The Doctor of Nursing Practice Essentials

A New Model for Advanced Practice Nursing

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**Cover Image (Title Page, Part Opener, Chapter Opener):**  
© Gurgen Bakhshetyan/Shutterstock  
**Printing and Binding:** McNaughton & Gunn  
**Cover Printing:** McNaughton & Gunn

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**Library of Congress Cataloging-in-Publication Data**

Names: Zaccagnini, Mary E., editor. | Pechacek, Judith M., editor.


Identifiers: LCCN 2019019348 | ISBN 9781284167078 (paperback)

Subjects: | MESH: Education, Nursing, Graduate | Advanced Practice Nursing—education | Nurse Clinicians | Nurse Practitioners | United States Classification: LCC RT75 | NLM WY 18.5 | DDC 610.73092-.dc23 LC record available at https://lccn.loc.gov/2019019348 6048

Printed in the United States of America

23 22 21 20 19 10 9 8 7 6 5 4 3 2 1
In Memory of Dr. Kathryn Waud-White, DNP, APRN, CRNA, FAAN

November 23, 1954–October 16, 2017

Dr. Kathryn Waud-White was born November 23, 1954, and died October 16, 2017, surrounded by family. She served the University of Minnesota School of Nursing as Clinical Associate Professor, and Director and Coordinator of the Certified Registered Nurse Anesthesia program.

Kathy is survived by her husband of 40 years, Richard; daughter Christine Staebell (Justin); son Jason; brother Dr. John Waud; and many other family, friends, and colleagues.

Kathy will be remembered for her deep commitment to the mission and advocacy for nurse anesthesia, and her tireless dedication to teaching and her students. Kathy was beloved for her sharp wit, dry sense of humor, capacity for love, and deep Christian faith. One of her most important accomplishments was serving as the co-editor and author of the first three editions of the The Doctor of Nursing Practice Essentials: A New Model for Advanced Practice Nursing.

We are grateful for her vision and contribution to the field of advanced nursing practice and the Doctor of Nursing Practice (DNP) degree. We will miss her deeply.
DEDICATIONS

This book is dedicated to the memory of my dear friend and colleague, Kathy White, who partnered, supported, and laughed with me during the first three editions of this book. I also dedicate this to the memory of my sister, Karen, who died suddenly during the writing of the first edition of this book.

Additionally, I dedicate this book to my family, who supported me through all of the long hours required to produce each of the four editions of this book.

Finally, it is dedicated to all of our current and future DNP colleagues, especially those who so graciously gave of their time and volunteered to author this book.

—Mary

This book is dedicated to my children Linnea Ester and Simon, my wife Lisa, and my entire extended family; they are a constant support in my life and provide me with much joy.

This book is also dedicated to all of my professional colleagues who willingly partner with me during many of my academic endeavors.

—Judith
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Preface

With healthcare costs continuing to rise exponentially, reaching 17.9% (CMS, n.d.) gross domestic product (GDP), the national and local focus on health care, the healthcare delivery system, and ways to provide higher quality at lower costs will continue to grasp our attention both socially and politically. Advanced practice nurses are now and will continue to be the nexus of healthcare transformation. With the development of the Doctor of Nursing Practice (DNP) program of study and the American Association of Colleges of Nursing’s (AACN’s) Essentials of Doctoral Education for Advanced Nursing Practice, we have the obligation to have a seat at the table and an opportunity to advance innovative ideas into action and bring them into nursing practice in ways never done previously. This text provides a nursing framework for transforming health care and the tools to make those changes.

The pace of change in advanced nursing education is rapid as well, and thus we are bringing the fourth edition of The Doctor of Nursing Practice Essentials to DNP students, graduates, educators, and policy makers. In this edition, we updated all chapters with a focus on the impact and relevance a DNP-prepared nurse has in healthcare transformation. This new edition includes revised content regarding the field of nursing informatics, which is a synthesis of data and information to generate knowledge and wisdom within the context of the world of information technology. We have also focused on the emerging role of the DNP-prepared nurse educator. The nursing faculty shortage is at an all-time high, with over 1,500 faculty vacancies in over 800 schools of nursing (AACN, 2017). This shortage is severely limiting the future education of advanced practice nurses.

This edition continues to include expanded information about the DNP project. This chapter continues to be unique in outlining a step-by-step template for the development of the DNP scholarly project. In addition, the appendix includes new and compelling abstracts authored by DNP graduates practicing in advanced roles.

This text is unique in that it is authored by nurses who practice at an advanced level and who have educationally achieved a DNP degree. Some fulfill traditional advanced practice roles and some have expanded roles as informaticists, administrators, educators, and entrepreneurs. We are grateful for each of these nurses who took hours out of his or her busy practice to author these materials.

 Purpose of the Text

This is intended to serve as a core text for DNP students and faculty to use to achieve mastery of the AACN Essentials as well as a “shelf reference” for DNP-prepared nurses as they practice in their chosen field, advancing innovation and policy change.
in healthcare transformation. The DNP Essentials are all covered herein; each essential is covered in adequate detail to frame the foundation of the DNP educational program. This text provides the infrastructure for students, faculty, and those practicing with a DNP to achieve and sustain the highest level of practice. Students who are exploring advanced practice nursing have Chapters 8 and 9 to refer to when investigating and imagining their new roles. This text gives students the foundation necessary to enter into the highest level of advanced practice nursing and develop that practice to the highest level possible for the benefit of their patients and the health of the country and the world. For faculty, this text provides a framework that they can partner with their creativity to make their own unique programs, different from each other but all coming to the same endpoint: graduates who practice at the clinical doctorate level. For doctorally prepared advanced practice nurses, this book serves as a reference to reinforce their knowledge and skills as they sit at the decision-making table of healthcare transformation. This text will support all nurses prepared with clinical doctorates to engage in advocacy, show leadership, and demonstrate the skills of clinical competency, collaboration, and use of informatics to develop new knowledge, ultimately impacting and improving the health of the nation.

References


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Introduction

IMAGINING THE DNP ROLE

Sandra R. Edwardson, PhD, RN, FAAN

Doctoral preparation in nursing has had a long development. Beginning with programs designed to prepare nursing faculty to the introduction of the DNP, the profession has experienced several forms of doctoral education. Before describing the development of the DNP concept, its roots in doctoral education in nursing will be summarized.

Beginning in the mid-1950s with the first pre- and postdoctoral research grants and the research fellowship program of the Division of Nursing Resources (precursor of the Division of Nursing within the U.S. Public Health Service), nursing leaders have gradually won recognition at both the federal and university levels. Although the first emphasis was on preparing faculty and developing research programs, the call for clinical or professional programs was ever present.

Stevenson and Woods (1986) identified four generations of nurses with doctorates:

■ 1900–1940: EdD or other functional degree offered through colleges of education to prepare nursing faculty
■ 1940–1960: PhD in basic or social science with no nursing content
■ 1960–1970: PhD in basic science with minor in nursing through nurse scientist programs offered in conjunction with basic science programs
■ 1970–present: PhD in nursing or DNS
■ 2000 and beyond: Programs projected “greater specificity within nursing” and “formalized postdoctoral programs” (p. 8)

To this chronology we can now add the practice doctorate. Since formally approved by the American Association of Colleges of Nursing (AACN) in October 2004, a special study commissioned by AACN reported that, by April 2014, there were programs offered by more than 250 schools. Although many of the programs are offered by schools that also offer research degrees, many are the only doctoral program in the school (AACN, 2011). Clearly the degree has made it possible for many schools unable or unwilling to offer research degrees to move into doctoral education. The Commission on Collegiate Nursing Education (CCNE) reported at least 259 accredited programs in 303 schools as of 2017 (CCNE, 2019). The National League for Nursing Commission for Nursing Education also reported accreditation of one DNP program (2019).

From the beginning, the primary reason for wanting doctoral preparation in nursing was to develop the knowledge necessary for practice and to gain credibility...
within the academy. Some of the early programs were DNS (doctor of nursing science) programs. In their earliest incarnations, the DNS programs were established as substitutes for the PhD (Meleis, 1988). This was because some states only allow the PhD to be offered through the main campus of the system or because the school was a baccalaureate-granting institution (Downs, 1989). In other cases, university officials believed that there was insufficient research and scholarship in nursing to justify a PhD degree. Therefore, some of the early schools seeking permission to establish PhD programs lacked a mechanism for doing so and chose the DNS as an option.

Early thinkers recommended PhD preparation for generation of new knowledge, and DNS programs to prepare individuals to apply that knowledge (Cleland, 1976; Peplau, 1966). This was in keeping with the statements of the Association of Graduate Schools and the Council of Graduate Schools, which distinguished the PhD from professional degrees: “The professional Doctor’s degree should be the highest university award given in a particular field in recognition of completion of academic preparation for professional practice, whereas the Doctor of Philosophy should be given in recognition of preparation for research whether the particular field of learning is pure or applied” (Council of Graduate Schools in the United States, 1966, p. 3). A recent update on the council’s position supports this definition (Council of Graduate Schools in the United States, 2007).

Over time, the purpose of DNS programs tended to move toward research preparation. Noting the number of articles describing the differences and similarity in types of nursing doctoral programs, Starck, Duffy, and Vogler (1993) proposed that the DNS prepares individuals “in a specialized area of practice for the purpose of testing and validating application of” knowledge that extends and generates nursing practice protocols (p. 214). They advocated for content, including healthcare practices; biologic, psychosocial, economic, legal, and ethical knowledge; and research methods for investigating clinical problems.

An analysis of the curricula of PhD and DNS programs showed that there was more clinical emphasis in the latter, but that differences between the programs as they were implemented were very subtle (Edwardson, 2004). Florence Downs (1989), the long-term editor of Nursing Research, conducted an informal review of topics by PhD and DNS authors in the journal. It revealed essentially the same number of manuscripts on clinical topics by each. Her bottom line was that she was less concerned about the structure and content of the programs than with their quality and excellence.

### Practice Doctorates

There are subtle though uncertain distinctions between professional degrees such as the DNS and practice degrees such as the DNP. The Council of Graduate Schools in the United States appointed a task force to examine the growth of professional programs, but it too has been grappling with defining exactly what they are (Council of Graduate Schools in the United States, 2007). European and Australian universities have also attempted to make meaningful distinctions between professional and research degrees. In those countries, professional doctorates have been attempts to

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1 DNS is used as a shorthand for Doctor of Nursing Science (DNS or DNSc), Doctor of Science in Nursing (DSN).
make the doctorate more focused on the application of knowledge to the solution of societal problems (Maxwell, Shanahan, & Green, 2001).

In the United States, professional doctorates have existed for many years in fields such as education (i.e., the EdD). Although subtle, the major distinction between a professional and a practice degree seems to be in the goals. In the view of Starck et al. (1993), the DNS has as its purpose the testing and validation of knowledge to extend and generate nursing practice protocols. In other words, the purpose is to extend the knowledge generated by research doctorates by testing it in practice. The practice doctorate, on the other hand, is the highest level preparation for the actual practice of the discipline. Holders of practice doctorates are in the business of applying knowledge as they provide direct service to clients. In so doing, they may also do systematic inquiry similar to that of the holders of professional or research degrees, but the primary purpose of the degree is to prepare practitioners.

The first nursing doctoral degree dedicated solely to practice was the doctor of nursing (ND) established at Case Western Reserve University in 1979 (Case Western Reserve University, n.d.). It began as an entry-level nursing degree but evolved into a program offering preparation for advanced practice. Few other schools embraced the ND degree, and by the late 1990s, only one program (University of Colorado) offered an entry-level program.

There are many examples of practice-focused degrees in other disciplines, including entry-level degrees such as the doctor of medicine (MD) and juris doctor (JD), and advanced practice degrees such as the doctor of psychology (PsyD). In the early part of the 21st century, existing practice-focused degrees in nursing were mainly advanced practice doctoral degrees. They included the ND at Case Western Reserve University, Rush University, and the University of South Carolina; a DNSc at the University of Tennessee, Memphis; the DNP at the University of Kentucky; and the DrNP at Columbia University.

The DrNP (now DNP) offered by Columbia provides greater depth and breadth of knowledge and practice than existing master’s programs in clinical science, informatics, and research methods. It is also designed to prepare students to admit and co-manage patients as well as discharge patients from hospitals. They are expected to be able to provide care from the outpatient to the inpatient setting and vice versa (Mundinger, 2005).

The AACN Role in Creating the DNP

This brief review of our history brings us to 1999. In that year, the board of the AACN appointed a task force to revise quality indicators for doctoral education and to address the differences among three types of nursing doctorates: PhD, DNSc/DNS/DSN, and ND degrees. The task force was able to prepare a revised version of the *Indicators of Quality in Research-Focused Doctoral Programs in Nursing* (2001) but found that, for all its attempts to make distinctions between research degrees (PhD) and professional degrees (DNS, DNSc, DSN), the faculty of programs that offer the DNS/DSN degrees saw the need for a common set of quality indicators for both. The task force members concluded that there may be differences in the roles for which the graduates are prepared and in the curricular content of the programs, but the basic requirements for quality programs were viewed as the same for research and professional degrees.
Based on its analysis, the quality indicators task force constructed FIGURE 1 to describe what was happening in the field. Although it was able to address the research half of the model, there was insufficient time and clarity to deal with the practice-focused half of the model. There seemed to be only one true entry-level doctorate (ND) left at the time, although the discussion suggested that a number of AACN member deans thought that the idea ought to be resurrected. Other programs, such as those at the University of Kentucky, Columbia University, and the University of Tennessee–Memphis, had emerged to give nurses advanced practice preparation at the doctoral level, but they too differed in goals and structure. Because of the lack of clarity concerning the right half of the model, the quality indicators task force recommended appointment of a second group to study it. The Task Force on the Clinical Doctorate in Nursing (later renamed the Task Force on the Practice Doctorate in Nursing) was established to focus on that issue alone (AACN, 2004). There were several resources available for the group’s work, but the task force also found it necessary to gather some information on its own.

Marion and colleagues noted discernible differences between practice-focused and research-focused programs. Practice-focused programs place less emphasis on theory, meta-theory, and research methods than do research-focused programs. Capstone projects are designed to solve practice problems or inform practice with an emphasis on scholarly practice and outcome evaluation. Clinical practica or residencies are required (Marion et al., 2003).

After considering published definitions and consulting with leaders in healthcare and nursing education, the task force defined practice as follows:

The term practice, specifically nursing practice, as conceptualized in this document, refers to any form of nursing intervention that influences health care outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and health care organizations, and the development and implementation of health policy. Preparation at the practice doctorate level includes advanced preparation in nursing, based on nursing. (AACN, 2004)

There was controversy about including in the definition roles other than nurse practitioner, clinical nurse specialist, nurse–midwife, or nurse anesthetist. But the task force concluded that caring for populations and seeing to the arrangements under which nursing is practiced were equally important as direct clinical care for advancing the health of the public. Omitted from the definition was preparation for nursing education. This omission is consistent with PhD and practice education in other
disciplines in which preparation concentrates on the specific specialty or subspecialty, and preparation for faculty roles is something that is added as a separate discipline. In short, the task force concluded that nursing faculty need substantive expertise in the subject matter of the discipline and not just pedagogical theory and practice.

Another topic of considerable discussion was the title. Whereas many in the task force might have preferred the simple doctor of nursing or DN label, a search of titles revealed that DN was reserved for the doctor of naprapathy (NaturalHealers, 2015). Similarly, the ND degree title was in use by doctors of naturopathy (Naturopathic Physicians, n.d.) in some states and not available to us. It was finally concluded that there should be only one title and that it should be doctor of nursing practice. It was thought to be the most descriptive title despite the assumption of some that it referred only to nurse practitioners. The task force recommended that the ND be phased out.

A transitional plan was also proposed. Knowing that most of the graduates of the programs would want or need specialty certification, it was clear that the education sector could establish the educational preparation for the role but had no control over the certification process. Therefore, the recommendation was that the many bodies that certify nurses set the year 2015 as the time when initial certification would require the DNP degree.

A final discussion focused on quality control. Whereas the quality of PhD programs is the responsibility of graduate schools, professional and practice degrees are typically awarded by professional schools without the built-in quality control mechanisms provided by graduate schools. For this reason, the task force recommended that an accreditation process similar to that for master's and baccalaureate programs be established to assure quality in DNP programs. The CCNE took up the challenge immediately, developed the criteria, and began reviewing DNP programs in the fall of 2008. The CCNE has since accredited at least 259 programs (CCNE, 2019). As of 2017, 303 programs were enrolling students across the nation, with additional programs under development (AACN, 2019).

### Factors Propelling the Practice Doctorate

From the outset, the DNP had significant opposition. Several nationally recognized leaders in nursing objected based on the fears that the degree would detract from the hard-fought growth and recognition of research in nursing and of nursing in the academy. Meleis and Dracup (2005) argued that the MS and PhD degrees are widely understood and accepted and that a new doctoral degree would amount to second-class citizenship. They believe that the nursing doctorate should be dedicated to advancing and translating knowledge and that separating the practice and research foci could thwart knowledge development and interfere with establishing evidence for quality and safety in health care. Having been among those who fought most vigorously for the acceptance of nursing as a bona fide academic discipline, they feared the DNP would lead to remarginalization within the academy. Others see the two degrees as complementary to one another (Edwardson, 2010). It is interesting to note that the schools represented by the six most vocal opponents now offer the DNP degree.

Many factors led to the perceived need for the DNP. First was the growing complexity of the healthcare environment, coupled with the rapid expansion
of knowledge required for practice. Groups such as the Institute of Medicine, the Robert Wood Johnson Foundation, and others urged health profession educators to meet this growing complexity with educational programs that acknowledge the high levels of scientific knowledge and practice expertise required to ensure high-quality patient outcomes. The Institute of Medicine, for example, emphasized the need for all health professions programs to prepare students to be able to deliver patient-centered care as members of interdisciplinary teams that emphasize evidence-based practice, quality improvement, and informatics (Institute of Medicine, 2003a).

Another Institute of Medicine report observed how management decisions in healthcare organizations had expanded the responsibilities of chief nursing executives, increased the scope of responsibilities for all nursing managers, and led to the loss of mid-level nurse managers (Institute of Medicine, 2003b). The result has been that nurses at all levels need increased knowledge and administrative skills to provide the needed leadership. The Institute of Medicine recommended preparation of nursing leaders for all levels of management and encouraged nursing managers to participate in executive decisions (Institute of Medicine, 2003b).

Another factor propelling the DNP was the movement to doctoral entry levels in related health professions such as pharmacy and physical therapy. These professions had recognized the need for advanced preparation to realize fully their potential contribution to health care. Lest it appear that this was a keeping-up-with-the-Joneses rationale, there were others who saw the need for doctoral preparation of practitioners. For example, a landmark study by the National Research Council of the National Academies (2005) noted the following: “The need for doctorally prepared practitioners and clinical faculty would be met if nursing could develop a new non-research clinical doctorate, similar to the M.D. and Pharm.D. in medicine and pharmacy, respectively” (p. 74). But the DNP, which is designed for nurses who are already licensed practitioners, is unlike the doctoral degrees in other health disciplines that are required for entry into the professions.

Leaders of national nursing, medical, and healthcare organizations with whom the Task Force on the Practice Doctorate met confirmed the need for nurses able to deal with the increasing complexity and sophistication of health care. In response to concerns that the DNP might amount to degree creep, they were sympathetic to the need for additional preparation and expressed confidence that such preparation would add value (AACN, 2004).

As noted earlier, eight clinically focused programs were in existence when the Task Force on the Practice Doctorate began its work. The task force survey of these programs showed considerable variation among the programs in design but also revealed some commonalities. The commonalities included content related to advanced clinical practice (including both patient and practice management), organizations, systems, leadership skills, research methods, and basic scientific underpinnings for practice (AACN, 2004).

Yet another issue propelling the development of the DNP was the way master's programs had responded to the inexorable growth in scientific knowledge and technological sophistication. To fulfill their obligation to provide adequate preparation and to meet the requirements of specialty certification bodies, nursing schools had gradually expanded their master's curricula. In many schools, programs required upward of 50% more credits than typical for master's programs, increasing the cost and time for completing the program. At one school, for example, the minimum
credits required from high school graduation to program completion for a family nurse practitioner degree and a PharmD degree were equal. This suggested that it was time to recognize the preparation with an appropriate degree.

Of course, curriculum length should not be the only criterion for a new degree. Despite the expanded credit requirements of master’s programs, practicing nurse practitioners continued to ask for additional preparation in health policy, management, informatics, evaluation of evidence, and advanced diagnosis and care management (Lenz, Mundinger, Hopkins, Clark, & Lin, 2002). Therefore, the Task Force on the Practice Doctorate and its successor, Task Force on the Essentials of the DNP, both recommended curricula that would not only meet the requirements of existing master’s programs but also respond to the Institute of Medicine’s call for greater faculty with evidence-based practice, quality improvement, and informatics (Institute of Medicine, 2003a). This is in keeping with the position of the National Organization of Nurse Practitioner Faculties, which called for additional preparation in business practices, information management, health literacy, end-of-life care, genetics, mental health concepts, caring for older adults, and managed care (Bellack, Graber, O’Neil, Musham, & Lancaster, 1999).

Some have objected to the DNP based on the assumption that it was preparation to replace physicians. This was especially troublesome to the American Medical Association (AMA), which saw the emergence of the degree as an attempt to educate nursing students with skills equivalent to primary care physicians. Its House of Delegates in June 2008 passed Resolution 214, which stated “that our AMA adopt a policy that those nurses who are Doctors of Nursing Practice must only be able to practice under the supervision of a physician and as part of a medical team with the final authority and responsibility for the patient under the supervision of a licensed physician” (AMA, 2008a). Resolution 232 from the same meeting declared that “the title ‘Doctor,’ in a medical setting, apply only to physicians licensed to practice medicine in all its branches, dentists and podiatrists” and that the organization should serve to protect, through legislation, the titles “Doctor,” “Resident,” and “Residency” (AMA, 2008b). More recently, the organization issued a statement on the Veterans Administration welcoming collaboration with nurses but added, “At the same time, we are disappointed by the VA’s decision today to allow most advanced practice nurses within the VA to practice independently of a physician’s clinical oversight, regardless of individual state law” (AMA, 2016).

Some nurses, too, feared that the growing role of advanced practice nurses in primary care could lead to abandoning the unique role and contribution of nurses. Yet there is growing evidence that advanced practice nurses can and do provide services that allow for the full expression of the nurse’s role while also filling gaps for needed services in the system (Brooten, Youngblut, Deatrick, Naylor, & York, 2003; Brooten et al., 1986; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Naylor & McCauley, 1999). Nurses are proving to have important roles in filling the need for primary and chronic care for all population groups, but especially the growing number of elderly and those living longer with chronic illnesses.

Finally, the shortage of doctorally prepared nursing faculty has been a growing concern within the discipline as schools find themselves turning away qualified applicants partly because of a shortage of faculty. Although the number of PhD programs grew substantially throughout the 1990s, most schools graduated fewer than four or five new PhDs per year (Edwardson, 2004). Schools, including those with PhD programs, had employed master’s-prepared practitioners to fill the need for
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faculty prepared to supervise beginning and advanced nursing students. Although the DNP was specifically designed as advanced preparation for the practice of the discipline, many saw DNPs as one way to fill the void for faculty with advanced practice expertise. They could complement and supplement PhD-prepared faculty whose time is increasingly consumed with the scholarship so necessary for the growth and contribution of the discipline (Sebastian & Delaney, 2013). As O'Sullivan, Carter, Marion, Pohl, and Werner (2005) argued, the myth that a practice doctorate would have an adverse impact on the PhD degree was countered by the reality that it will help “to preserve the integrity of the PhD as a true research degree” (p. 7).

The Future

Although educators, practitioners, and administrators agree that the added content found in the DNP education brings value to health care, the master's of science in nursing (MSN) continues to be available as a route for entry into advanced practice nursing, with limited impetus to replace the MSN with the direct path to the DNP from the BSN degree. Several barriers to the growth of the BSN-to-DNP as entry into advanced practice have been elucidated by the RAND study completed in 2014. Those barriers include lack of faculty resources, budgetary concerns, lack of administrative support, and lack of differentiation between MSN- and DNP-prepared nurses on the part of employers (Auerbach et al., 2014).

The nursing profession has followed a long and varied path for preparing its practitioners. DNP graduates hold promise for investigating and solving some of the vexing problems facing our healthcare system and delivering the highest level of nursing practice. As knowledge workers, nurses can no longer rely on tradition and task orientation as their substantive base. Rather, they need facility with obtaining and maintaining the most current and evidence-based knowledge to inform their practice. The DNP has been designed to give its practitioners the tools for navigating complex systems and mining the latest available knowledge. Early indications are that DNP-prepared nurses are up to the task.

References


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