

COMPETENCE LITERATURE REVIEW

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Introduction

The literature on the concept of competence is myriad and encompasses many related descriptors. For the purposes of this review the concept of competence will be addressed in the following categories: competence, lack of competence, and the factors that affect/impact on competence. However, when discussing categories of competence in the health care and nursing literature, further divisions based on nursing role can be analyzed, i.e. competence of staff nurses, nurse administrators, educators and other specific specialty roles (e.g. perioperative nurses).

In the 1970's, the realm of nursing education and preparation for practice began a shift to focus on the concept of competence-based education. The educators at Alverno College in Wisconsin instituted the first competency-based baccalaureate nursing education program. However, even though this competency-based approach to education has been evident in nursing for the past 30 years, little consensus exists regarding the definition and application of competence in nursing (Trivett, 1975; Ewens, 1979; Mentkowski, et.al., 1982.). This review synthesizes a significant amount of literature related to the definitions and descriptions of "competence" as a concept inherent to nursing practice. Subsequent to a focused review of literature, issues inherent to the definition and utilization of the concept of nursing competence are discussed.

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Part I: Competence

Conceptual Clarity

The number of definitions and descriptions of the term “competence” is myriad, and, therefore, impossible to cover all of the variations in this paper. As a result, a select few have been chosen to reflect the aspects most often related to nursing and the health care education environment. Although they may sound similar, competence and competency are not necessarily synonymous. Competence refers to a potential ability and/or a capability to function in a given situation. Competency focuses on one’s actual performance in a situation. This means that competence is required before one can expect to achieve competency. Thus, competence makes one capable of fulfilling his/her job responsibilities. Competency is determined by comparing current work functioning with established performance standards developed in the work environment according to a specific role and setting. By achieving competence and competency, one can expand his/her range of nursing skills and provide patients with confident care.

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Definitions

In the health care literature, the term competency is often used to describe the knowledge to be able perform at a particular task. According to Norman (1985) competency is more than knowledge. It includes the understanding of knowledge, clinical, technical, and communication skills, and the ability to problem solve through the use of clinical judgment. Competence is the ability to perform a specific task, action or function successfully. Competencies are used to create unique standards within disciplines and specialties. This encompasses educators, learners, and practitioners. According to Verma (2006), “competencies in education create an environment that fosters empowerment, accountability, and performance evaluation, which is consistent and equitable. The acquisition of competencies can be through talent, experience, or training.” Barr (2005) offers the following examples of collaborative competencies:

- “Describe one’s roles and responsibilities clearly to other professions.
- Recognize and observe the constraints of one’s role, responsibilities and competence, yet perceive needs in a wider framework.
- Recognize and respect the roles, responsibilities and competence of other professions in relation to one’s own.
- Work with other professions to effect change and resolve conflict in the provision of care and treatment.
- Work with others to assess, plan, provide and review care for individual patients.
- Tolerate differences, misunderstandings and shortcomings in other professions.
- Facilitate interprofessional case conferences, team meetings, etc.

- Enter into interdependent relations with other professions.”

A definition of continuing competence is “the ongoing ability of a registered nurse to integrate and apply the knowledge, skills, judgment, and personal attributes required to practice safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs.” Saskatchewan Registered Nurses’ Association, (<http://www.srna.org/registration/ccp.php>, date accessed 10/01/08).

Black and Wolf (1990) describe competence as the ability to perform in effective ways on different occasions including in differing and unexpected contexts [cited in While, 1994]. However, even if performance can be measured, there is a lack of evidence to suggest that good performance is always an adequate indicator of high degrees of competence [Stedman 1985, cited in While 1994, 9]. This example illustrates the case of a false positive where a nurse can answer a question correctly on an exam but from a false premise. A false negative example is that of a nurse who may have the skill or knowledge to perform a task but fails to perform the task correctly in an examination situation. These examples suggest that performance alone may not be an adequate indicator of competence.

Continued competency has been defined as the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse’s practice role, within the context of public health and safety (NCSBN, 1996, 1998). Many nursing specialty organizations offer examinations and other processes for certification, suggesting that certification is associated with continued competency. Competency has been defined as a “documented validation of the professional achievement of identified standards of practice of an individual registered nurse” (CCI, 2002). Board certification has been linked to competency and has been found to have intrinsic and extrinsic rewards (Gaberson, et.al., 2003; Sechrist, et.al. 2006).

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Descriptions

Miller, et. al. (1988) suggest there are two senses in which competence can be defined. The first is competence equating to performance, which is the ability to perform nursing tasks, and the second is competence as a ‘psychological construct.’ That is, the ability to effectively integrate cognitive, affective and psychomotor skills when delivering nursing care. The state of Washington Nurses Association (2006) offers a position statement on continued competence stating that competency-based performance evaluation is defined as a criterion-referenced summative evaluation process that assesses a participant’s actual ability to meet a predetermined set of performance standards under controlled conditions and protocols. Elements of nursing competence are variable, dependent on setting and evaluator. They offer some possible examples:

- Practice and Educational Settings: Assessment and intervention, communication, critical thinking, teaching, human caring relationships, management, leadership, knowledge integration.
- Regulatory Oversight: Standard based upon current entry-level competency. Standard based on a generalist core-competency for the profession. Standard based on competence needed for safe and effective practice in the focused area of practice. Testing prior to initial and subsequent licensure.

- Individual Evaluation: Performance review, peer review, professional certification, self-assessment, personal professional profiles, clinical practice area continuum of skill-mastery.
- Public Expectation: Nurses' mastery of current technologies. Optimal health care outcomes. Inclusion of complementary and alternative health care into personal health care treatment options. Consumer involvement in health care decisions.

Bradshaw and Merriman (2008) examine how nurses are prepared to be clinically competent and safe at the time of registration or licensure, so that they are fit for practice and purpose. They examine the ideology of preparing the 'knowledgeable doer'. In 2003, the Institute of Medicine (IOM) issued a report, *The Education of Health Care Professionals: A Bridge to Quality*, in which professional competency was viewed as a shared responsibility of both the public and private sectors. The IOM report recommended that all professional boards move toward requiring licensed health care professionals to periodically demonstrate their ability to deliver care within five competencies. These career encompassing competencies are (1) deliver patient centered care, (2) be members of an interdisciplinary team, while emphasizing (3) evidence-based practice, (4) quality improvement, and (5) informatics (IOM, 2003). To summarize, competence in nursing practice is complex and involves cognitive and kinesthetic aspects. Conceptually, it is more than just passing an exam or test. It involves action and demonstration of both the physical and cognitive skills used by nurses in the practice environment.

A Lack of Clinical Competence

The main focus of competence in nursing has primarily been in the area of the clinical practice setting. It is in this setting where there exists the highest risk of harm and/or poor patient outcomes that can be directly linked to nursing practice activities. The 2001 Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* concluded that all health care professionals, in all disciplines, should receive specific education regarding patient-centered care. The training that these professionals receive should be on an interdisciplinary team, with emphasis on evidence-based practice, quality improvement approaches, and information. The IOM report compared competencies both within and across health professionals, which focused on the efforts of the American Board of Internal Medicine Foundation (ABIMF), (ABIMF, 2002) the American

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Association of Medical Colleges, (AAMC, 2001) and the Center for the Advancement of Pharmaceutical Education Advisory Panel on Educational Outcomes.

In 2004, the Citizen Advocacy Center (CAC) presented a road map for continued competence. This road map is a two-phased plan built upon the actions of conducting research, seeking regulatory mandates, using evidence-based methods to demonstrate continuing competence, changing educational programs, and reforming continuing education program. In addition, the Pew foundation lists twenty-one competencies for future clinicians which organizations like the National League for Nursing Accreditation Commission (NLNAC) use (Verma, 2006).

Example and sources such as these serve to establish a link between clinical competence and error in nursing and

medical practice.

Factors that Impact on Competence

Suffice it to say, competence does not exist in a vacuum. As the definition implies a type of action, so must it have the ability to be acted on. There are several factors that impact on competence, but some of the most prevalent that have been identified include: mentoring, system and environmental issues, ethics, and the evaluation of competence.

Mentoring

Mentorship is an extremely powerful tool that can help build competence, leadership skills, self-awareness and morale (Prevosto, 2001). The United States military has successfully used mentoring to promote competence for some time. Many business organizations have used mentoring as well to foster competence in the workplace (Phillips-Jones, 2004). In addition, Phillips-Jones (2004) notes that the strategy of using mentoring groups or circles can help mentees accomplish two tasks: set important development goals and build competence and character to reach those goals.

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Having a mentor and/or coaching a learner can lead to the development of competence and confidence in the learner's own skills and abilities (Fumiano, 2007). Strategies have been identified for mentoring in the field of education from the classroom to the online learning environment. Rayner, et. al. (2004) purport that coaching is an important skill to add to a leader's repertoire of competence. Mentoring and the related topic of coaching in health care environments have been topics of research for some time. A study by Byrne and Keefe (2002) examined how mentoring can be used to build research competence in nursing in various professional and geographic settings. The researchers explored the databases, MEDLINE & CINAHL from 1990–2001, as well as personal reflections on mentoring and mentored experiences to study this phenomenon. Their results suggest that choices among mentoring models can be made in accordance with resources, priorities, and objectives congruent with a given nursing setting and time, but optimum scholarly productivity requires experts and sustained support. Competence, thus, can positively influenced by the use of a mentor or mentoring groups. Mentoring continues to be an effective educational strategy that develops and enhances competence.

System and Environmental Issues

Demand for nurses has exceeded supply in certain types of patient care specialties, such as critical care, cardiac, neonatal, and perioperative nursing (ANA, 2000). Indeed, demand has intensified for more baccalaureate-prepared nurses with skills in critical thinking, case management, and health promotion skills across a variety of inpatient and outpatient settings (Goode, et al., 2001). While there is a demand for more nurses, it is implied that the nurses be competent to practice. An essential aspect of nursing practice is the development and maintenance of competence.

The current health care system needs not only more practicing nurses but also competent practicing nurses. The American Nurses Association (ANA) through the American Nurses Credentialing Center (ANCC) established the Magnet Hospital Recognition Program to identify excellence in the provision of nursing services. An obvious correlation here is that competence is an integral part of excellent in nursing practice. The Magnet program recognized those health care institutions that acted as a “magnet” for professional nurses by creating a work environment that rewarded quality nursing services. The name of the program was changed in 1996 to the Magnet Nursing Services Recognition Program for Excellence in Nursing Services. Currently, the Magnet Nursing Services designation is bestowed for four years and the highest level of reward that can be accorded to organized nursing services in health care organizations (ANCC, 2001). Nurse scientists have continued to evaluate magnet hospitals. Recent studies have substantiated improved patient outcomes within organizational environments that support professional nursing practice. The Magnet Nursing Services designation remains a valid marker of excellence in nursing care (Aiken, Havens & Sloane, 2000).

The American Association of Colleges of Nursing (AACN) Task Force on Hallmarks of the Professional Practice Setting (AACN White Paper, 2002) identified characteristics of the practice setting that best support professional nursing practice and allow baccalaureate and higher degree nurses to practice to their full potential. Examples of these hallmarks, which are present in health care systems, hospitals, organizations, or practice environments, include the following: manifest a philosophy of clinical care emphasizing quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability; recognize contributions of nurses’ knowledge and expertise to clinical care quality and patient outcomes; empower nurses’ participation in clinical decision-making and organization of clinical care systems; maintain clinical advancement programs based on education, certification, and advanced preparation; and demonstrate professional development support for nurses. Thus, the environment in which one works as well as the type of organizational system in which one works and learns can affect the development of competence. This stems from the literature on education and the learning environment. It also translates the work of nurse researchers (Aiken, et.al.) who document the impact that the environment has on the satisfaction of nurses at work. Learning and competence, it seems, occur best in environments in which the employee, in this case the nurse, feels empowered and able to freely learn.

Ethics

Ethics and competence involve two related aspects; first is the ethical nurse who practices competently and second, there is a component of being ethically competent. The development of ethical competence is of importance when it comes to being able to both reduce practice errors and retain nurses in health care. Ethics in perioperative practice has become especially prominent as a focus on patient safety has come to the forefront. Perioperative nurses have a tradition of promoting patient safety by intervening to minimize the risks related to surgical infection and injury (Beyea, 2002). The action of intervening in high-risk situations may be motivated by practice standards, professional duty, ethical values and beliefs. When surgical errors happen, there is the responsibility or duty to report the errors – and that is where the ethical imperative enters into nursing practice.

Ethical practice is important to nursing as it underpins the fiber of the practice itself by providing an action guide for nurses. With the increased awareness of medical malpractice in general, and surgical or perioperative errors in particular, it has become imperative for nurses to be able to speak out when errors, or the potential for errors, become evidenced. According to Hettiarchy (2001), “surgical errors often appear the worst...the end points in surgery are often more concrete and immediate than in medicine – survival or death, cure or failure.”

The American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements (2001) third provision asserts that the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient. This relates to the ANA Code statement that “as an advocate for the patient, the nurse must be alert to

and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice...” (p. 14). This provision specifically directs nurses to take some type of action to support the rights of their patients. The concept of ethics as an action guide is inherent in nursing practice and nursing practice involves nurses having the power and knowledge to competently care for patients.

In a variety of studies, participants perceived themselves as patient advocates (Lutzen & Nordin, 1994; Schroeter, 2004; Sellin, 1995; Snowball, 1996), but also felt a sense of powerlessness at times in their ability to assist their patients (Erlen & Frost, 1991; Gaul, 1995). This sense of powerlessness as voiced by nurses was related to their roles as nurses as well as a perceived lack of support by their nursing managers or hospital administration (Schroeter, 2004).

Powerlessness may also affect the nurse’s ability to act in the role of patient advocate and may also contribute to a nurse’s sense of moral distress. Snowball’s (1996) study of dilemmas was concerned primarily with issues of advocacy and staff nurses’ difficulties and frustrations with the role of advocate. Both studies (Snowball, 1996, Schroeter, 2004) supported the idea that advocacy is an essential part of nursing practice and both identified nurses’ perceived lack of power to consistently advocate for patients’ ethical issues in practice. Therefore, in order for nurses to practice ethically, they must feel safe in their practice setting such that their management team supports appropriate nursing actions. And in order for nurses to provide the care as designated by standards and guidelines, they must be able to demonstrate ethical competence.

Evaluation of Competence

Qualification for practice is assured by licensing laws and by professional standards. Familiar examples in nursing for assuring competency include: licensing exams for practice entry, continuing education (CE) for renewal of practice license, work-based orientation programs, and graduation from an accredited program of study. It is traditionally assumed that licensure of health care professionals indicates that they are minimally competent.

In order to ensure competence in nursing practice, there must be reliable means by which this practice can be assessed.

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Can standardized examination for certification and continuing education for recertification ensure continued competency? Continuing education and testing provides a limited picture of an individual’s knowledge and/or skill acquisition in a limited area at one point in time. Laws and rules are generally considered to uphold the lowest minimum standard for practice. Licensing laws for example, protect patients from harm, but do not hold professionals accountable to a skill level that promotes quality. Competency is a complex construct that requires numerous measures. To practice competently requires us to comply with external competence measures and to reflect ethically about competence

The methods by which competence is evaluated also must be included in a review of the overall issue of competence. In order to ensure competence in nursing practice, there must be reliable means by which this practice can be assessed. Currently, there are many means used to evaluate competence. In addition to examinations, there are other methods and frameworks utilized for continuing competency assessment (Vandewater, 2004). Portfolios,

simulation, skills checklists, peer, patient, and self-evaluations have been used by many academic and health care systems to validate skills, knowledge and abilities. Portfolios are being utilized more frequently to document and assess nurse performance (Cook, et.al., 2003; Carraccio & Englander, 2004; Gannon, et.al., 2001; Gadbuy-Amyot, et.al., 2003; Gordon, 2003; Joyce, 2005; Monson, 2005). The Competency & Credentialing Institute (CCI) Research Committee conducted an integrative review of the literature on the use of professional portfolios as a method of assessing, demonstrating, and validating professional nursing competency. They found that portfolios are a “portable mechanism for evaluating competencies that may otherwise be difficult to assess, such as practice-based improvements, use of scientific evidence in practice, professional behavior and creative endeavors” (Byrne et al. 2007, 24-25).

Self-reflection is an initial, ongoing and integral step to assuring competence. Self-reflection is essential when speaking broadly of competency as “... the knowledge, skills, and values essential in carrying out one’s role ...” or more narrowly defining it as the ability to do a given skill correctly (Oermann, 1998). Reflection is directly tied to experience and job role and intimately influenced by one’s spiritual, physical, intellectual, and emotional well-being. Self-reflection on practice may take different forms, but ultimately it is an active process.

It would seem that competence is a complex concept and difficult to measure. Even the direct measurement of performance is not necessarily a strong indicator of competence although it may infer competence. If competence is seen as a normative concept, incorporating more than just the ability to perform tasks, it is likely that the indicators used to imply competence should be those, which indicate the possession of a broad range of normative items including cognitive, affective and psychomotor skills and abilities. It is suggested that these elements need to be integrated into the concept of competence if this term is to have any utility in assessing the degree to which nurses can be seen as safe practitioners with an adequate skill and knowledge base to practice.

Because nursing requires complex combinations of knowledge, performance, skills and attitudes, a holistic definition of competence needs to be agreed upon and operationalized. This could facilitate greater acceptance of the concept and also underpin the development of competency standards and the tools required for the assessment of such. As professionals, nurses must individually and collectively raise questions related to competency measurement. The primary question to address is, which method is the best to use? New methods are being devised, such as portfolios and simulations, but which method will ultimately reflect the best assessment of competence in an individual practitioner? Perhaps more than one method should be used in order to obtain the best assessment of competence.

Other questions to address include: What is the minimum standard of care? When are we meeting the minimum care standard? When should we strive to go beyond the minimum standard? What can we do to assure minimal standards? What can we do to help move beyond the minimal standard of care? How can we be active in defining competency? What external measures will best verify the public trust in our competence? How is the changing health care environment impacting on competency and the delivery of competent care? How can competency be measured for nurses in non-clinical settings such as policy, research, and education? Clearly, there are many definitions, clarifications, and descriptions used for the term “competence.” There are many questions that arise as well when exploring competence. There appear to be many avenues left to explore when it comes to researching aspects of competence and competency in nursing practice.

Part II: Role Competence

Competence of Staff Nurses

The competence, as well as the incompetence, of staff nurses has been studied for years. It is, and always will be, a concern of many who advocate for safe patient care and outcomes. Activities related to identifying and establishing nursing competencies have been the focus of state nursing associations, regulatory boards, educators, professional associations, external stakeholders and individual registered nurses. The Washington State Nurses Association (WSNA) put forth recommendations that nurses from all practice areas must be actively involved in decisions about professional competence determination within their own practice settings. As a constituent of the American Nurses Association, the Washington State Nurses Association supports continued efforts by ANA to define continued competency in nursing, as well as continuing efforts by individual registered nurses to participate in activities related to competency in their workplace settings. The ANA Code presently supports the concept of continued competency in nursing for Nurses and professional nursing standards within the discipline of nursing.

Hasson and Arnetz (2008) in a study of nursing staff competence, work strain, stress and satisfaction in elderly care found that the lack of competence development, high levels of work strain and low levels of work satisfaction among nursing staff have been associated with high turnover. Nursing staff perceptions of their competence, work strain, stress and satisfaction were measured by questionnaire. In general, staff in home-based care reported significantly less sufficient knowledge compared with staff in nursing homes. Obviously this information has relevance to clinical practice as lack of competence development may have significant negative implications for work satisfaction.

If competence is seen as a normative concept, it is likely that the indicators used to imply competence should be those which indicate the possession of a broad range of normative items.

A 2006 study by Farrand, McMullan, Jowett, and Humphreys sought to examine whether the implementation of competency recommendations has led to improvements in the confidence of nursing students in their clinical skills. They found the positive effect that the competency recommendations had upon levels of confidence in nursing practice. Not surprisingly, they discovered that there is a relationship between competence and confidence.

The rapid expansion of computer-driven technologies into multiple aspects of modern health care suggests that many of the important competencies of the 21st century nurse will encompass mastery of computer technology. Little agreement was found regarding specific computer-focused competencies necessary for nurses. Taken as a whole, however, there is consensus that the computer-competent nurse possesses a general knowledge and understanding of computer technology, coupled with a positive attitude toward computers and software. In addition, such a nurse is skillful in the use of computer hardware and software and able to grasp how such technology benefits nursing, patient care and the overall health care environment.

Traditionally, emotional competencies may have been placed under the umbrella called, “professionalism;” a term often overused and under-explained by nursing faculty when communicating about soft skills, or emotional competencies. Performance criteria inherent to “professionalism” such as self-awareness, initiative, empathy, conflict management, integrity, team management and other emotional competencies commonly referred to as “soft people skills” are typically missing from the evaluation checklist. In fact, these “soft people skills” are often

cited by administrators as being noticeably missing from nursing practice. Yet, the very skills necessary to manage self and others are grounded in emotional competence and are essential to the delivery of excellent patient care. The competence of the clinical nurse encompasses a wide variety of practice areas from generic to specialty. There is much room for further research when examining the intricacies of competence (e.g. emotional to technical).

Competence of Nurse Educators

Clinical education is a critical part of preparing health care providers for practice (Smith, et.al, 2007). The ability to manage self and others are not only valuable skills, but foundational to the development of five core competencies outlined in the Institute of Medicine's landmark publication, *Health Professions Education: A Bridge to Quality* (IOM, 2003). Technical skills and knowledge specific to the discipline, remain fundamental to health professions education. However, complex challenges inherent in the health care system have forced educators to contemplate the hidden curriculum embedded in clinical education.

Although educators may have less trouble evaluating traditional nursing skills and application of nursing knowledge to practice, the evaluation of personal and social competencies are more difficult. Articulation of desired competencies must be clear in order to communicate student expectations. Daniel Goleman's Emotional Intelligence framework is useful for identifying and describing emotional competencies as part of the clinical evaluation (Goleman, 1995, 1998).

The competence of nurse teachers is important for the quality of nursing education. There are few studies related to the competence and evaluation of nurse teachers. The reasons are the lack of valid instruments for evaluation and the diversity of the functions of nurse teachers. Also the competence requirements differ in various countries. (Holopainen et al. 2007). Johnsen, Aasgaard, Wahlm and Salminen (2002) researched nurse educator competence related to nurse educators' opinions of the importance and application of different nurse educator competence domains. Determination of the relative importance and application of different competency domains in nursing education has implications for graduate level nursing curriculum development, as well as for professional development activities for nurse educators.

Dewing and Traynor (2005) developed a competency project to work collaboratively with specialist nurses to facilitate the development a competency framework that reflects the needs of the Admiral Nursing Service – a specialty area caring for patients with dementia. They designed a competency framework made up of eight core competencies with three levels of competency statements, loosely structured around standards and guidance documentation to illustrate how work-based evidence can be generated to demonstrate competence. This "Admiral" competency framework was designed to enable these specialty nurses to demonstrate their level of specialist practice, as individuals and collectively as a service and it also promotes the principles of nurses as life long learners. This may have relevance to other groups of specialist nurses. It shows that nurses can be involved in designing and testing a competency framework as collaborators.

Nurse Manager/Administrator Competence

Research findings support the pivotal role nurse managers have in influencing all aspects of the nursing environment. Yet, there is a need to better understand the competencies needed by contemporary nurse managers and the challenges in the role. Rose, et. al.(2007) explored the viewpoints of 120 nurse manager participants on the contemporary nurse manager role and to gain perspective on the critical leadership skills and competencies to build a nursing leadership competency model. The researchers used a grounded theory methodology to capture the perspectives of the nurse managers interviewed about their roles. Six competency categories emerged from the research findings to form a nursing leadership competency model. Two major themes identified from the data

included the nurse manager role as a career choice and the stressors and challenges in the role. The results of this study led to the design of a nursing leadership competency model and confirmed that there is a need to formally develop and mentor our next generation of nurse leaders.

A systematic review was conducted on the professional practice of the nurse and developing and sustaining a healthy work environment in healthcare. The aim of this systematic review was to identify the best available evidence on the relationships between the knowledge, competencies and behaviors of nurses exhibiting professional practice in their workplace, and the development of a healthy work environment. Nineteen studies were included in the review. Overall, the evidence suggests that professional practice has a positive impact on the work environment in terms of nurses' role satisfaction and patient outcomes.

A study comparing clinical competencies between nursing students with degrees and traditional students (Williams, et.al., 2008) was performed because students with second degrees have been recently considered as an answer to the nursing shortage. They are thought to possess greater ability to critically think and engage in self-directed learning behaviors, and possess greater motivation to master clinical skills. Their results yielded statistically significant differences on two of the 36 competency measures identified in the study. Second degree students indeed are different in maintaining client confidentiality and developing appropriate, prioritized nursing diagnosis. Therefore, this study supports that second degree nursing students have greater clinical competency in professional behaviors of client confidentiality and critical thinking with nursing diagnosis. It was interesting to note that the results did not support second degree students as superior in mastering 17 basic nursing clinical skills.

Issues related to competence are not easily resolved but are nevertheless crucial to the trust that has been placed in nursing by society. The accountability of the profession demands that nurses individually and collectively: identify competencies central to nursing; participate in groups influential to competency measurement; be informed about competency issues; and think proactively and raise questions about competency whether it is broadly or narrowly defined.

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Conclusion

A series of national commissions have documented significant problems related to safety and quality in the U.S. health care system (Kohn, et.al, 2000; Cronwett, et.al., 2007). In light of these problems, reports from multiple national committees concluded that if health care is to improve, providers need to be prepared with a different set of competencies than are developed in educational programs today (VanGeest & Cummins, 2003).

Cronenwett, et.al. (2007) addressed the challenge of preparing nurses with the competencies necessary to continuously improve the quality and safety of the health care systems in which they work. The group adapted the Institute of Medicine competencies for nursing (patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics), proposing definitions that could describe essential features of what it means to be a competent and respected nurse. Using the competency definitions, the authors propose statements of the knowledge, skills, and attitudes (KSAs) for each competency that should be developed during prelicensure nursing education.

Nursing, however, is based on the values of quality and safety competencies as evidenced in nursing publications (Maddox, et.al. 2003; Arnold, et.al, 2006), standards of practice, and accreditation guidelines (NONPF, 2001; Arnold, et.al., 2006). The American Association of Colleges of Nursing Task Force on the Essential Patient Safety Competencies for Professional Nursing Care (2006) completed an enhancement to the Essentials of Baccalaureate Education for Professional Nursing Practice to include exemplars of quality and safety competencies.

Competency Issues for Future Consideration

Will competencies need to be redefined in the future? A Robert Wood Johnson Foundation funded group on Quality and Safety Education for Nurses (QSEN, 2007) was designed to address these gaps in competency development and education. Before teaching strategies could be developed, however, the QSEN faculty needed to identify specifically what was to be achieved. The ultimate goal of this team was to describe competencies that would apply to all registered nurses. The QSEN report outlined the definitions of competencies to be shared with the profession with the hope that nursing, through its professional organizations, can benefit from the work. If nursing constituencies find their competency definitions clear and compelling, over time the competencies may serve as guides to curricular development for formal academic programs, transition to practice and continuing education programs. In addition, the definitions can provide a framework for regulatory bodies that set standards for licensure, certification, and accreditation of nursing education programs (QSEN, 2007).

If nursing constituencies find their competency definitions clear and compelling, over time the competencies may serve as guides to curricular development for formal academic programs, transition to practice and continuing education programs.

In addition, questions have been put forth by groups and individuals relating to how continued competence will be considered in the future. The WSNA asks the following questions:

1. For continued competency assessment, how will skill mastery, unique practice. Setting, experience opportunity be measured, and by whom?
2. If peer reviewed, how will similar peers be selected, from what practice areas, how will objectivity and observation periods be determined?

3. Who is responsible for evaluating continued competence and who will incur the cost?
4. How will nurses in non-traditional and non-direct clinical settings be evaluated (utilization review, consultants, nursing management)?
5. How will the profession determine competence for those nurses returning to the profession after a hiatus from practice while maintaining licensure?
6. What is the valid and legal ramification of nurses doing self evaluations, preparing personal professional profiles areas for continued learning in the changing technological and health care environment?
7. Will “competence” be used to make health care cost-containment decisions?
8. How does professional credentialing relate to competency?

A review of the literature indicates there are many more questions that need to be answered within the field.

And yet more questions abound: How do the characteristics of practice change over time? To what extent do factors specific to the individual nurse (e.g., age, gender, type of basic nursing educational program, propensity for self-study, etc.) influence the evolution of practice? To what extent do environmental factors (e.g., work setting, mentors or preceptors, continuing education, work experience, knowledge resources, etc.) influence the evolution of practice? What are the characteristics of safe versus unsafe practice?

Recommendations

A review of the literature indicates that while the importance of nurse competence and competency have been studied and documented, there are many more questions that need to be answered within the field. To guide future research the following recommendations are presented for consideration (WSNA Board of Directors 2006):

1. Actively involve nurses from all practice areas in decisions about professional competence determination within their own practice settings.
2. Include stakeholders from education, regulatory bodies, state nurses associations and consumers in identifying core competency expectations.
3. Consider the practice setting where competency will be determined, (e.g., education, research, direct patient care areas), as determination of competency in these areas will require different evaluation measures.
4. Involve nursing specialty organizations in clinical competency determination. Professional nurses rather than institutional policy must determine professional competency.
5. Obtain legal representation to ensure competency policies, regulations, and conflicting expectations do not serve as barriers to nurses entering and continuing practice.

Clearly, there are many areas of competence yet to be explored. This will be the work of nurses and nursing organizations that must adapt to the ever changing environment of health care. Based on this literature review the need for more research is recommended. A robust agenda for future research into the topic of competency

can include the following:

- Relationships between competence and specialty nursing practice.
- Description of competence by nurses as related to aspects of their practice, such as levels of confidence and errors.
- Identifying and addressing the continuing challenges to maintain competence in the workplace.
- Defining how competence affects nurses from a generational perspective.
- Describing new methods of assessing competence in health care.
- Defining what competence is in a variety of practice settings.

Clearly, there are many areas of competence yet to be explored. This will be the work of nurses and nursing organizations that must adapt to the ever changing environment of health care.

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