Evolution of Accreditation in Continuing Nursing Education in America

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Abstract

There is widespread agreement that nurses must acquire and maintain the specialized knowledge needed to provide highly skilled care and to demonstrate their competence to the public, their employers, their profession, and patients on an ongoing basis throughout their work lives. Nurses report that continuing nursing education is the third most vital component of nursing skill building. Nurses from states that mandate continuing nursing education, as well as those from states that do not, rank continuing nursing education just after their workplace experience and their basic nursing education in importance. A wide range of organizations create and disseminate continuing nursing education to nurses in states with and without mandated continuing nursing education requirements. Although there is no governmental standard for the field, nursing monitors education across work-life stages. The National Council of State Boards of Nursing monitors nursing licensure and continuing nursing education. The credentialing arm of the American Nurses Association, the American Nurses Credentialing Center, acting in synch with national organizations that call for accreditation standards in the health care professions, provides review and accreditation of providers and approvers of continuing nursing education on a national basis and is, itself, internationally certified by International Standards for a Sustainable World.


Studies have shown that as health care has become increasingly complex, consistent educational opportunities are associated with increased job satisfaction as well as improved job performance (Bibb, Malebranche, Crowell, & Altman, 2003; Tang, 2003; Vaughn, 2003; Whitehead & Martiniano, 2007; Wolak, Klish, Smith, & Cairns, 2006). Many nurses are employed in settings without easy access to information about the evidence-based practices they are expected to use in patient care. A recent government report (Health Resources and Services Administration [HRSA], 2004) identified five major employment settings for nurses: hospitals (56%), nursing homes and extended care facilities (6.3%), community and public health settings (14.9%), nursing education (2.6%), and ambulatory care settings (11%). Despite their predominant employment in organizations removed from the educational mainstream, nurses have a demonstrated commitment to lifelong learning and to updating their knowledge and skills on an ongoing basis. In addition to completing required continuing nursing education, about 23% of the registered nurse (RN) population in 2004 completed additional academic nursing education (HRSA).

The mandatory accumulation of continuing nursing education contact hours has been used as one means for assuring that nurses maintain an adequate knowledge base in 22 of the 61 state boards of nursing in the United States....
States and its territories. The number of members does not correlate with the number of states in the union, as some states have a separate board for each level of nursing (National Council of State Boards of Nursing [NCSBN], 2008). In 2007, three new states moved to mandated continuing nursing education, as has been the trend during the past several years for states in which heretofore there has not been mandated continuing nursing education (Barker, 2006; Kelly, 2007; Tedford, 2003; Yoder-Wise, 2008). There is widespread agreement that nurses must acquire and maintain the specialized knowledge needed to provide highly skilled care and to demonstrate their competence to the public, their employers, their profession, and patients (Vaughn, 2003). Continuing education made available to nurses through a wide array of options (i.e., the Internet, conferences, college workshops, and the mail) bridges the gap between nurses practicing in the field and those who research best practices (DePalma, 2007; DeSilets, 2007).

**WIDTH AND BREADTH OF CONTINUING NURSING EDUCATION CURRENTLY**

A simple Internet search for “continuing nursing education” produced more than 21,400,000 entries in March 2008, giving evidence of high community-wide interest in the topic. Leaders in the field include nursing professional organizations, institutions of higher education, governmental entities, and for-profit companies (or vendors), each of which creates and disseminates continuing nursing education in one form or another. These organizations are monitored by several professional nursing governing and accrediting bodies.

One national leader, the NCSBN, has been tasked to assist its member boards of nursing in promoting safe and effective nursing practice in the interest of protecting public health and welfare for more than 25 years. Backed by research, information, and support from the NCSBN, state boards set requirements for licensure and approve licensure based, in part, on the performance of the nurse graduate in the form of a passing score on a standardized examination given annually by the NCSBN. As a health care regulatory body, the NCSBN is charged with protection of the public from unsafe practices of health care professionals. Boards of nursing both prevent unqualified individuals from entering the nursing profession and monitor the maintenance of adequate ongoing competence in various ways. One method of monitoring continued competence in most states has been the use of continuing nursing education across the nation under a model in which each state has set its own standards.

The NCSBN conducts research on nursing education and practice at all levels. In 2002, an extensive four-stage study of continuing nursing education was conducted by the NCSBN because it is believed that there is a link between continuing nursing education and the development of professional competence. Surveys were sent by the NCSBN to all licensed, active nurses in the United States. There was a 30% return rate. The demographics of those who responded matched the overall national demographics for nurses.

The findings of the NCSBN study on continuing nursing education were analyzed by nursing degree and by states with and without mandated continuing education. RN respondents had an average of 35.2 contact hours in the previous 12 months, of which 28.3 were related to current work, 6.5 were related to new or future duties, and 4.2 were unrelated to work or interest. Licensed practical nurse (LPN) respondents had, on average, 28 contact hours in the previous 12 months, with 21.7 related to current work, 7 related to new duties, and 5.7 unrelated to work or interest. The RNs and LPNs who lived in states with mandated continuing education tended to collect more total hours related to current work, but the differences between them and nurses practicing in states without mandated continuing education were not statistically significant. However, the RNs and LPNs who lived in states with mandated continuing nursing education collected significantly greater numbers of contact hours unrelated to their current or future work than did nurses living in states without mandated continuing education. This may indicate that nurses working in environments with a demonstrated high regard for the value of continuing education are self-motivated to seek more education and therefore attend more events where contact hours may be earned.

Respondents to the NCSBN survey were asked to rank their abilities at two points using the Nursing Quality Indicators identified by the National Quality Forum (2007): their first nursing job and their current status of nursing ability. Beginning ability rankings ranged from 30 to 45 points on a 90-point scale. Respondents ranked current ability between 78 and 85 points. When asked to explain the factors that led to their improvement in ability, nurses at all levels gave the highest number of points to work experience, followed by basic nursing education and continuing nursing education after graduation.

In the 2002 study by the NCSBN, only 78% of the RNs and 65% of the LPNs reported that their employer provided continuing nursing education for their needs. Among employers, hospitals were reported as providing the most opportunity to earn contact hours. When
asked about barriers to obtaining continuing nursing education, about 44% of all nurses reported that they “frequently” or “sometimes” were not allowed time off to attend continuing education meetings. About 60% of RNs and 50% of LPNs reported lack of reimbursement for one or more aspects of professional development increased the difficulty of obtaining continuing nursing education.

Nurses who worked in states with mandated continuing nursing education were more likely to earn contact hours from professional organizations and conferences (75% with a mandate vs. 66% without) and from institutions of higher education (43% with a mandate vs. 27% without). Nurses living in states with mandated continuing nursing education were more likely to report receiving contact hours from continuing education vendors than were those living in states without (63% with a mandate vs. 47% without).

There have been calls for federal management of health care work force regulation. For example, the Pew Health Commission Taskforce published a report in 1995 that recommended a national oversight board composed of members from the public sector who would hold final authority over all aspects of the health care work force, including ongoing board assessment of clinical competency for health care workers (Macy Foundation, 2008). The Pew recommendation was criticized by the Interprofessional Workgroup on Health Professions Regulation (IWHRP). The IWHRP investigated the allegations made by the Pew Taskforce and concluded that the prevalence of an incompetent work force was not demonstrated, nor was a meaningful degree of public endangerment documented. Due to these considerations, it is believed by state and national nursing professional oversight groups that the continuous improvement model by which professions design their own programs for assessing competence and remediating incompetence should be the standard, when used alongside an annual progress report provided to the credentialing body. The American Nurses Credentialing Center’s (ANCC) Commission on Accreditation (COA) and staff have spent more than 2 years examining its processes and procedures and documenting them in accordance with International Standards for a Sustainable World (ISO). ISO, a non-governmental organization, is the world’s largest standards-developing organization. Certification from ISO is the “stamp of approval” that designates an organization as successful in providing state-of-the-art products, services, processes, materials, and systems. The ANCC’s process of undergoing a self-study and review for certification with ISO was a proactive demonstration of the ANCC’s commitment to providing high-quality services. Following an exacting 2-year process, the ANCC was informed that it had achieved ISO 9001:2000 certification, which is granted in 3-year time periods, pending successful annual surveillance audits. This certification has branded the ANCC as a world-class organization serving as the leader in the field of continuing nursing education.

Nationally, the largest and oldest professional nursing association, the American Nurses Association (ANA), has several credentialing programs in place, partially through its credentialing arm, the ANCC, to pave the way for movement toward a national goal of excellence in nursing. As a member of the National Quality Forum, the ANA (Gallagher, 2005) and its programs partner in creating and endorsing the highest standards to measure the quality of health care in the United States. All departments within the ANA are dedicated to promoting consumer understanding and use of these quality performance measures that apply to their area of expertise; promoting and encouraging the enhancement of system capacity to evaluate and report on issues that impact health care quality; and “raising the bar” of best practices for accredited organizations. The programs of the ANCC, such as the Magnet Recognition Program (“Magnet hospitals”), that focus on quality in the work environment and those programs that focus on credentialing of nurses or continuing nursing education providers work together to address a multitude of competencies in the profession. For example, in some Magnet hospitals, “nursing grand rounds” have been initiated to provide an ongoing venue where clinical expertise and nursing best practices are shared in a collegial forum. The expectation is for presenters to describe how a specific health issue influences nursing practice and patient outcomes, discuss the evidence-based approaches for management of the issue, and show how the approaches could be incorporated into everyday nursing practice (Winslow, Blankenship, Palmer, & Black, 2007).

One indicator of competency is provided by the statement of accreditation of the COA of the ANCC, the credentialing arm of the ANA. Accreditation by the COA validates an educational activity’s level of quality, integrity, credibility, and adherence to national standards. By noting the ANCC accreditation status of an educational activity, the executive knows that it is a quality activity that meets national standards, is widely accessible through a broad network of providers and venues, and is relevant to the quickly evolving nursing world.

**BACKGROUND OF THE ANCC AND THE COA**

The authority for accreditation of continuing education in nursing derives from an action of the 1974 ANA Commission on Accreditation (COA) of the ANCC, the credentialing arm of the ANA. Accreditation by the COA validates an educational activity’s level of quality, integrity, credibility, and adherence to national standards. By noting the ANCC accreditation status of an educational activity, the executive knows that it is a quality activity that meets national standards, is widely accessible through a broad network of providers and venues, and is relevant to the quickly evolving nursing world.
House of Delegates to establish a system for accreditation and approval of continuing education in nursing. Accreditation was defined as a voluntary process in which an institution, organization, or agency submits to an in-depth analysis to determine its capacity to provide or approve quality continuing education over an extended period of time. After the ANCC was incorporated in January 1991 as a subsidiary of the ANA, the COA was established as the accrediting body that same year. As of February 2008, the ANCC had 288 accredited providers and approvers of continuing nursing education. The contact hours made available to nurses number in the millions, and hundreds of thousands of nurses depend on ANCC-accredited contact hours for professional development. In the United States, only Iowa, Nevada, and Wyoming do not have accredited organizations. Worldwide, Scotland, Lebanon, and Singapore each have at least one accredited organization.

There are currently approximately 80 volunteers supporting the work of the ANCC’s COA. These volunteers include Lynore DeSilets and Pamela Dickerson, associate editors for The Journal of Continuing Education in Nursing; and Patricia Yoder-Wise, editor-in-chief of The Journal of Continuing Education in Nursing. Volunteers also serve as additional site visitors in the voluntary peer review recognition process employed by the COA’s accreditation program.

The ANCC’s COA is composed of nine appointed members who govern the accreditation program, develop policy, and maintain program alignment with contemporary educational practice. Members of the COA represent the Congress of Nursing Practice of the ANA constituent member associations, nursing specialty organizations, colleges and universities, health care facilities, and others (e.g., federal nursing services, commercial product companies, and professional education organizations). Most members are RNs who have major responsibility for the continuing education activities of an accredited provider organization, with one member serving as a doctorally prepared RN with expertise in evaluation and research. The COA also includes a non-nurse member with a doctorate who is employed in a college or university setting in the area of adult education or continuing education. The COA has extensive information from regulatory agencies, nurses in the field, researchers, and continuing education experts in other health care fields to help establish policy and procedures that safeguard the best interests of health care delivery. Central to the function of the COA is the creation and implementation of continuing education and professional standards in the delivery of professional development to nurses, and acknowledgment of organizations that meet and exceed these quality standards.

**COA Accreditation Criteria**

Institutions or organizations are accredited as approvers or providers of nursing continuing education. Organizations eligible for accredited approver status are state nurse associations, specialty nurse organizations, or federal nurse services. An accredited approver has been reviewed for its capacity to approve quality continuing education developed and provided by other organizations. The official accreditation manual provides extensive information for potential accredited organizations regarding the period of COA accreditation (2 to 6 years, depending on the level of expertise of the organization and its tenure as an accredited organization) and on other features of accreditation. All accredited organizations are continuously monitored for compliance to best practices in continuing nursing education, and the standards themselves are under continuous review and improvement.

Organizations eligible to be accredited providers include state nurse associations, specialty nurse organizations, federal nurse services, schools of nursing, health care facilities, commercial product companies, pharmaceutical companies, publishing houses, private continuing education companies, and foreign-based agencies. An organization accredited as a provider has submitted to an in-depth analysis to determine its capacity to provide quality nursing continuing education activities for a 6-year period. Organizations that are accredited or approved as providers may not approve educational activities planned and implemented by other providers.

The accreditation criteria for approvers and providers are based on the ANA’s Standards for Nursing Professional Development: Continuing Education and Staff Development. The accreditation criteria address aspects of administration, human resources, material resources, and facilities; educational design; professional practice; and records, reports, and evaluations. The standards call for and strictly measure the separation of content and information from any bias that could potentially arise from either financial interest or professional or familial conflict of interest. For this reason, the COA specifically requires co-signed documentation for all co-provided and sponsored activities. The statement of accreditation assures the consumer that the provider of nursing continuing education uses these best-practice standards and criteria when planning and producing continuing education activities, and requires that all conflicts of interest and sponsorship are clearly disclosed to activity participants.
The importance of educational design in nursing continuing education is evident in that the largest component of accreditation rests on the applicant organization’s expertise in this area. All continuing nursing education must be grounded in adult learning theory. Each activity design must incorporate measurable behavioral objectives and require the learner to report achievement of each objective. The first requirement is for activity development to begin by selecting a subject from topic requests obtained during needs assessments of target audiences. The nurse planner assists in identifying appropriate goals for the educational activity, selecting expert presenters (content specialists), and formulating specific learner objectives and the appropriate educational design, teaching methods, and evaluation process.

The standardization of the educational process, as implemented through the application of the ANCC’s accreditation criteria and educational designs, provides the COA with a framework in which to encourage the use of expanding technologies in new and creative educational designs that continue to meet the highest standards for continuing education and design of educational activities. For nurse executives, this standardization of the educational process provides an assurance of the quality of the continuing education activities that they consider for their staff members. With this framework in place, the COA has begun to consider ways to facilitate and expedite the accreditation process. A task force has been formed to examine these possibilities, to extend the benefits of accreditation to an increasing number of organizations. The interests of the general public are clearly served by nurses who continually update their knowledge base and skills through high-quality continuing nursing education.

CONTINUING NURSING EDUCATION OVERSIGHT

Many authors have reported the importance of evaluation of the effectiveness and efficiency of continuing education programs (Bibb et al., 2003). Although little has been published regarding the utility of continuing nursing education provided for clinical experts at the bedside or unit level (Wolak et al., 2006), many educational programs collect information from participants that tracks their knowledge acquisition and ratings of course value. In Canada, the requirement for continuing nursing education is extended beyond simply collecting a specific number of contact hours to conducting an annual self-assessment, peer review of performance and developing an annual learning plan. A portfolio of nurses’ career-long, self-set goals and annual evaluation of progress made toward those goals is used to demonstrate “continuing competence” in the field (Winslow, 2007).

In the United States, the IWHPR has recommended that every discipline-specific continuing education program participate in a review and accreditation process to ensure high levels of practice competency within professions through standardization of excellence in continuing education. It was recommended that new interprofessional collaborative efforts would enhance the discipline-specific efforts to research continuing education impact and extend the limited resources of each board. The ANCC’s COA has joined forces with the continuing education arms of the Accreditation Council for Continuing Medical Education (ACCME) and the Accreditation Council for Pharmacy Education (ACPE). Partnerships with the ACCME and the ACPE were established in 2000 and continue to create opportunity and structure in the field of health care professional development. Given that the issues faced by an interprofessional health care work force are similar and that treatment teams are interdisciplinary, the ANCC, ACCME, and ACPE have instituted a task force to review their application and accreditation standards and to integrate the three methodologies into one. When this process is complete, organizations will be able to apply for accreditation from all three entities at one time, using a joining accreditation recognized by all three entities, as...
well as to continue to use only the discipline for which they are primarily responsible.

When selecting continuing education activities for staff members, nurse executives face complex decisions on how best to direct continuing education budgets. Factors to be considered include educational quality, timeliness and relevance of educational topics, national acceptability of contact hours, accessibility, accountability, and cost-effectiveness. However, most nurse executives are unable to review each educational activity that will incur staff expenses and reimbursement; these decision makers are in great need of indicators of quality for the activities that they consider.

Nurses need to show how they make decisions about educational strategies and how those decisions effect better health care outcomes for patients (Yoder-Wise, 2007). Continuing nursing education must be offered based upon the identified needs of the target audience (Haggard, 2007). The most effective type of needs assessment is one in which the administrator supplies general content areas and some identified topics, and respondents both “check a box” to demonstrate their interest in various identified topics and write in their own ideas about topics of interest (Haggard). It is important that nurses set personal learning goals for which they use ongoing continuing nursing education opportunities so that meeting state-mandated contact hours is not an artificial and empty activity, but a meaningful movement toward personal goals (Yoder-Wise).

In a true evidence-based education session, the instructor would present a summary of current practice, outline identified best practices that support a particular practice guideline, and provide citations for each component of the slide and handout. Instructors explain why each action has been identified as a best practice, and clearly demonstrate the manner in which the new knowledge can be used by participants in their daily work settings (DePalma, 2007). The benefit of this presentation protocol is evident through two levels of participant knowledge gain. First, the participant can use the knowledge in the practice of nursing. Second, the participant knows where to access additional information on the topic via the references provided.

Only the most current information that is legally and ethically supportable should be provided as continuing nursing education (DeSilets, 2007). As the country moves toward a national level of high-quality, best practice, continuing nursing education providers will increasingly be basing their activities on:

1. A search for the best evidence.
2. A process through which the information is synthesized.
4. Demonstration of the steps to practice implementation.
5. A follow-up after practice change to evaluate patient outcomes and implementation effectiveness.

Evidence of high-quality continuing nursing education is a demonstration that the learning experiences offered build on the basic knowledge nurses obtained prior to graduation and are not specific to an organization, an instrument, or a vendor. Although high-quality continuing nursing education may be provided through lectures, conferences, teleconferences, print materials, videos, web-based seminars, or multimedia (CDs or DVDs) (DeSilets, 2006), it must be based on a needs assessment of the target audience and must be evaluated by participants on completion.

**SUMMARY**

Continuing and staff development educators are key to ensuring that practicing nurses have the knowledge, skills, and abilities to provide patient-centered care that is evidence-based and interdisciplinary in nature (Gallagher, 2005). Nurses can earn contact hours regardless of whether they are mandated to do so. Nurses with a continuing nursing education mandate attend more hours of continuing nursing education and may have greater access to some sources of continuing nursing education.

Access to continuing nursing education varies by work setting and population. Rural nurses reported experiencing less growth in their level of knowledge and "ability" than nurses from urban settings.

All organizations with the capacity to develop and deliver high-quality continuing nursing education are welcome to submit a self-study and application for accreditation biannually. However, not every organization can, or should, create and deliver continuing education on its own because good educational practices are not easily implemented. There is a growing need for continuing nursing education across the country. Nurses in the field must continue to move toward widespread use of continuing nursing education that will directly enhance their competence and daily performance. The credentialing bodies have clearly established guidelines for issues related to educational integrity of continuing nursing education when there is paid sponsorship of programs. The field is already addressing these important issues, as contact hours are, and will be, increasingly provided by a wide array of institutions, organizations, health care facilities, and others. It is in the best interest of nurses on the receiving end of professional development to have the ANCC serving as an oversight organization to pro-
key points

Accreditation

1 Lifelong learning is recognized by nurses as a key to excellence in professional performance in their field, regardless of whether continuing nursing education is required by their state.

2 Although there is no governmental standard for regulation of continuing nursing education, several professional organizations monitor lifelong learning opportunities and provide accreditation for those continuing nursing education activities that reach excellence.

3 The credentialing arm of the American Nurses Association, the American Nurses Credentialing Center, provides review and accreditation of providers and approvers of continuing nursing education on a national basis and is, itself, an internationally certified body.

In a process of continual quality improvement, the ANCC’s national plan to advance nursing professional development and sustain a high standard for professional continuing nursing education that is affordable, accessible, and meaningful will ensure that health care becomes more closely tied to the use of evidence-based research in practice in every nursing setting.

REFERENCES