Texas Board of Nursing
Education Guideline 3.7.5.a.
Defining Quality Indicators for Baccalaureate Degree Nursing (BSN) Education
As Indicated in the Differentiated Essential Competencies (DECs) of
Graduates of Texas Nursing Programs
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Overview:

Consistent with the Institute of Medicine's (IOM) Future of Nursing recommendation, the Board of Nursing (BON) commends registered nurses (RNs) who are actively engaged in advancing their education by enrolling in RN-to-BSN programs. The BON also commends nursing programs that are expanding their RN-to-BSN programs and offering educational opportunities to accommodate the work schedules and personal responsibilities of working diploma and associate degree prepared RNs. The achievement of the BSN by practicing nurses serves to enhance nursing care to individuals, families, populations, and communities. As such, the IOM established a target of 80% BSN-prepared RNs by 2020.

The pressure to meet the challenge to raise the educational preparation of diploma and associate degree prepared RNs to the baccalaureate degree level has resulted in innovative RN-to-BSN nursing programs delivered in accelerated models using online and other delivery options. This guideline has been developed to promote:

1. equivalent high quality education for all RNs entering BSN education, and
2. assurance that the BSN programs for RNs are designed to effectively bridge the gap between Associate Degree(ADN)/Diploma nursing competencies and BSN competencies.

This document focuses on the identified differences in expected competencies between ADN/Diploma and BSN graduates as described in the *Differentiated Essential Competencies of Graduates of Texas Nursing Programs (2010)*. The higher level competencies are classified under major content areas and define the "giant step" taken when graduates from ADN/Diploma nursing programs advance their education by completing a BSN program.

Introduction:

The expected outcomes for graduates from the different types of pre-licensure professional nursing programs directly relate to the educational preparation in each of the program types. Though the graduates from Diploma, Associate Degree, and Baccalaureate Degree programs are all eligible to take the same NCLEX-RN® examination for entry into practice as registered nurses, the BSN education includes additional coursework in nursing and a broader range of studies in other disciplines. An analysis of the differentiated competencies in the DECs for BSN graduates reveals that their educational preparation and expected outcomes are more advanced. Differences in abilities between graduates from the various programs may not be evident in the early stages of nursing practice, but will become more pronounced as nurses gain experience and confidence in the clinical area. After a time of transition into practice, the effects of the educational preparation begin to surface as BSN graduates draw upon their broad-based education for a more comprehensive approach to patient care. BSN graduates will usually have greater opportunities and responsibilities in their career paths.

Didactic instruction in BSN education provides an extensive base of support courses in the sciences and liberal arts, equipping graduates with a broad range of theories on which to base their understanding of the psychosocial and physiological behaviors of their clients. A background in the sciences and liberal arts is essential for students being educated for the BSN scope of practice and decision-making.

Because of current emphasis on BSN education, an increasing number of registered nurses prepared at the diploma or associate degree level are enrolling in RN-to-BSN programs.
RN-to-BSN programs should therefore provide a curriculum that enriches the nurses' repertoire in their current practice, and expands their clinical expertise as they apply new principles and concepts in courses and assigned clinical learning experiences. RN-to-BSN education builds upon previous nursing education, but the commonly identified content areas associated with BSN education (e.g. expanding the focus of care to include families, populations, and communities; and adding expertise in research, community health, evidence-based practice, and leadership) are only a portion of the additional knowledge gained by RN-to-BSN students. BSN education for RN-to-BSN students moves the practice of professional nursing to a higher level where the nurse can apply a wider theoretical framework for reflection, critical thinking, and clinical decision-making.

With the proliferation of new programs and the focus on achieving the BSN degree in an expedient manner, several concerns have been identified related to RN-to-BSN education including the following:

- The BSN degree is a university degree and implies that the additional courses beyond the associate degree are at the upper division level. As university level courses are increasingly being reduced towards a target of 1 academic year (30 credits), care must be taken to assure RN-to-BSN students receive an equivalent amount of upper division content as that received by traditional prelicensure students.
    o Recommendation: While avoiding duplication of courses/content provided at the associate degree level, provide DEC-related BSN content in courses at the upper division level.
- Students who enter an RN-to-BSN program have been educated for practice at the Diploma/ADN level. BSN role-related content typically provided in clinical courses in a BSN pre-licensure program will need to be provided. As such, RN-to-BSN programs may reasonably need to extend program length beyond the number of credit hours required to produce a pre-licensure BSN graduate.
    o Recommendation: Include a transition course or content in RN-to-BSN programs.
- A background in science and liberal arts is an essential element in BSN practice. Though the seasoned ADN nurse may have perfected practice skills, preparation to make decisions from the perspective of the BSN education requires exposure to a full array of liberal arts courses and opportunities to apply new concepts into practice.
    o Recommendation: RN-to-BSN programs should be designed to assure exposure to content in science and liberal arts as well as opportunities to apply new concepts to practice at the level of the BSN-prepared nurse.

The DECs distinguish between the levels of education, provide a comprehensive description of practice competencies based on educational level, and outline the knowledge areas necessary to develop the competencies. The didactic content in RN-to-BSN programs should be designed to broaden the educational foundation to enable the BSN graduate to synthesize information from various disciplines, think logically, analyze critically, and communicate effectively with patients and other health care professionals. The American Association of Colleges of Nursing (2008) stated that the baccalaureate graduate uses research findings and other evidence in designing and implementing care that is multi-dimensional, high quality, and cost-effective. BSN graduates are expected to demonstrate all the competencies of the preceding levels of education, but with greater depth and breadth of application and synthesis.

The curricula in RN-to-BSN programs are often designed with the assumption that the student has gained experience in clinical practice and may not need the same clinical learning experiences required for students in traditional BSN programs. The challenges for RN-to-BSN programs include assessing the experiential level of each student and providing an educational experience for each student to achieve the same outcome competencies. Student assignments and clinical-based learning experiences may vary for

individual students, but they should challenge each student to assure the student develops BSN level competencies.

Identifying Quality Indicators in the DECs for BSN Education:

This document was written in response to questions about quality indicators for RN-to-BSN programs to ensure that graduates are provided the skills to practice at the BSN level. The DEC is a comprehensive guideline describing the knowledge base and competencies that define the expected outcomes of BSN education. The document contains information related to:

- a description of the distinctions between expectations of Diploma/ADN graduates and BSN graduates
- differences in client groups that may be served by BSN graduates
- a listing of types of theories, models, and principles specifically indicated for BSN education included in the DECs (classified under topics: leadership and management; population and communities; research; and interdisciplinary)
- global goals for BSN education
- skill sets to be attained by the BSN graduate
- a detailed list of BSN competencies that focuses on the use of foundational BSN education in nursing practice with a variety of clients in a variety of settings

RN-to-BSN programs should find this information helpful for benchmarking their programs against outcome measures in the DECs and for assuring their graduates are prepared for their full potential as nurse leaders and providers of care.

Distinctions in educational preparation (the level of education reflected in the didactic content and course objectives) among the types of pre-licensure professional nursing programs account for the differences in the expected level of performance after graduation. Students in RN-to-BSN programs should be provided educational opportunities to ensure graduates will possess the same competencies as described in the DECs for graduates from a traditional BSN program. Registered nurses who complete an RN-to-BSN degree program should be able to demonstrate a difference in their decision-making abilities and provision of care to all patient types in a variety of settings. These distinctions in competencies are expressed in the DECs and may be categorized under several broad based headings:

- leadership and management
- populations and communities
- research
- interdisciplinary practice

The goals for BSN education are more global in nature than those for Diploma/ADN education and pertain to:

- population risk reduction
- community risk reduction
- improving the delivery system
- legislative advocacy
- policy development
- financial accountability
- interdisciplinary teams
- staff development

Client groups for Diploma/ADN graduates are: patients and their families.
Client groups for BSN graduates are expanded further to include:

- populations
- communities
- vulnerable populations

BSN graduates have an expanded approach to nursing practice related to:

- A broad knowledge base from the liberal arts, humanities, and natural, social, and behavioral sciences as they apply to planning care and reducing risks for patients, families, populations, and communities
- Multiple theoretical perspectives from many disciplines (stress and crisis, change, conflict management, human resource management, teaching and learning, organizational behavior, information systems management, etc.) that may be applied to the health care system
- A historical perspective of health care and providers
- Knowledge and skills in:
  - Administration
  - Research process and clinical reasoning models
  - Research findings as a basis for decision-making and comprehensive patient care
  - Legislative advocacy process to influence public policy
  - Processes for developing and evaluating standards of care using evidence-based practice
  - Communication skills for writing, speaking, and presenting information to further the profession of nursing and to disseminate knowledge
  - Nursing frameworks, theories, and models that relate to managing and evaluating health care delivery
  - Collaboration with individuals inside and outside health care delivery systems to provide comprehensive care
  - Safe environmental management and a culture of safety
  - Comprehensive assessment of community and population, synthesis of data, analysis of community needs, and a comprehensive approach to meeting health needs
  - Comprehensive nursing care in a variety of settings

Knowledge Base

BSN students are provided with a broader knowledge base as listed below. The location of each knowledge area in the DECs is indicated for reference. Some areas may be repetitious but their application is to a different client group or context, as noted below.

Theories, Models, and Foundational Areas:
- legal principles and practice theories and principles relative to health care. I.B.2.b. knowledge
- role theory, change theory, management and leadership theory. IV.A.3.a. knowledge
- theories of leadership, organization, and group dynamics. IV.A.3.c. knowledge
- theories of evaluation of organizational behavior. IV.G.1. knowledge
- theories of leadership and management, including critical thinking, change theory, assertiveness, conflict management, budgeting, principles of delegation, supervision, collaboration and performance appraisal. IV.D.2. knowledge
- theories and models of therapeutic and non-therapeutic communications. II.E.2. knowledge
- communication theories
  --and their impact on nursing practice. II.C.2. knowledge
  --as applied to populations and communities. IV.D.1. knowledge
  --and group process. IV.G.2. knowledge

- theories and strategies of effective communication and collaboration including assertiveness, negotiation, conflict resolution, and delegation. IV.A.2. knowledge
- theories of disease prevention, health promotion, education, and rehabilitation. II.C.3.a. knowledge
- theory and principles of case management, population characteristics, and epidemiology. IV.C.2. knowledge
- theories of leadership I.C.5.b. knowledge
- change theory, change agent role, and methods for evaluating the effectiveness of change. II.H.7. knowledge
- change theory and conflict resolutions strategies for effective and efficient resource management. IV.D.4 knowledge
- motivation theory and research/evaluation outcome measures to evaluate efficacy and effectiveness of care II.F.3. knowledge and IV.F.4.c. knowledge
- theoretical models of epidemiology and communicable disease prevention and control for populations and communities. III.C.1.a. knowledge
- systematic processes (research, epidemiology, psychosocial, management). II.B.1.b. knowledge
- models for health care delivery in organizations and communities. II.D.2.b. knowledge
- models of care delivery including integrated care. IV.A.1.c. knowledge
- systematic approach based on the liberal arts, sciences, and research studies. II.A.1.a. knowledge
- advanced sciences (such as epidemiology, pathophysiology, genomics, neurobiology, pharmacology, chemistry, etc.), and the humanities. II.A.1.a.knowledge and II.F.2. knowledge
- ethics and logical and ethical reasoning. II.B.4. knowledge
- code of ethics, ethical practices, current issues, and patient's rights in the health care delivery system. II.D.8. knowledge
- nursing frameworks, theories, and models that relate to managing and evaluating health care delivery with consideration of related costs of patients, families populations, and communities. II.A.1.c. knowledge
- links between nursing history, and medical, social, political, religious and cultural influences. I.C.1. knowledge
- past, present, and future issues affecting health care policies. IV.C.7. knowledge
- economic and political factors that influence health care delivery for populations and communities. IV.B.1.b.knowledge
- family systems theory. IV.C.3.b. knowledge
- models for understanding the dynamics of functional and dysfunctional relationships. II.C.1.b. knowledge
- health behavior change strategies. II.E.1.c. knowledge

Leadership and Management:
- management of group processes to facilitate meeting patient goals. IV.D.3. knowledge
- management and systems theory. IV.F.2.f. knowledge
- models and theories of stress, crisis response, and conflict management. II.D.7. knowledge
- organizational theories/principles of organizational behavior. II.H.2. knowledge
- organizational structure including various health care delivery systems. IV.G.4.b. knowledge
- management and communication within an organization. II.H.5.a. knowledge
- leadership and management theory, practice, and skills. II.H.5.b. knowledge
- workplace unit budgeting and workforce resource management. II.H.4.a. knowledge
- safe environmental management and promoting a culture of safety. II.H.3.b. knowledge
- evolving leadership roles in the advancement of the nursing profession; distinction of roles and scopes of practice among nursing and other health care professions. I.C.5.a. knowledge
- processes for developing standards of nursing practice and care. I.B.l.b. knowledge
- processes of continuous quality improvement and application of quality improvement data. IV.A.5.d. knowledge
- quality improvement, environmental management, and risk management with a focus on patient safety. III.B.1.b. knowledge

- health policy. IV.F.2.a. knowledge
- health care policies and regulations related to public safety and welfare, mandatory reporting, and development of the future workforce. IV.B.4. knowledge
- role modeling to maintain professional boundaries. I.B.7.c. knowledge
- formal and informal sources of power and negotiation processes. IV.b.3.b. knowledge
- historical development of professional advocacy groups and the growth of consumer advocacy. IV.B.3.c. knowledge
- principles and task of quality improvement and outcome measurement in systems of care delivery. I.B.8. knowledge
- utilization of health care delivery system resources. II.E.10. knowledge
- role of committees in developing health care policies, procedures. I.B.6.c. knowledge
- systems of nursing care delivery. II.D.4.c. knowledge
- integration of comprehensive patient needs into health care system. II.B.5. knowledge
- a variety of systematic approaches for problem-solving and decision-making for prioritizing and evaluating the plan of care. II.C.6. knowledge
- systematic processes to assess methods for evaluating patient outcomes, including reliability and validity of evaluation tools. II.F.1. knowledge
- cost factors in multiple settings. II.C.5. knowledge
- decision-making models. II.D.5.b. knowledge
- human resource management and performance evaluation processes. I.B.5.b. knowledge
- models of priority setting and organization management. II.D.3.c. knowledge
- resource management and organizational behavior. II.D.1.f. knowledge
- information and communication systems for managing population-based data. IV.E.1.a. knowledge
- information management-
  --in the delivery of safe patient care. II.B.10. knowledge
  --for health care systems. IV.E.1.c. knowledge
- inquiry, analysis, and information approaches to address practice issues I.C.2.b. knowledge
- principles of staff development and learner behaviors I.B.4.b.
- communication skills in the areas of writing, speaking, and presenting as required to function in a leadership position. I.B.6.d. knowledge
- legislative processes related to health care. IV.A.4.b. knowledge
- strategies to influence legislative action processes and public policy. I.C.5.c. knowledge

Populations and Communities:
- evidence-based risk reduction. III.C.1.b. knowledge
- epidemic and pandemic prevention and control. III.C.1.c. knowledge
- disaster preparedness, response, and recovery. III.C.1.d. knowledge
- international standards and guidelines for infection control. III.C.2. knowledge
- leadership role in organizational committees involved with improving the quality of health for populations and communities. IV.B.3.a.knowledge
- role of the nurse as advocate for populations and communities. IV.B.2.b. knowledge
- research and theories related to advocacy for access to health care for patients, families populations, and communities. IV.B.2.c. knowledge
- methods for improving access to health care for populations and communities. IV.C.5. knowledge
- implications of demographic, epidemiological, and genetics data on the changing needs for health care resources and services. IV.C.6.b. knowledge
- components of comprehensive databases and methods for data collection, health screening, and case finding. II.B.3.c. knowledge
- analysis of nursing research, epidemiological, and social data to draw inferences and conclusions about the health of populations and communities. II.B.2. knowledge
- systematic approach to performing a community assessment. II.B.1.c. knowledge
- political, economic, and societal forces affecting health care for population intervention and solutions. II.B.11. knowledge
- techniques for assessment of community health literacy, learning needs, and factors affecting

quality of life and health care II.G.1.c. knowledge
- learning theories and best practices for evaluating methods, strategies, and outcomes of learning and teaching. II.G.2.b. knowledge
- health care for populations and global communities. II.B.12. knowledge
- methods for advocating for population and community health. II.G.3.b. knowledge
- social, economic, and political processes impacting access to and delivery of health care in communities. IV.A1.b. knowledge
- state and federal referral resources. IV.C.1. knowledge
- federal and global resources for risk reduction, and health promotion, maintenance, and restoration. IV.C.8. knowledge
- characteristics, concepts, and processes related to communities, including epidemiology, risk factors, and preventive health practices and their implications for vulnerable populations, resources and resource assessment techniques, environmental factors, and social organizations. II.B.6. knowledge

Research:
- research studies. II.A.1.a.
- research utilization and evidence-based practice. II.A.3.a. knowledge
- analysis of reliability, validity, and limitations of quality of evidence. II.A.3.b. knowledge
- informed consent for participation in research. II.A.3.c. knowledge
- research and evaluation methodologies. II.A.4.b. knowledge
- research related to organizational and societal change. I.C.3.b. knowledge
- evidence-based practice and research findings related to health care. IV.A.5.a. knowledge
- process of translating current evidence into practice. IV.A.5.b. knowledge
- clinical reasoning models and research process. II.A.2.b. knowledge

Interdisciplinary Practice:
- evolving leadership roles in the advancement of the nursing profession; distinction of roles and scopes of practice among nursing and other health care professionals I.C.5.a. knowledge
- nursing theories, research findings, and interdisciplinary roles to guide nursing practice. II.B.8. knowledge
- interdisciplinary interventions including nursing care across all settings. II.C.4.b. knowledge

Judgments and Behaviors

BSN graduates are prepared for more advanced nursing behaviors as outlined in the DECs competencies. These behaviors demonstrate the use of a wide range of theories and perspectives in clinical decision-making and in providing safe, competent nursing care. They also describe the BSN-prepared nurse's ability to assume leadership roles in the health care setting and in the community. The competencies include the following:

Leadership and Management:
- using management, leadership, team building, and administrative skills; organizing, managing, and evaluating the functioning of groups of individuals and staff. II.H.4.b. behaviors
- using leadership skills to provide staff education to members of the health care team to promote safe care. IV.G.1.a. behaviors
- evaluating the effectiveness of the process for staff development. IV.G.1.b. behaviors
- using leadership skills to promote team building and team work. IV.F.2.b. behaviors
- planning and managing activities to develop competency levels of team members. IV.F.3.b. behaviors
- supervising others in nursing care by using best practices of management, leadership, and evaluation. IV.G. core
- demonstrating a leadership role in achieving population, community, and management goals.

II.H.5.b. behaviors
- developing new policies and procedures. IV.G.1.c. behaviors
- participate in designing systems that support quality nursing practice. I.B.5.d. behaviors
- communicating and managing information using technology to support decision-making to improve patient care and delivery systems. IV.E. core
- identifying, collecting, processing, and managing data in support of administration and research. IV.E.1.a. behaviors
- applying concepts and skills from management theory to assigning and delegating nursing care in a variety of settings. II.d.4. behaviors
- assisting in the development of clinical practice guidelines using evidence-based practice and research findings. II.C.3.b. behaviors
- analyzing patient data and using research findings and a variety of systematic processes to compare expected and achieved outcomes for patient behaviors. II.F.2.b. behaviors
- participating in designing, conducting, and evaluating quality improvement studies. IV.E.1.d. behaviors
- using current technology and informatics to enhance all aspects of care in delivery systems. IV.E.3.a. behaviors
- assigning and/or delegating care based upon an analysis of patient or organizational need. IV.F. core
- participating in committees that promote quality, safety, and risk management. III.E.4.a. behaviors
- collaborating in the development of standards of care based on evidence-based practice congruent with organizational structure and goals. II.H.6.b. behaviors
- developing and using evidence-based clinical practice guidelines to guide critical team communications during transitions in care between providers. IV.D.4. behaviors
- assessing the management structure and nursing care delivery system within a health care organization and recommending changes for improvement. II.H.1.b. behaviors
- designing and implementing strategies to respond to the need for corrective action to promote a safe work environment. II.H.2.b. behaviors
- using change theory and strategies in the work environment for effective and efficient resource management and improvement of patient care. IV.D.7. behaviors
- managing quality improvement processes for safe patient care. III.A.5.b. behaviors
- collaborating with others inside and outside the health care industry to promote nursing. I.C.3.b. behaviors
- synthesizing links between nursing history and medical, social, political, religious, and cultural influences to promote professional nursing practice. I.C.1.a. behaviors
- using scholarly resources to address ethical and legal concerns. II.E.8.behaviors
- interpreting and guiding others toward safe and legal clinical practice. III.E.4.b. behaviors
- identifying systems issues that impact nursing practice. III.E.4.c. behaviors
- analyzing the impact of professional organizations and regulation upon the nursing profession and the roles of nurses. I.C.4. behaviors
- advocating for standards of practice using professional and legislative processes. I.B.2.c. behaviors

Populations and Communities:
- providing direct and indirect care-
  --to patients and families in disease prevention and health promotion and/or restoration. II.E.13.a. behaviors
  --in community-based programs. II.E.13.b. behaviors
  --in community-based programs whose primary goals are disease prevention and health promotion and/or restoration. II.E.13. behaviors
- developing, implementing, and evaluating teaching plans for populations and communities to address health promotion, maintenance, restoration, and population risk reduction. II.G. core
- assessing learning needs of populations and communities related to health promotion, maintenance, and restoration. II.G.1.a. behaviors
- assessing the adequacy of the support systems for populations and communities. IV.C.1.a.

behaviors
- using models of health care delivery to plan and improve health care for families, families, populations, and communities. IV.A.1.b. behaviors
- promoting and providing leadership in the effective coordination of services to patients, families, populations, and communities. IV.A.2.b. behaviors
- working with family and community resources to develop and strengthen support systems for patients, families, populations, and communities. IV.C.1.b. behaviors
- identifying providers and national and community resources to meet the needs of patients, families, populations, and communities. IV.C.1.c. behaviors
- developing, implementing, and modifying teaching plans and strategies for health promotion, maintenance, and restoration, and risk reduction of populations and communities. II.G.2.b. and II.G.3. behaviors
- teaching populations and communities about access to reliable and valid sources of information and resources including health information. IV.B.3.c. behaviors
- referring populations and communities to resources. IV.B.5.a. behaviors
- evaluating learning outcomes of comprehensive teaching plans for populations and communities. II.G.4. behaviors
- developing teaching plans with special considerations for vulnerable populations. II.G.5.b. behaviors
- teaching health promotion and maintenance and self-care to groups based upon teaching needs. II.G.5.c. behaviors
- providing populations and communities with information needed to make choices regarding health. II.G.6.a. behaviors
- anticipating risks for exposure to infectious pathogens in populations and communities. III.C.2.b. behaviors
- assisting in developing policies and procedures to prevent exposure to infectious pathogens, communicable conditions, and other occupational hazards. III.C.3.a. behaviors
- participating in programs and systems to address safety of populations and communities in the event of emergency or disaster. III.C.3.b. behaviors
- implementing risk reduction strategies to address social and public health issues. II.G.6.b. behaviors
- using theoretical analysis of available data to formulate goals and outcomes to reduce the risk of health care associated infections. III.C.1. behaviors
- using epidemiologic process to manage and reduce risks related to medication and treatment administration and modifying techniques in a variety of settings. III.B.3.c. behaviors
- promoting and managing a safe, effective environment for populations and communities. III.B.1. behaviors
- formulating goals and outcomes using an evidence-based and theoretical analysis of available data to reduce community risks. III.C. core
- participating in organizational initiatives that enhance a culture of safety for families, populations, and communities. III.B.6.b. behaviors
- advocating-
  --for health education, healthy lifestyles, and early detection and treatment of disease, targeting vulnerable populations. II.G.7. behaviors
  --on behalf of populations and communities with other members of the interdisciplinary health care team by implementing strategies for improving health care delivery systems. IV.B.3.b. behaviors
  --for public policies to support health care access for vulnerable populations. IV.C.3.c. behaviors
- applying case management and population based service models for coordinating delivery of health care services across levels of care in the community. IV.D.2.b. behaviors
- assisting vulnerable populations to communicate needs to their support systems and other health care professionals. IV.C.3.b. behaviors
- serving as a member of the health care and community team to provide services to communities with unmet needs. IV.B.5.b. behaviors
- initiating and participating in community partnerships and coalitions to provide health care to

targeted, diverse populations. IV.B.5.c. behaviors
- using multiple referral resources for patients, families, populations, and communities, considering cost; confidentiality; effectiveness and efficiency of care; continuity and continuum of care; and health promotion, maintenance, and restoration. IV.C. core
- applying legal and ethical principles to advocate for human and societal well being and preferences. IV.B.1.b. behaviors
- identifying unmet needs of populations and communities from a holistic perspective. IV.B.2.a. behaviors
- assessing genetic, protective, and predictive factors that influence the learning needs of patients, families, populations, and communities, related to risk reduction, and health promotion, maintenance, and restoration. II.G.1.b. behaviors
- evaluating and reporting family, population, and community outcomes and responses to therapeutic interventions in comparison to benchmarks from research findings. II.F. core
- evaluating evidence-based data for use in providing comprehensive, efficient, cost effective care to diverse patients, families populations, and communities. II.F.6.b. behaviors
- coordinating human, information, and materiel management resources in providing care for populations and communities. II.H. core
- using informatics to promote health care delivery and reduce risks in populations and communities. IV.E.3.c. behaviors
- analyzing demographic and epidemiological data on the changing needs for health care resources and services. IV.C.4.b. behaviors
- participating in meetings/organizations addressing past, present, and future issues affecting public/government/private health care services, programs, and cost to patients, families, populations, and communities. IV.C.4.c. behaviors
- interpreting and analyzing health data of populations and communities, including pathophysiology, genomics, and epidemiological considerations. II.B.7. behaviors
- examining populations at risk from epidemiological, social, and environment perspectives. II.B.9.b. behaviors
- using epidemiological, social, and environmental data to draw inferences about the health status of populations and communities. II.B10. behaviors
- synthesizing theory and research-based knowledge from arts, humanities and sciences for delivery of safe and compassionate care to patients including populations and communities. II.C.1. behaviors
- implementing plans of care to assist communities and vulnerable populations to meet comprehensive physical and mental health care needs in multiple settings. II.E.1. behaviors
- performing comprehensive assessments and monitoring changes to include factors impacting health status and health needs of populations and communities II.B.2. behaviors
- communicating with state legislators and representatives of other regulatory agencies to promote a competent nursing workforce and protection of the public's safety and welfare. I.C.3.d. behaviors
- applying communication theory and techniques in maintaining professional relationships with populations and communications. II.E.9.b. behaviors
- evaluating evidence supporting traditional and complementary health care practices used by populations and communities. II.B.3.b. behaviors

Research Based Care:
- providing nursing interventions safely and effectively using current research findings and evidence-based outcomes. II.E.12.b. behaviors
- modifying plan of care based on research findings and evaluation data. II.F.4. behaviors
- using evidence-based findings to initiate accident prevention measures for patients and implementing measures to prevent risk of patient harm resulting from errors and preventable occurrences. III.B.8. behaviors
- identifying links between physical and mental health, lifestyle, prevention, and cost and access to health care. II.B.6. behaviors

- analyzing patient data using research findings, evidence-bsed practice guidelines, and a variety of systematic processes to compare expected and achieved outcomes of care. II.F.2.b. behaviors
- expanding and modifying data collection tools using evidence-based practice. II.B.1.b. behaviors
- using research findings to help explain deviations from plan of care and revise plan of care with interdisciplinary health care team. II.F.3.b. behaviors
- applying research findings and principles of research to enhance evidence-based practice. I.B.5.e. behaviors
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Interdisciplinary Practice:
- facilitating communication among clients and interdisciplinary team to use institutional or community resources to meet health care needs. IV.C.2.a. behaviors
- collaborating with-
--the interdisciplinary health care team to use human and materiel resources that are optimal, legal, and cost-efficient to achieve patient-centered outcomes, meet organizational goals, and promote health in the community. II.H.3. behaviors
--interdisciplinary team and using knowledge of financial resources to demonstrate fiscal accountability for health care of populations and communities. II.C.6. behaviors
--the interdisciplinary team on principles and tools of quality improvement and outcome measurement in systems of care delivery. I.B.9. behaviors
- advocating with members of the interdisciplinary health care team and community resources on behalf of vulnerable populations to procure resources for care. IV.C.3.a. behaviors
- using evidence-based findings to develop interdisciplinary policies and procedures related to a safe environment including safe disposal of medications and hazardous materials. III.B.7. behaviors
- providing leadership in collaboration with the interdisciplinary health care team. I.C.2. behaviors
- applying leadership and management concepts with skills in collaboration with the interdisciplinary health care team to implement quality patient care. I.B.4. c. behaviors
- involving populations and communities in collaboration with interdisciplinary health care team members for planning health care delivery to improve the quality of care across the lifespan. IV.A.1.a. behaviors
- using leadership and role modeling skills to promote professional boundaries among the members of interdisciplinary team. I.B.7.b. behaviors
- using leadership skills in-
--interdisciplinary team meetings. IV.D.6.b. behaviors
--creating processes that facilitate joint decision-making with the interdisciplinary health care team. IV.D.1.c. behaviors
- applying leadership and management concepts in assisting the interdisciplinary health care team to implement quality, goal-directed patient care. IV.D.3.a. behaviors

Recommended Reading:
McEwen, M., & Pullis, B. R. (2012). National survey of RN-to-BSN programs. *Journal of Nursing Education,* 51(7), 373-380.