is a Nurse Practice Act?

Q8) Do national professional organizations (NPOs) provide scope of practice documents for APRNs? **Yes** ☐ **No** ☐

Q9) Once becoming an APRN, do RN administrative rules still apply? **Yes** ☐ **No** ☐

Q10) Does an APRN need an active national certification in order to practice in the state of MT? **Yes** ☐ **No** ☐

Q11) Do you currently feel comfortable navigating the Montana Board of Nursing website in order to find necessary documents for APRN scope of practice? **Yes** ☐ **No** ☐ **Never Attempted** ☐

Post-Education Presentation Questionnaire

Q12) Does Montana issue temporary licenses for APRNs? **Yes** ☐ **No** ☐

Q13) Have you taken the class N612 (Ethics, Law, & Policy) yet? **Yes** ☐ **No** ☐

Q14) What does an NP's certification represent?

- ☐ a. Population focus
- ☐ b. National Professional Organization
- ☐ c. Certifying body

Q15) A: Is a nurse practitioner's certification indicative of the setting in which they must practice? **Yes** ☐ **No** ☐

B: Can an FNP work in the hospital setting? **Yes** ☐ **No** ☐

Q16) Is it considered 'standard of practice' for the FNP to participate in health policy activities at the local, state, national, and international levels? **Yes** ☐ **No** ☐

Q17) In MT, is regulation of APRN prescriptive authority solely regulated by the Board of Nursing? **True** ☐ **False** ☐

Q18) Do you currently feel comfortable navigating the American Association of Nurse Practitioner's website for necessary documents offering guidance for SOP? **Yes** ☐ **No** ☐ **Never Attempted** ☐

Q19) National certification is established for a specific population of interest (foci). Population is not only defined by diagnosis, gender, and age, but also by acuity and type of care needed. **True** ☐ **False** ☐

Q20) What are considered to be the two broad categories of NP preparation?

Q21) Per the MT BON, the FNP is required to maintain an individualized quality assurance plan within their SOP and population foci. Do you understand what this entails? **Yes** ☐ **No** ☐ **If yes, please offer a brief description.**

Q22) Is an FNP allowed to expand scope to a different specialty without completing a basic NP program in that specialty? **Yes** ☐ **No** ☐

Q23) Can an FNP work as an in-patient provider caring for individuals who are critically ill or unstable? **Yes** ☐ **No** ☐

Post-Education Presentation Questionnaire

Q24) The FNP can only provide health care services for which competency has been established and maintained? **True** ☐ **False** ☐

Q25) It is the expectation of the FNP to utilize appropriate judgment to determine if a specific role or procedure within a patient care situation is within the SOP that he or she is prepared to provide from their formal education? **True** ☐ **False** ☐

Q26) According to the literature regarding SOP, experience as an RN and the personal comfort of the FNP are not sound basis for accepting an assignment or role beyond the FNP's SOP. **True** ☐ **False** ☐

Q27) Is there such a thing as overlapping SOP between specialties? **Yes** ☐ **No** ☐

Q28) Is it within the SOP of an FNP to work and solely provide psych care in a setting caring for psychiatric mental health patient populations? **Yes** ☐ **No** ☐

Q29) In the state of MT, an APRN with prescriptive authority may not prescribe controlled substances for self or members of the APRN's immediate family. **True** ☐ **False** ☐

Q30) In the state of MT, an FNP is required to maintain competency development within the relevant role, scope of practice, population focus, and practice setting? **True** ☐ **False** ☐