Nurses’ views on competency indicators for

AUSTRALIAN NURSING

This paper reports on a project commissioned by the Australian Nursing Council Inc that sought to develop an approach to the maintenance of continuing competence in nursing broadly acceptable to nurses in all states and territories. This project involved extensive consultation with nurses, consumers and key stakeholders on appropriate competence indicators. Findings suggest that a majority of nurses support the development of competence indicators but most are confused about the nature of competence. By

Alan Pearson, Mary FitzGerald and Ken Walsh

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Introduction
A project to identify indicators of continuing competence in nursing was commissioned by the Australian Nursing Council Inc (ANCi) in 1997 and carried out in 1997/1998 (Pearson et al 2000). The objectives of the study were to develop:

• a statement of indicators of continuing competence in nursing;
• an explanation of the basis for each of the identified indicators;
• a description of any boundaries, contexts, applications or qualifications which apply in respect of each indicator; and
• recommendations for any further action or research.

Competence as with most terms has no singular definable meaning. A generally accepted belief is that competence is not a directly observable quality, but can describe a set of “characteristics or attributes that underlie and enable competent performance in an occupation” (Heywood et al 1992 p16). The existence of competency indicators allows for a more readily available assessment of a person’s skills irrespective of the differences in training background with the focus being on the person’s ability to complete tasks against predetermined standards (Anderson 1994). The benefits of having a system of competency indicators for a given profession range from consistent recognition across states and territories; a readily available benchmark to compare skills of staff with different educational backgrounds or skills acquired in other countries; clearer training and progression within an occupation; and more ready comparison and progression with related occupations (Heywood et al 1992).

Alan Pearson RN ONC DipNEd DANS MSc PhD FCN(NSW) FINA FRCNA FRCN, Professor of Nursing, La Trobe University, Melbourne, Australia. E-mail: alan.pearson@latrobe.edu.au
Mary FitzGerald RN RNT DipNurs(London) MNurs(Wales) PhD (UNE), Senior Lecturer, The University of Adelaide
Ken Walsh RPN RGN BNurs PhD (Adelaide), Lecturer, The University of Adelaide
It is important that the standards set as competency indicators allow for current needs, as well as recognise the future needs of a profession with respect to changes in technology, professional knowledge and work culture. This allows for a continually smooth accommodation of new technology and practices as they enter the industry allowing for the best outcome for the consumer.

When the nature of competence was discussed participants referred frequently to the individual’s ability to be accurately aware of her/his own expertise or limitations; this was usually defined as “insight”.

To frame this in a nursing context, the ANCI has developed a beginning competence, or entry level competence, for professional nursing practice. These arose from a need to standardise nursing registration and enrolment across Australia. Each state and territory’s respective nursing regulatory authority adopted these competencies in 1990 following a process of extensive consultation (ANRAC 1990, ANCI 1995). This process is extended legislatively in all states and territories, where nursing registration organisations have been initiated to establish and maintain standards of nursing care in their respective region. While legislation has provided the framework for the development of these bodies, none of the relevant Acts has addressed issues of continuing competence beyond recency of practice. Inherent in this interpretation of continuing competence is the assumption that nurses who have practised within the last five years will be safer and more competent in their practice with respect to changes in technology, pharmaceutical interventions, treatment strategies, and patient demographics (Queensland Nursing Council 1997).

To determine factors that could complement current re-registration requirements, and improve the assessment of continuing competency amongst registered nurses, ANCI commissioned a project to identify indicators of continuing competence in nursing. The project design was based on four key stages:

- Stage 1 - Detailed Project Planning and Identification of Appropriate Competency Indicators
- Stage 2 - Data Analysis and Development of Pilot Instruments
- Stage 3 - Testing Indicators within the Australian Context, and
- Stage 4 - Development of an Options Booklet and a Survey of Nurses

This paper reports on Stages 1 and 2 of the project regarding nurses’ views of appropriate indicators of continuing competence in nursing.

**Methodology and approach**

Data collection involved extensive consultation with key stakeholders in each of the major capital cities. In each city, a researcher led an open forum, a meeting with representatives from the Directors of Nursing Association and the Health Department/Health Commission, and a meeting with representatives from each of the state nursing regulatory bodies.

**Participants and procedure**

All levels of the profession were represented as participants in the consultation including clinicians, nursing educators, nursing managers, nursing academics and officers of the major professional and industrial nursing organisations.

**National meetings**

A total of 147 participants attended an open forum and 102 participants attended the other meetings. In addition, a meeting was also held with representatives from the New South Wales College of Nursing and the principal investigator met with representatives from the Royal College of Nursing, Australia and the Australian Nursing Federation in Canberra.

**Video and tele-conference meetings**

Video and tele-conferences were conducted to ensure that nurses from rural and regional areas had an opportunity to participate in the consultation process. A total of 75 rural nurses were involved in the consultancy from 11 rural sites.

**Consultations**

A total of 22 consultations were conducted in both urban and rural areas of Australia. During the consultations the researchers particularly sought response to questions pertaining to: the type of evidence provided by nurses to show competence, how nurses identify lack of competence in a colleague or how they know a colleague is competent; and ascertaining their preference for a system to ensure continued competence. Finally they were asked to articulate where the responsibility for competence should lie. The consultation also focused on consumer requirements and questions pertaining to consumer requirements were asked.

**Written submissions**

To generate further discussion, advertisements were placed in The Weekend Australian, The Sydney Morning Herald, The Melbourne Age and the Australian Telegraph calling for written submissions from professional nursing associations, individual nurses and the general public to the consultancy. Eleven submissions were received. Of these, five were from individual nurses, two were from divisions of the Australian Nursing Federation, one was from a university faculty of nursing, one from a hospital staff development unit and one from a division of the Western Australian Health Department.

An interactive Internet web site was also set up to provide information regarding the project and that could accept electronic written submissions to the project.

This component of the project focused on the need to define a national approach to continuing competencies in nursing. As nurses have obvious difficulties with both the concept of competence and related issues, it was difficult to find a common definition of the term. Concerns about the definition of competence have been compounded by attempts to assess levels of it in the workplace.
### TABLE 1: THEMES IDENTIFIED AFFECTING DEFINITION OF COMPETENCE

- The nature of competence
- The nature of incompetence
- Conflicts and confusion over the above definitions
- Instruments for the organisational monitoring of competence

### Data analysis

The data resulting from the forums, consultations and written submissions were analysed to elicit views on the nature of competence in nursing, and a number of indicators for measuring competence and approaches for testing competency indicators developed.

Issues of competence in nursing were analysed from two main perspectives: viewing competence as a psychological construct to the performance of nursing tasks and a contrary view that suggests competence may be viewed through an individual’s performance (Runciman 1990, Grot 1993).

Following transcription, data were analysed using the NUDIST qualitative research software package (non-numerical unstructured data indexing, searching and theorising) (Richards et al 1992) in order to determine key themes arising from the transcript records. In addition to the taped inputs, the preliminary literature review identified some analysis of existing and future options and mechanisms to assess and promote continuing competence.

After reading and re-reading the transcriptions of the consultations, analysis proceeded using a computer-assisted manual thematic analysis procedure, and recurring themes and sub-themes were identified. These themes are displayed in Table 1.

### Results

No new ideas regarding what might constitute an indicator of continuing competence were forthcoming from the consultations. There were a number of broad themes emanating from the analysis of the data and these are further explored below.

#### The nature of competence: Insight

This theme was the most consistently mentioned and agreed upon concept to emerge from the consultations. When the nature of competence was discussed participants referred frequently to the individual’s ability to be accurately aware of her/his own expertise or limitations; this was usually defined as “insight”. This theme also ran strongly through the discussions on incompetence. It was often linked to actual and potential unsafe practice since nurses without “insight” were seen to be unable to make adjustments necessary to update their knowledge and skills; participate actively in professional development; and accurately determine their own ability in relation to their peers. However, participants recognised the difficulty of using insight as an assessable or measurable indicator.

#### The measurement of competence

The issue of measurement, and the inadequacy of indicators in current use, were recurrent themes through the transcripts. Participants felt that the measurement of competence involved more than the arbitrary listing or determination of key areas of concern. There was a feeling that indicators relating to competence are not easily defined and that they relate to forms of knowledge that remain beyond the description of basic skills. Potential indicators identified are displayed in Table 2.

All of these indicators were seen by participants to have some potential in the assessment of continuing competence, but many of them were also seen to have inherent limitations. Some are worthy of brief discussion here.

At a broader level, many participants believed that the demonstration of existing ANCI competencies should be evident within any nursing practice setting across Australia.

### Evidence of recency of practice

This commonly used indicator has the potential to infer currency of knowledge and skills in the practice area but participants suggested that it fails to provide sufficient inference of competence or safety in practice.

#### Participation in appropriate continuing education activities

This indicator, which dominates in overseas countries and in other health professions in Australia, has the potential to develop and improve reflective skill, knowledge and psychomotor skills and to stimulate activity. While these factors ultimately promote currency of knowledge and skills, participants noted that involvement in educational activity alone was not a reliable inference of competence.

#### Evidence of participation in research, health care committees and quality assurance programs

These activities as indicators have potential, according to the participants, to infer currency and involvement in practice and the desire to develop professionally.

### TABLE 2: POTENTIAL INDICATORS OF COMPETENCE IN THE NURSING INDUSTRY

<table>
<thead>
<tr>
<th>Evidence of recency of practice</th>
<th>Maintaining a professional journal of reflective self assessment that is used as a basis for regular critique by a peer or mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in appropriate continuing education activities</td>
<td>Participation in relevant active professional organisations</td>
</tr>
<tr>
<td>Evidence of participation in research, health care committees and quality assurance programs</td>
<td>Participation/completion of accredited assessor nursing courses</td>
</tr>
<tr>
<td>Writing and publication in refereed health journals</td>
<td>Credentialing of advanced practice within nursing specialties</td>
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<td></td>
<td>Maintaining a professional portfolio</td>
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However, it was noted that membership and participation does not directly infer competence.

**Writing and publication in refereed health journals**
Although participants saw this as an indicator with some potential, most were of the view that publication may only infer competence in a particular area of practice rather than the broad, continuing competence associated with the maintenance of registration.

**Maintaining a professional portfolio**
The notion of maintaining an ongoing, written account of an individual’s practice and of a broad range of activities that could be related to a selection of indicators, was discussed by many participants. There was some discussion about the time and effort needed to develop a professional portfolio.

Generally, nurses consulted throughout Australia believed that no degree of valid inference about continuing competence is possible using a single indicator. Within a framework bounded by reasonable costs and processes for Boards and nurses, participants generally preferred an approach that seeks to determine a higher level of inference of competence through the use of a variety of ‘evidence’ streams. This view was reflected in the indicators tested in Stage 3 of this project.

A range of indicators was deemed preferable to provide evidence of competence rather than a solitary requirement such as recency of practice.

**Boundaries of incompetence**
By default, the participants’ descriptions of competence were automatically contrasted with what it means to be ‘incompetent’. Incompetence has been regularly mentioned as a benchmark and as a wider area of concern. Participants encountered the same difficulty in reaching agreement on incompetence as they did in defining competence.

Just as definitions of competence embrace less concrete and intuitive aspects of performance, incompetent work practices may also involve similar features that are difficult to measure such as attitude and insight. In effect, incompetence is assessed in the negative, in the absence of positive and competent qualities and has the same evasive characteristics.

Where new trends in management efficiency seek predominantly to measure competence against cost, there was a concern that this may overlook some of the more intuitive and rewarding aspects of nursing.

A common observation was that incompetence may only apply to a very small percentage of the nursing population, and that this may require the dedication of an unreasonable amount of time and energy in ‘hunting down these people to catch them out’. When talking about competence and incompetence, there appeared to be some confusion amongst participants on a number of issues. From the transcripts it became apparent that the participants see differences between levels of competence and incompetence.

**Confusion over levels of competence**
When talking about competence the nurses consulted often started to talk about specialist and advanced practice. This included the attributes and practices that they expected of good nurses with experience who were able to accept responsibility. Interestingly, and in somewhat of a contradictory manner, they would then refer back to the beginning or core competencies when talking about developing a basic measure for all nurses linked to re-registration. Context was often mentioned as something that had to be taken into account when measuring competence, but when they began to talk of nurses being able to nurse in areas they were not familiar with, they again returned to the idea of basic general competence.

This basic approach to competence was regarded as a ‘starting point’ and something to be improved upon with time. These basic or core attributes were seen to be part of a broader level of competence and essential elements of competence in nursing. At a broader level, many participants believed that the demonstration of existing ANCI competencies should be evident within any nursing practice setting across Australia.

Within these areas of discussion there was a belief in the need for professional development, the need to be able to move beyond beginning competence as experience increased or when employment roles and responsibilities changed over time.

Participants tended to favour a focus on core competence. That is, the ability of the nurse to follow certain fundamental procedures and carry them out safely without hesitation and over a long period of time despite changes in roles and occupational status.

**Higher levels of competence**
Specialities are seen to form part of more advanced training. Looking towards the future, the basic nature of nursing was seen to be in a state of change with a continuing necessity to keep abreast of this change in terms of technical and more specialist skills. There was a feeling that competence at an advanced level should be assessed but be independent to re-registration.

**Influence of other professions**
In these times of uncertainty and change, nurses often asked what other professions did to monitor continuing competence. Some nurses made comparisons between nursing and other professions in terms of basic qualifications and the ongoing maintenance of professional status. Part of these discussions related to the individual, but predominantly the ongoing responsibility for monitoring continuing competence was seen to relate to broader professional and organisational requirements.

**Regulation**
The participants thought that the importance of determining continuing competence related to both practice and safety issues. In logistical terms, the monitoring of competence may be difficult to standardise over a number of locations. Additionally, some people felt that mechanisms of determining continuing competence were already in place but might need to be standardised across different areas. There were concerns that nursing is already heavily regulated and it was observed that the concept of regulation by definition implies a form of constriction and limitation.
Responsibility for competence
There was a strong belief that the employer should have the interest and concern to ensure that staff are keeping up with their individual responsibilities. Others felt that there was a more general level of responsibility to be shared across a number of bodies along with the individual nurse.

At the same time professional concerns were seen to provide a growing influence in debates over competence and the monitoring of competency in nursing. Some people felt that professional issues were going to have some influence on how these credentials and work obligations were fulfilled.

In terms of professional responsibilities and obligations, the participants raised a number of queries regarding whether these competency indicators will remain within the domain of the individual or whether professional organisations also have a role to play.

Consumer rights and expectations
Issues of quality improvement and patient satisfaction were frequently cited as some of the more common issues within a whole range of concerns. While several nurses thought that consumers were not aware of levels of competence and were generally happy if their basic needs were fulfilled - such as a hot cup of tea, or a pillow, or a smile - there is some indication that this perspective is changing.

Discussion returned to a central issue over measurement and quantification and there seemed to be some disagreement over the practices involved in such an exercise. Along with a general consensus that consumers are going to be more intensively involved in the activities of assessment and information, there was some uncertainty among the participants as to how this would take place and conflicts over consumer expectations were apparent.

The nurses saw some areas of nursing as being more consumer driven than others. The solitary nature of independent midwifery practice posed some problems in terms of appraisal and performance indicators. Midwifery depends on ‘word of mouth advertising’ and a good response from patients. At the same time there was a concern that the professional status of such work should not be determined solely by public commentary.

Summary and Conclusion
The consultations covered a range of stakeholders and stimulated lengthy debate. Nevertheless while issues such as self-regulation and the presence of ‘insight’ came through strongly in the data, no definitive alternate indicators for continuing competence were forthcoming. Nurses were able to identify evidence that would indicate competence and incompetence in a nurse but there was confusion over how these subjective measures could be effectively monitored while recognising the broad scope of nursing practice. Confusion over levels of competence echoed throughout the data with discussions alternating between basic and advanced practice. Levels of competence were frequently described as being context bound and this further clouded the issue. It was generally agreed that maintaining continuing competence should be shared between the individual and professional organisations. A range of indicators was deemed preferable to provide evidence of competence rather than a solitary requirement such as recency of practice.

Nurses also expressed an interest in the regulatory and continuing educational practices of other professions’ professional organisations, and some strongly felt that there were already sufficient mechanisms in place within nursing to monitor their activities as a group. These include qualification requirements for specialty areas, staff appraisal systems and a range of disciplinary procedures under various Acts. Nevertheless, the role of monitoring competence was seen to be important to debate, particularly with changes in the health care environment, current trends in the nursing profession and an increasing sense of accountability to consumers and consumer awareness.

It was generally agreed that while minimum standards of practice may operate to provide a baseline requirement for practice, for the regulation of continuing competence in a rapidly changing nursing environment, there needs to be some thought given to future requirements of the profession. While the responsibility for maintaining competence may fall back on the individual, some structured guidelines need to be developed. These guidelines would provide a framework for determining competence into the next century.

Incorporating these views, the challenge of developing a coherent multifactorial continuing competency assessment tool will be beneficial to the nursing profession in Australia. What has become apparent following this period of consultation is that this tool will be difficult to develop if it is to be applied across specialties and is to measure more than basic competence. To gain the approval of nurses and respective nursing Boards across the country, the tool will need to be simple to administer, allow monitoring of standards of competence, and provide options/pathways to those not meeting competence requirements. The concept of ongoing competency indicators appears to have support among nurses, but care needs to be taken to ensure these indicators can be applied across specialties and not be too invasive. The assessment of ongoing competency in nursing will complement ANCI’s current standards of beginning competence, and will allow for a more comprehensive indicator of nursing competence than is currently in place.

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