

Texas Nursing Competency

Summary of Request: This report is to inform the board of two initiatives to promote, evaluate and test new models of nursing competency in the state of Texas.

Texas Nurse Association Task Force on Continued Competence

The Texas Nurses Association (TNA) has completed their five-year project on recommendations for continued competency. The purpose of this work is to promote methodologies for reviewing competency that are accurate, timely, thorough and ensure the ongoing delivery of safe nursing practice.

Attachment A is an a copy of the report.

Based upon the work of the TNA Continuing Competence Task Force and national and state influences, the following are recommendations for the next two Texas legislative biennia.

2009-2011 Biennium

- Change the BON Rules and Regulations to allow nurses to document their continued competence through EITHER 20 hours of continuing education in their **area of practice** per licensing period from an approved provider OR national certification in a specialty area. This process will involve an evaluation by the BON regarding the consistency of testing by certifying bodies.
- Implement a pilot study to develop an Evidence-Based/Best Practice Center. The Center will be responsible for developing online learning activities based on evidence-based/best practices. Specific goals of the pilot study include:
 - 1) Develop processes by which content areas for the learning activities are identified and modules are developed, peer-reviewed and distributed via the Internet and
 - 2) Develop, distribute and evaluate 20 evidence-based/best practice modules during the two year pilot study. The pilot study will develop a process to differentiate among modules that are appropriate for various types of educational activities from undergraduate through continuing professional development.
- TNA will evaluate the fit of recognition of the ANCC Nursing Skills Competency Model with the desired intent of documenting competence.

2011 – 2013 Biennium

- Continue continuing education and certification in the nurse's area of practice as options for validating competence.
- Review legislative authority to encompass an Evidence-based/Best Practice Center into the state system for nursing. This will include reviewing legislative options for funding.
- Expand BON rules and regulations to allow nurses to document their competence through validation in approved organizations or assessment centers.
- Develop a process for use of career portfolios as a means of documenting continued competence.

Staff will be developing rule revisions to §216 Continuing Education for Board consideration regarding certification and criteria for certifying bodies.

Texas Nursing Competency Consortium

Board staff have been participating in the Texas Nursing Competency Consortium which is a group of several schools of nursing, employers and other pertinent stakeholders whose vision statement is *Safe patient care through competent nursing practice for all Texans*. On April 30th - May 2nd this group provided a workshop in Lubbock entitled *Bridging the Gap Between Patient Safety and Nurse Competency: From Pieces to Policy*. (Attachment B).

Of particular interest was an overview by Dr. Patricia Benner of the Carnegie Study whose purpose was to examine current signature pedagogies in six professions (nursing, medicine, engineering, clergy, teaching, and law). Dr. Benner reviewed the strengths and challenges of nursing education as compared to other health disciplines.

An initiative called the Quality Safety Education in Nursing (QSEN) was reviewed by Dr. Gwen Sherwood. This project received \$1,094,477 from the Robert Wood Johnson Foundation. According to the QSEN website www.qsen.org, the long-range goal of QSEN is to:

“reshape professional identity formation in nursing to include commitment to quality and safety competencies recommended by the Institute of Medicine (IOM)for nursing and proposed targets for the knowledge, skills, and attitudes to be developed in nursing pre-licensure programs for each competency: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics”.

The importance of this work is that it may provide valuable, evidence based resources to the Board for revision of the Differentiated Entry Level Competencies which are up for review and revisions.

Staff Recommendations: None, this report is for information only.

Continuing Competence: Movement toward Assurance in Nursing©

Texas Nurses Association

Task Force on Continuing Competence

Austin, Texas

March, 2008

Attachment A

Task Force Membership

'04-'05

Michael Evans, Chair
Susan McConnell
Cole Edmonson
Kathy Thomas
Susan Distefano
Susan Sportsman
Anna Pearl Rains
Mary Beth Thomas
Mary Pat Rapp
Pat Yoder-Wise
Susan McBride

'05-'06

Same as above

'06-'07

Susan McConnell, Chair
Susan Distefano
Susan Sportsman
Anna Pearl Rains
Mary Beth Thomas
Pat Yoder-Wise

'07-'08

Susan McConnell, Chair
Anna Pearl Rains
Ken Dion
Mary Beth Thomas
Pat Yoder-Wise
Sharon Ransom
Susan Distefano
Susan McBride
Susan Sportsman
Tammy Straps

Executive Summary

Technically, this report is the culmination of 10 years of work in Texas related to continuing competence. SB 617 (1997) provided for the Board of Nurse Examiners of the State of Texas (BNE) (now the Texas Board of Nursing) to initiate pilot programs to evaluate mechanisms for continuing competence. Subsequently, in 2000, the BNE completed a report, *Ensuring Professional Nursing Competence*, which recommended that a continuing competency program, not simply related to continuing education, be established. In 2001, the Texas Nurses Association (TNA) House of Delegates adopted a resolution to develop an agenda for continuing competence for the profession of nursing. Since the fall of 2003, the TNA has undertaken the considerable task of addressing continuing competence for nurses. This complex issue continues to remain a concern of nurses, health care leaders, patients and the public. Continuing competence has dual aspects-- professional and regulatory, both of which require specific consideration.

The TNA Board of Directors authorized the work of task forces over these past years based on specific resolutions, which the TNA House of Delegates adopted. These resolutions, and evolving work in nursing and related professions, served as the foundation of the work by the 2007-08 Task Force.

Several factors influenced the development of the work to date. Philosophical issues guided the nature of the discussions. A model for framing continuing competence in light of the complexity of the reality of nursing careers illustrated how complex the issue of continuing competence is. Definitions of terms along with identified pathways to document competence and descriptions of care domains are products of the Task Forces' work.

The original work of the task force was based on the work of Dr. Patricia Benner (1984) and the recommendations of the Institute of Medicine (IOM, 2000). Further, work from groups such as The Joint Commission, the National Quality Forum, and the Agency for Healthcare Research and Quality (AHRQ) provided insight into the competencies to be considered by healthcare professionals.

Nurses, as individually licensed professionals entrusted by society, are accountable for their ongoing competence. While healthcare organizations and schools of nursing, among other agencies, provide services and systems to support continuing competence, the individual solely is accountable to the Texas Board of Nursing. In turn, the Texas Board is accountable to protect the public.

What are the markers of competence in a complex work environment? This question stimulated considerable discussion and focused primarily on the recommendations of

Attachment A

the IOM and competencies of various practice/role areas derived from numerous professional societies. Patient safety goals and measures, such as derived from The Joint Commission and the National Quality Forum, and work on Healthy People 2020 are important influences on the care domains.

Two critical elements drive how individual nurses can convey competence. The first element is care domains of competence. The care domains are concentrated in four broad areas: clinical judgment, organization and management of safe care, interpersonal relationships, and professional and ethical practices. The second element is the identified pathways to provide supporting evidence about competence. Identified pathways are focused in five broad areas of continuing education, certification, assessment, approved organizations, and portfolios.

All nurses, irrespective of clinical area or role function, are expected to be competent; and because the nature of that competence may vary based on role, clinical focus or setting, the Task Force believes that nurses must have options for documenting continuing competence. In essence, individuals must decide on the care domains and pathways in context of their own individual situation. For re-registration purposes, pathways would be phased in, beginning with an existing system of continuing education and the addition of certification. After an evaluation period of the remaining pathways (designation of approved organizations where an individual works for at least 6 months, the development of portfolios, and a plan for assessment centers), some or all of those pathways could be added. Because nurses have individual choice regarding the pathway, they may choose different options for re-registration purposes. So, for example, a nurse who is certified and seeks recertification (typically every five years) could meet the competency requirement through that avenue. The information documentation must coincide with the two year licensure renewal period so that competence can be linked to re-registration of a license to practice nursing. In the prior example, a nurse who is renewing his/her license would provide documentation of current certification.

The work produced here is descriptive of competence, not prescriptive of it. For regulatory purposes, only random audits of individual nurses is feasible due to 1) the number of nurses (201,631 registered nurses, 83,600 licensed vocational nurses, and 11,771 advanced practice nurses(as of 01/25/08)), 2) the multiple clinical and functional areas in which nurses practice and 3) the financial considerations of costs to the state, organizations, and individuals. Recognition of Magnet™ organizations, Pathway to Excellence organizations (formerly Texas Nurse Friendly designations) and Beacon™ units (a designation for critical care units) could provide guidance in the approved organizations category. Baldrige and the Nursing Skills Competency Program designations should be considered when Texas organizations achieve such designations.

Attachment A

Based upon the work of the TNA Continuing Competence Task Force and national and state environmental influences, the following are recommendations for the next two Texas legislative biennia.

2009-2011 Biennium

- Change the BON Rules and Regulations to allow nurses to document their continued competence through EITHER 20 hours of continuing education in their **area of practice** per licensing period from an approved provider OR national certification in a specialty area. This process will involve an evaluation by the BON regarding the consistency of testing by certifying bodies. Implement a pilot study to develop an Evidence-Based/Best Practice Center. The Center will be responsible for developing online learning activities based on evidence-based/best practices. Specific goals of the pilot study include: 1) Develop processes by which content areas for the learning activities are identified and modules are developed, peer-reviewed and distributed via the Internet and 2) Develop, distribute and evaluate 20 evidence-based/best practice modules during the two year pilot study. The pilot study will develop a process to differentiate among modules that are appropriate for various types of educational activities from undergraduate through continuing professional development.
- TNA will evaluate the fit of recognition of the ANCC Nursing Skills Competency Model with the desired intent of documenting competence.

2011 – 2013 Biennium

- Continue continuing education and certification in the nurse's area of practice as options for validating competence.
- Review legislative authority to encompass an Evidence-based/Best Practice Center into the state system for nursing. This will include reviewing legislative options for funding.
- Expand BON rules and regulations to allow nurses to document their competence through validation in approved organizations or assessment centers.
- Develop a process for use of career portfolios as a means of documenting continue competence.

Background

Definition of Continued Competence

Attachment A

Continuing competency has multiple meanings depending upon its context, although the American Nurses Association, in 2000, defined continuing competence as ongoing professional nursing competence according to a level of expertise, responsibility and domains of practice (Whittaker, Carson, & Smolenski, 2000). Because of the multiplicity of definitions and perceptions of continued competency, validation of nurses' continuing competency has been an ongoing concern to regulators, professional organizations, educators, employers, and the nurses themselves.

Current State of Documenting Continued Competence

Texas, like 28 other states, uses continuing education as a means for documenting competence. North Carolina has elected to have a reflective practice model to support continued competence. This model is defined as "a process for the assessment of one's own practice to identify and seek learning opportunities to promote continued competence" (NCSBN, 2005, p. 1).

Historical Perspective of the Texas Nurses Continuing Competence Framework

The Texas Nurses Continuing Competence Framework was developed over a 10 year time period. In 1997, the 75th legislature amended the Nursing Practice Act, allowing the Board of Nurse Examiners for the State of Texas (now known as the Texas Board of Nursing, BON) to use pilot programs to evaluate the effectiveness of a variety of mechanisms typically used to maintain clinical competency in nurses' practice area (BON, 2000).

- As part of the implementation of the 1997 legislation, the BON used a modified research program model to examine whether existing or innovative approaches to evaluating clinical competency were effective in insuring that registered nurses maintain competence in their areas of practices. The BON funded six pilot studies, including 1) evaluation of a mandatory competency evaluation program of an urban county hospital and the validity and reliability of a 360 degree performance appraisal system in a urban specialty hospital, 2) delineation of competencies for nurses working in rural health care settings, 3) the use of vignettes for targeted continuing education in psychiatric nursing, 4) assessment of certification in ACLS and PALs as a valid indication of competence, 5) identification and assessment of competencies of nurses in long-term care, and 6) development of reliable and validity information for assessing home health nurse competences. Based on evidence from the pilot program studies, in a 2000 report, *Ensuring Professional Nursing Competence*, the BON Competency Advisory Committee identified the following two conclusions: A variety of mechanisms can be used to assess ongoing competencies.
- Each of the methodologies have the potential of assuring the public that nurses have the knowledge, skills, and judgment to provide safe and effective care (BON, 2000, p. 7).

Attachment A

These six pilot studies formed the basis for consideration of ways to judge competence. Some of the pilot studies focused on specific nurse populations by clinical area and practice setting. If those restrictions were eliminated, it would be possible to convert these six approaches to be applicable across the nursing population. Similarly, care domains could be considered as the evolution of the competencies for nurses in various roles.

One of the recommendations drawn from these conclusions was that the BON should require each licensee who elects to maintain an active RN license to meet minimal competency maintenance program requirements. Further, the Competency Advisory Committee noted that acceptable components of competency maintenance programs should NOT be limited solely to continuing education hours. The committee suggested the following as acceptable methods to maintain clinical competence: a) participating in institutional competency evaluation programs, b) achieving certification or re-certification, c) completing targeted continuing education activities, d) developing portfolios that document ongoing competence, or e) any other mechanisms approved by the board. The committee suggested that if documentation of competence is through portfolio development, feedback from peers or other external evaluators should be part of the process (BOD, 2000, p.8).

In 2001, the TNA House of Delegates (HOD) passed a resolution instructing TNA to develop an agenda for continued competence for the profession of nursing. Over the next several years, the TNA Council on Practice (COP), the Council on Workplace Issues (COWI), and the Governmental Affairs Committee (GAC) included this initiative in their business plans. Because of the complexity of the issue and competing priorities for the committees, in 2004 a Nurse Competency Task Force was appointed to develop the plan.

In 2005, the TNA House of Delegates affirmed its believe that a competency validation system tied to re-registration for RNs will improve patient care and that TNA should develop such a system, in collaboration with other nursing stakeholders. The competency developed system was to be based on the following principles:

- The methods for validation should be multi-pronged and evidence-based.
- The system should be based on Benner's model of career development with different and appropriate competency validation at each stage.
- The bulk of the BON activity should be in oversight of nurses who are "triggered" out of the system.
- RNs assume the personal responsibility for maintaining competency validation.

In 2006, the House of Delegates reaffirmed the above principles and directed the TNA Task Force on Continued Competency to continue to refine concepts of employer-based competency testing and free standing competency centers. In addition, the

Attachment A

HOD endorsed the first element of the continued competency plan –a continuing education model tied to registration, which required that CE-recognized course work be evidence based and conclude with validation of the nurses' mastery. The BON's Standards for Professional Nursing Practice state: be responsible for one's own continuing competence in nursing practice and individual professional growth. Consistent with that statement, the BON changed the continuing education requirement to read: Twenty hours of Type I CE credit will be required each biennium. This change in the requirement for continuing education strengthened the existing pathway to documenting competence.

The 2001, 2005 and 2006 TNA HOD resolutions provided the direction for the development of the TNA Continuing Competency Framework. As the plan for the framework developed more specificity and a variety of complex issues were addressed, the focus of the plan changed slightly. For example, initially the plan was designed to be implemented by nurses chosen through random sampling, as well as those who experienced practice problems. However, various implementation challenges were identified including. 1) the number of nurses (201,631 registered nurses, 83,600 licensed vocational nurses, and 11,771 advanced practice nurses(as of 01/25/08), 2) multiple clinical and functional areas in which nurses practice and 3) financial considerations of costs to the state, organizations, and individuals. Thus, it seemed appropriate to have the BON focus on nurses who experienced practice problems reportable to the board and to focus the sampling related to competence to those nurses applying for re-licensure. In many cases, the nurse is competent, but an assessment/validation has not been documented, even though The Joint Commission now requires employers to maintain records related to competency validation. But, not all nurses are employed by an organization, not all employers are healthcare organizations and not all healthcare organizations or hospitals are accredited by the Joint Commission.

Recommendations for Implementation

The Continuing Competence Regulation Long-Term Strategy should be implemented over several years as suggested by the 2003 IOM study, *Health Professions Education: A Bridge to Quality* to facilitate full acceptance of the plan. During the **2009-2011** biennium, TNA will seek to change the BON Rules and Regulations to allow nurses to document their continued competency through EITHER 20 hours of continuing education in their area of practice per licensing period from an approved provider OR national nursing certification in a specialty area. This process will involve an evaluation by the BON regarding the consistency of testing by certifying bodies.

As previously noted, the TNA Task Force on Continued Competence developed a continued competence framework that identified four care domains of nursing practice. As individual nurses choose the focus of their continued education, they may

Attachment A

choose programs that address their learning needs in any of four domains. An important skill for nurses is their ability to think critically; their choice of learning activities demonstrates this ability, as it relates to their obligation to maintain their own continuing competence and professional growth.

During the **2009-2011 Biennium**, the Task Force also recommends that a TNA/TNF be implementing a pilot study to develop a Evidence-Based/Best Practice Center. The Center would be responsible for developing online learning activities based on evidence-based/best practices. Specific goals of the two year pilot study include: 1) Develop processes by which content areas for the learning activities are identified and modules are developed, peer-reviewed and distributed via the internet and 2) Develop, distribute and evaluate 20 evidence-based/best practice modules during the two year pilot study. Priority content for these modules would be identified by determining the most prevalent health conditions as determined by the Texas Department of Health Statistics and by performing a literature review regarding areas of NCLEX-RN failure, clinical limitations of new graduates, and patient safety and practice concerns of national and state health care leaders and organizations. To accomplish the work in a timely manner, external funding is likely to be needed.

Traditionally, the Texas Board of Nursing has not accepted any content covered in pre-licensure nursing curricula as continuing education programs, based on the assumption that graduates have already mastered this content. While this assumption may be correct related to basic nursing concepts that remain constant over time, given the rapidity with which health care knowledge is evolving, pre-licensure students often learn new information that practicing nurses should know, but weren't taught. A component of the pilot study will be to work with the BON to develop a procedure to differentiate between basic and new knowledge, so that practicing nurses can have access to this appropriate information.

TNA will evaluate the use of the ANCC Nursing Skills Competency Model by conducting a pilot study of three employer-based competency testing center.

During the **2011 – 2013 Biennium**, Continuing education and certification in the nurse's area of practice would continue to be options for validating competence. In addition, TNA would review legislative authority to encompass the Evidence-Based/Best Practice Center into the state system for nursing a logical, equally attractive approach was available. This will include reviewing options for funding. The Evidence-Based/Best Practice Center, conceived through the TNA Committee on Education, was originally envisioned to provide ready access to common nursing practices in modular format so that any faculty member could use this source as a learning strategy for students in undergraduate or graduate education. Using such an approach could decrease the replication of work across the state in schools of nursing where faculty work intensively to provide students with the best, most current information related to the practice of

Attachment A

nursing. Upon further analysis, however, the Task Force on Continuing Competence recognized that this information would also be useful in practice situations because knowledge changes so quickly. Thus, these modules could be designated by year of development and level of application (undergraduate, graduate, continuing) and used as a way to provide a solid source of current information for nurses in practice. This approach to create this center would include requesting legislative approval for funding. TNA would also request that the BON rules and regulations be expanded to allow nurses to document their competence through validation in approved organizations. As previously noted, ANCC has initiated an approval process for organizations that offer competency validation. Organizations that receive this designation may use some sort of simulation to validate competence. By the 2011-2013 Biennium, a number of Texas organizations would certainly have received this designation. This approach would provide the necessary structure to implement the strategy of using competency validation completed in approved organizations. Because of the variety of options available to nurses to document their competence, portfolios would be a pathway through which nurses may submit their documentation.

Conclusion

Multiple stakeholders, including nurses themselves, have a vested interest in documenting nurses' continued competence. The TNA Continued Competency Task Force proposes the implementation of a "phased-in" regulatory approach designed to insure multiple mechanisms for nurses to document their competence. This approach is designed to build on past efforts to strengthen how well information about each individual's competence can be documented. In addition, it will be necessary to determine how this information, singularly or in aggregate, will be shared with the public so that patients may be more confident in their providers of care.

TNCC Invitational Conference
Bridging the Gap between Patient Safety and Nursing Competency:
Pieces to Policy

April 30, 2008 to May 2, 2008
Lubbock, Texas

A 'competent nurse': acts independently and reliably to integrate knowledge (evidence), interpersonal, and technical skills to provide safe, effective and ethical care in role and context specific situations.
Hosted by Texas Tech University Health Sciences Center School of Nursing

This second invitational conference was sponsored through grants from WorkSource of South Plains and from the Robert Wood Johnson Executive Nurse Fellow (RWJENF) Alumni Association with matching funds from Texas Tech University Health Sciences Center School of Nursing, Texas Christian University College of Nursing, and Seton Health Care System.

Conference Background

In 2006, thirty nursing leaders, engaged in various aspects of work related to nursing competencies, met in Lubbock, Texas for an invitational conference on nursing competency. The first conference evolved from the workfaculty at Texas Tech University Health Sciences Center School of Nursing had been engaged in for four years under the auspices of grants funded by U.S. Department of Health and Human Services and the National Science Foundation. Those invited to join the Texas Tech team included others across the state who were engaged in similar work related to competence assessment of student and employed nurses and policy issues related to assuring a competent nursing workforce in the state.

The goals of the first conference were to begin the process of a) creating consensus among Texas leaders in nursing practice, education, and administration on the meaning of competency and best practices for measuring competency, b) identifying priorities for a functional electronic competency management system, c) creating common understanding among these leaders about existing and emerging competency models, and d) establishing a preliminary framework for a National Invitational Working conference on the Science of Competency-Based education.

Because it was believed nursing was behind in the competency movement and it was unlikely that a national agenda would soon emerge, innovations in competency assessment and policy were much more likely to emerge from states such as Texas which was already actively engaged in this work. One outcome of the initial conference was the formation of the Texas Nursing Competency Consortium (TNCC) composed of the primary groups across the state that were committed to moving the science related to competency

assessment forward. The Vision of TNCC became: “Safe patient care through competent nursing practice for all Texans (TNCC Vision Statement, 2006. pg 1)” The second conference was thus planned and held in May 2008.

Conference Summary

Acknowledging the criticality of *continuing competency* as an integral requirement to patient safety, over one-hundred educators and practice leaders participated in a second invitational conference designed to further the work of the TNCC, entitled “Bridging the gap between patient safety and nurse competency: From pieces to policy.” Keynote speakers included Drs. Patricia Benner, Rodney Hicks, Carole Kenner, and Gwen Sherwood. During the Pre-Conference Day, Dr. Hicks presented on the necessary context for continuing competency through issues related to safe medication use and nursing students, and the state of nursing science and safe use of medications. Dr. Sherwood explored issues related to the transformation of nursing education to achieve competencies in quality and safety.

Day One of the conference included Dr. Benner’s review of the Carnegie Nursing Study and the integration of teaching practices as foundations for clinical competency. These presentations were complemented by a review by Dr. Carole Kenner of the IOM Competencies in relation to nursing education and staff development, and a discussion of the QSEN-IOM Competencies and safety in nursing education. In Day Two, Dr. Benner continued her focus on teaching, illustrating the relationship between apprenticeships and ongoing competencies, while a panel presentation by Joyce Batcheller, Kim Judd, and Dr. Patricia Cornett discussed current approaches to ensuring clinical competence in the clinical setting. A second panel of Susan McConnell and Drs. Susan Sportsman, Mary Beth Thomas, and Patricia Yoder-Wise outlined the “Texas experience” in developing a Regulatory Model of Nursing Competence.

Throughout the conference days, there was opportunity for reflection, discussion, and sharing of new learning lead by Dr. Patricia Yoder-Wise resulting in the opportunity to incorporate new learning into nursing education programs and to further explore a model of nurse competency assessment for the state of Texas.

Issues Related to Safe Use of Medications and Students

Dr. Rodney Hicks, RN, PhD, FNP-BC

Referring to a landmark study on medication errors (Wolf, Hicks, & Serembus, 2006), by nursing students by Dr. Hicks identified that omission, improper dose, wrong time, and extra dose accounted for 80% of medication errors. However, rather than perpetuating the current punitive culture focusing upon the person who made the error, we should be asking “what happened to the system?”

Eighty percent of errors were performance and knowledge deficit related – i.e. competencies. Leading causes of errors were performance deficits (51%), not following policy & procedure (32%), and knowledge deficit (27%). Contributing factors were primarily confined to inexperience (77%) and distractions (21%). Over 300 different products were involved in the errors.

Nursing competency is integral to patient safety and is an identified standard of care by the Institute of Medicine (IOM). Strategies to reduce the potential for medication errors could include: the monitoring of student preparation and administration of medications as a shared responsibility of the instructor and unit staff; revising the curricula to incorporate medication safety throughout all courses; encouraging single-task accomplishment for beginning RNs, (multi-tasking may be an appropriate skill only for experienced RNs); and striving for an environment where system errors are non-punitive.

State of Nursing Science for Safe Medication Use

Dr. Rodney Hicks, RN, PhD, FNP-BC

In his second presentation, Dr. Hicks elaborated upon the causes of medication errors (iatrogenic events), and a taxonomy to document them without the “culture” of blame (as the IOM terms such situations), that tends to accompany such errors.

Participating in event reporting programs is “one mechanism to expand knowledge about the underlying systems-related factors that contribute to the events (Wachter & Shojania, 2004). One such medication error taxonomy is NCC MERP (National Coordinating Council for Medication Error Reporting and Prevention), an organization dedicated to reporting and eliminating medication errors. The taxonomy provides a standardized approach to record, interpret, and trend the time and has four reporting segments: error category, event detail, product information and patient information. There are also four subscales within the tool: potential error, actual error-intercepted, actual error – no harm, and actual error – harm. Other data collected includes: type of error, cause, contributing factors, and leading products involved. Dr. Hicks also reflected on errors occurring during the prescribing, transcribing, and dispensing activities of medication preparation. Possible solutions could include computerized prescriber order entry (CPOE), electronic prescriptions, bar coding, automated dispensing devices, and double checks.

In summary, “the science of safe medication use is in its infancy; it will be through the continued reporting of errors and understanding of how the *system* allowed the error to occur, that the vision of the imagined future where no one is injured because of a medication error, will happen (Hicks, 2008)”.

Quality Safety Education for Nurses (QSEN)

Dr. Gwen Sherwood, PhD, RN, FAAN

What are the driving forces for integration of quality and safety into nursing? The complexity of care, information technology, the increasing role of patients and families in care, longer and more costly orientations, new graduates entering the system with expectations that they already have a certain set of competencies, and the fact that no one discipline can provide all care, are all market factors dictating a focus on the quality of care. Working in systems with poor quality lowers satisfaction and is a deterrent to retention, while a quality culture encourages inquiry, investigates incidents from a system perspective, and employs evidence-based standards and interventions. Health care is lagging behind other high performance industries (aviation, automobiles) in examining quality from a system's perspective. There is glaring evidence that care does not meet the six measures of quality that are necessary for transformation: safe, patient-centered, timely, accessible, evidence-based, and equitable (IOM, 2003a).

Faculty need to be cognizant of how emerging quality and safety standards, regulations, and initiatives in practice settings are stimulating changes in health care. For example – continuous quality improvement, root cause analysis, sentinel events, trending, variance reports are all emerging strategies. How is the gap between current curriculum and practice realities, or faculty preparation and practice changes being reduced? How can nurse leaders in education and practice begin to support and participate in these needed changes? Education should be promoted as a bridge to quality.

Knowledge, skills, and attitudes (KSAs) have been defined for six (6) general competencies: patient-centred care, safety, teamwork and collaboration, quality improvement, evidence-based practice and informatics. Faculty reported needing help with, and students having difficulty achieving the KSAs of quality improvement, evidence-based practice and informatics. On the other hand, faculty reported expertise in, and students' satisfaction with achievement in patient-centred care, safety, teamwork and collaboration competencies. QSEN is one such comprehensive resource for some of this required competency content.

What are the competencies needed by nurse graduates to work in health care settings related to quality and safety, what content is currently in the curriculum, and what changes are needed to help graduates develop the KSAs that define the six (6) competencies? For example, the new graduate must be able to function effectively within nursing as well as inter-professional teams. Even though most care is delivered by teams, education has been primarily focused on developing individual responsibilities rather than across multi-disciplinary teams. Inadequate communication and poor working relationships are the most frequent root causes of safety events and near misses, and poor communication skills undermine teamwork. Communication competencies help nurses to be assertive and to “raise the red flag” to halt questionable activities and review actions.

A focus on quality and safety requires new KSAs about how care is delivered, monitored, and improved. Nursing schools must integrate these changes into their curricula so graduates are adequately prepared to work in quality-focused settings. Faculty need development in quality improvement processes, safety and error prevention techniques, and expanded informatics.

Strategies to assure a quality and safety focus in the curricula could include: integrating QSEN competencies into simulations, unit orientations that attend to all the competencies, spending longer time on one site, posing questions that require reflection, using retired providers such as nurses and physicians as mentors, employing team-based learning, or incorporating the observations of other health professionals.

Reframing Nursing Curriculum and Teaching Strategies within a Context of Quality and Safety Science

Dr. Gwen Sherwood, PhD, RN, FAAN

Dr. Sherwood then focused her next presentation upon effective pedagogical strategies to achieve necessary educational curricula changes; how to evaluate and re-design clinical learning in pre-licensure programs to balance between carefully monitored student learning experiences; and system exposure to achieve quality and safety competencies? Can we “let go” of the traditional single patient assignment for a “real” world experience? Is there a role for computerized manikins (simulation labs) or standardized patients? What are the barriers to academic and clinical partnerships and are there barriers that we need to consider in order to implement new ways of educating students?

Strategies to address some of these barriers include: sharing clinical quality outcome data from the facilities with faculty; having faculty attend grand rounds and in-services; inviting clinical partners to share faculty development activities, design student assessment strategies, or suggest curriculum content; or creating opportunities for students to use information and communication technologies as part of their training. The use of *TeamSTEPPS* (Strategies and Tools to Enhance Performance and Patient Safety) (AHRQ, 2006), has been recommended for an evidence-based curriculum. Shared mental models could also help inter-professional teams know what to expect and how to synchronize care, such as with critical language or key phrases that are understood by all team members ‘call-out’, check-back’, or ‘hand-off.’

A further strategy is “AI” or Appreciative Inquiry, a highly flexible process to engage people in building an organization/world in which they want to live, to “own” their world. Using curriculum as a point of change, faculty can ‘discover’ the best of what is currently in the curriculum, ‘dream’ by challenging the status quo, ‘design’ by creating a new potential, and define their ‘destiny’ by creating a plan for a transformed curriculum with integration of quality and safety.

“The challenge for educators is to educate all health professionals to deliver *patient-centered care* as members of *interdisciplinary teams*, emphasizing *evidence-based practice, quality improvement, (safety), and informatics.*” QSEN hopes to accomplish: development of evidence-based teaching strategies; evaluation and assessment; graduates who are prepared to meet practice needs; and a restoration of meaning and purpose of work through a quality focus.

IOM Implications for Nursing Education and Staff Development

Dr. Carole Kenner, DNS, RNC, FAAN

Dr. Kenner highlighted a number of IOM reports that directly impact on nursing education and staff development. In their document “To Err is Human” (IOM, 1999). IOM identified a number of common care-management problems (failure to monitor, observe, or act, use of incorrect protocol, wrong treatment plan, etc.) which could be used as “teachable moments” in nursing education. IOM also concluded in its 2001 document “Crossing the Quality Chasm” (2001), that: performance varies considerably; the healthcare system is fragmented, poorly organized, and does not make the best use of resources; increasing chronic illness has had a major impact on the system; and the system is confusing and too complex for consumers.

The IOM developed a two-dimensional Quality Framework. The first dimension identified six (6) improvement aims: safety, effectiveness, patient-centred, timely, efficient, and equitability. The second dimension was a focus on the consumer perspective (staying healthy, living with illness or disability, etc.). Twenty priority areas of care were identified, from care coordination, pregnancy and childbirth, and self-management/health literacy, to a variety of illness states such as cancer, and nosocomial infections (IOM, 2003a). A Public Health action plan has been suggested with competencies to improve public health services, such as informatics, communication, cultural competence, global health, policy and law.

In yet another ground-breaking work, IOM published “Keeping patients safe: Transforming the work environment of nurses” (2004). This report focused on how various aspects of the nurses’ work environment actually impacted negatively upon the care and mortality of their patients (understaffing, reduced orientation, medication administration, among many aspects). Available nursing time can be more strategically used: technology to support ease of charting, organization of needed supplies, etc. This transformation of care is also part of the work of the Institute for Healthcare Improvement (IHI, 2008).

A final key report by the IOM entitled “Health Professions Education: A Bridge to Quality (2003b), addressed five core competencies that apply to all health professions: providing patient-centred care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and using informatics.

The Carnegie Foundation National Nursing Education Study
Dr. Patricia Benner, RN, PhD, FAAN, FRCN

Dr. Benner reviewed the Carnegie study whose purpose was to examine current signature pedagogies in six professions (nursing, medicine, engineering, clergy, teaching, and law). Medicine and nursing were the only two professions studied simultaneously.

There are many challenges to the teaching of practice. It is impossible to make the knowledge embedded in practice be completely formal or explicit. Much clinical knowledge is only elicited by the situation, i.e. context dependent. Clinical and ethical reasoning for making decisions and taking action in practice are forms of practical reasoning in specific contexts. Practical reasoning requires reasoning across transitions in the patient, the situation, and in the clinician's understanding. Teaching a practice requires experiential learning, thinking-in-action (situated cognition), situated teaching and learning (readiness), cases and situations, and ethical comportment (in actions and outcomes). In other words, context, framing, and sequencing cannot be done through artificial means.

All of the Carnegie professional studies use "apprenticeships: **cognitive; practical reasoning and clinical skilled know-how; and ethical comportment.** Within **cognitive** apprenticeship there is a high variability found across types of nursing schools with teaching to the NCLEX prevalent and thus almost no interdisciplinary teaching. There is also confusion and high variation over what constitutes 'cognitive reasoning'. Taxonomies proliferate in both nursing and medicine with a good deal of substitute and redundant language for critical thinking. However, for the moment, Nursing Diagnosis is virtually the only taxonomy available to nursing.

The second apprenticeship, **practical reasoning and clinical skilled know-how**, is often quite strong in situated teaching and clinical practice settings, especially when faculty are coaching the student, but not in the student-patient context. Teachers are not always 'tapping into' what students are learning from their patients, such as through journaling. Learning how to communicate with the patient is crucial, thus not overloading the student with other tasks is essential. Other problems with the second apprenticeship include limited good clinical placements and a too heavy reliance on clinical staff to mentor and teach (while not receiving the same support themselves).

In addition to improving clinical placements, strategies to improve the 2nd apprenticeship could include: improving post-clinical debriefings, focusing on developing clinical inquiry and self-improving practice; increasing follow-through on students' patient assignments; creating formal links from students learning from patients, to curricula; increasing student welcoming and sponsorship; teaching the students to make a clinical case for intervention; enriching the

number and type of patient simulations; bringing clinical into the classroom; and obtaining daily feedback on classroom and clinical learning.

Ethical Compartment, the third apprenticeship, is the most integrated apprenticeship, however, students and faculty do not see much more than ethics as theory, or as abstract principles. Everyday ethics equals good practice. Students need to be assisted in understanding the difference between high technical and preventative low technical care, and the ethical principles involved. Ethical concerns must be moved into health care policy discourse. Teachers need to present students with classical ethical dilemma situations encouraging them to practice ethical reasoning and consultation, teaching principles of reasoning and judging about competing ethical goods and concerns. Students need the learning skill of involvement and professional boundaries.

Nursing's signature pedagogies are: experiential learning; practical reasoning; dialogues between theory and practice; ethical compartment; and patient-centred care and patient advocacy. Coaching is the "case law" pedagogy; it is quite well developed by educators. It is the art of asking questions and thinking out loud so the student can see the 'bootstrap work' the teacher has experienced. The goal of coaching is to help the student explore, make connections, realize what he/she knows, and how and why it is relevant to the situation. It is also to produce experiential learning in the situation and help the student gain self-confidence.

In the pedagogies of experiential learning, for example, the student is allowed to call the instructor the night before clinical to clarify questions (pre-clinical prep). Post-clinical, experiences are shared. In the classroom, students are 'pulled' (engaged) into discussion, using their clinical experience and examples – drawing on their own practice. In an integrative teaching situation, the student is placed in a collaborative nursing role with the instructor. The case is presented in terms of patient-nurse concerns – what the patient is experiencing and what the nursing actions should be. The student is asked to respond to the patient's situation. The case continues to evolve over time as the patient's condition changes.

Exploring the Relationship Between Apprenticeships and Ongoing Competencies

Dr. Patricia Benner, RN, PhD, FAAN, FRCN

In the last 20 years the focus on teaching and learning has waned at major research universities. As well, formation and ethical compartment have lessened with the growth of "technical professionalism (T. Parsons). More interdisciplinary work is needed and expected. A refocus on teaching and learning should address curriculum, signature pedagogies, studying how students learn to think like their professional role models, and strategies for classroom and clinical practice. The professions hold certain aims in common including: making judgements in time of uncertainty; learning from experience; creating and

participating in a responsible and effective professional community; developing capacity to engage in complex forms of professional practice; possessing fundamental, academic knowledge; and providing worthwhile service in pursuit of important human and social ends.

Benner highlighted four pedagogies - **interpretation, formulation, performance, and contextualization**, and provided illustrations from among the selected professions. Within the pedagogies of **Interpretation** it is important to situate the student in the 'world' of tradition, where practice communities can act as interpretive communities. Critical thinking within Interpretation is as a means to using reflective scepticism to move students towards service or some action response. **Formation** pedagogies provide methods by which a person is prepared for a particular task or is made capable of functioning in a particular role. The understandings and how one views oneself are relevant to the understanding of formation. The view of oneself is created by defining ones relationship with a tradition and a practice.

The pedagogies of **Performance** include the activities around the situation and how the person performs them, and the person/patient/client that is in receipt of the activities. For example, Clergy educators teach to prepare students to perform their religious traditions as ways of living into or embodying the activity of God in the present. The expert practitioner always knows more than he/she can tell.

Contextualization, a fourth pedagogy, presents the challenge to know and be known without "othering"; to be able to respect another person as an individual, but also, for example, be able to appreciate what he is suffering. There needs to be capacity for empathetic consciousness, an ability to facilitate mutual understanding, and to foster the reciprocity of dialogue.

In comparing medicine and nursing pedagogies, nursing has more cross professional time than medicine. Nursing has extensive pre-clinical prep – medicine almost none. Nurses learn the roles of other professions, medicine less. However, neither nursing nor medicine learns in interdisciplinary teams which would improve the quality of health care delivery.

Developing a Regulatory Model of Nursing Competence – A Team Approach

Dr. Susan Sportsman, Dr. Mary Beth Thomas, Susan McConnell, and Dr. Patricia Yoder-Wise

A panel of nurses composed of Dr. Susan Sportsman, Dr. Mary Beth Thomas, Susan McConnell, and Dr. Patricia Yoder-Wise presented the Texas experience. The Texas Nursing Association is self-regulating and as such the Board has been given authority to review continued competence. The 1997 Texas

Legislature amended the NPA (Nursing Practice Act) to conduct pilot studies “to evaluate the effect and efficacy of innovative applications of nursing education programs”, with seven (7) grants being awarded centered on psychiatric mental health, home care health, certification, and continuing competence, among others.

Since 2001, there have been a number of initiatives dealing with continuing competence including development of a common vision. The purpose of the Regulatory Model was determined as: provision of assurance to the public that nurses are maintaining competence to function as safe practitioners over a lifetime of service; addressing concerns related to the Sunset Review and a re-enactment of the NPA in 2007; and addressing the major issues related to the redesign of nursing practice. Challenges facing the profession that framed this work included: managing the growing knowledge base; ensuring that all nurses have the skills necessary to meet public demands; and meeting the demands for increased enrolments and provision of strategies to support a declining workforce.

The process involved many activities: development of a philosophical framework and definitions; identifying key stakeholders and essential competence components; critical domain identification, and preparing of regulatory model components. Specific IOM competencies were woven throughout the Model represented by four core nursing competencies: clinical judgement in the provision of holistic care; organization and management of safe care; personal, professional, ethical development and practice; and communication of others.

Activities for 2009-2011 will revolve around how nurses can document their continued competence (twenty hours of CE or national specialty certification), conducting a pilot study of three employee-based competency testing centers to evaluate the use of the ANCC Competency CE Model, and implementing a pilot study to develop an Evidence-Based/Best Practice Center by the TNA/TNF. For the 2011-2013 period initiatives will include continuing certification and continuing education efforts in the nurse's practice area as options for validating competence, and reviewing the legislative authority to encompass the Evidence-Based/Best Practice Center into the state system for nursing. Efforts will also be focused on expanding the BON(Board of Nursing) rules and regulations to enable nurses to document competence through validation in approved assessment centers and organizations, and to develop a process for use of portfolios as a means to document continued competence.

Current Approaches to Ensuring Clinical Competence

Kim Judd, Patricia Cornett, and Joyce Batcheller

Three approaches to continuing competence at the University Medical Center, the Seton Magnet Hospitals, and Versant RN Residency program were

highlighted in this presentation. As described by Kim Judd, at the 413 bed acute care University Medical Center (UMC) in Lubbock, the goal of nursing competency evaluation is to assure provision of safe, effective, patient-centered care. The initial competency evaluation consists of a self-assessment during the interview process, evaluation by the Clinical Educator as to the length of orientation required, and completion of specialty specific entrance competency exams. The 'Technical Procedure Privileging' process tracks the nurse's technical skills. A remediation process allows additional time for a person to address identified areas of weakness. The organization also has an 'Individual Competency Profile' to meet Joint Commission requirements.

For the 3000 nurses at Seton hospitals, some of which are Magnet institutions, Joyce Batcheller outlined the network shared governance model that has been in place for thirteen years. There is a nursing executive committee representing the various sites and a Nursing Congress that meets monthly with representatives from all sites, plus sub-specialty counsels. There are clinical ladders with the top, RN5 requiring a Masters degree. As it has proved difficult to ensure that everyone has the same orientation (not really possible in such a sub-specialized environment on different campuses), educational instruction have been "bundled" into specific topics: skin, back, ventilator acquired pneumonia bundle,

The organization has studied why there has been a new graduate turnover of 33% in the first year after hire. The Versant residency eighteen (18) week program for all new graduates was introduced. The calibre of new graduates has since increased and there is actually competition for the vacancies! Preceptors have enhanced their levels of competence and there is now a skills laboratory and simulation centre.

Patricia Cornett described the impact and implications of the Versant RN Residency program. The program was developed to increase an organization's capacity to manage high numbers of novice RNs by: facilitating transition; improving competency and confidence; increasing organizational commitment; and reducing turnover. The Residency standardizes how to bring onboard numbers of novice RNs in an organized 360 degree fashion.

The Residency has four (4) components: clinical experience with 1:1 preceptors, formal mentoring, practice-driven learning, and debriefing with self-care groups (6-8 participants and 2 facilitators, one of whom may be another discipline). All content is online. There are 64 basic competencies with additional specialty competencies. Residents have three opportunities to complete a competency and the Manager can track the Resident's progress online.

Evaluations are conducted at 12, 24 and 60 months. Several interesting findings have been noted including the turnover intention (TI), a global measure of when staff are intending to leave. It has been predicted that if the RNs' first choice is not available at hire, they are 4 ½ more likely to be in the TI group. Of those who

say they have no intention to leave at 24 months, 11% do; of those who say they are going to leave at 24 months, 25% do so. Other findings identified that those RNs who use the organization as social support tended to leave, as did those with a low organizational commitment. The presence/absence of appropriate pay, professional status, group cohesion, and nurse satisfaction were also predictors of intent to leave.

Observations from the participants at the Conference: Call the new nurse a beginner, not a novice; competence for medical-surgical nurses may take longer because of their diverse population. At what should educators do a better job...competencies that students really struggle with are patient education and interdisciplinary communication.

DRAFT

Dialogue and Synthesis

Over the course of the two day Conference the participants were lead by Dr. Patricia Yoder-Wise in reflective dialogue with emphasis improving competency assessment and policy across the state. Some of the very salient observations included:

- Competency is not just at one end of the spectrum as a student, but the whole spectrum.
- What if we assessed the gap between education and practice and used the gap analysis to improve education and practice?
- Continue to foster the notion that we are on a continuum. Experience and education need to work hand in hand. Nurses must use a different mindset, so there are not interruptions of learning, and practice; one should flow into and complement the other.
- There must be a fundamental shift in how we provide nursing experience. For example, having a cross appointment; the faculty member belongs to the nursing unit. Faculty and students are not 'guests'.
- More open dialogue between practice and education must occur.
- Is it realistic to expect to produce a competent nurse at graduation?
- What are the policy barriers that prevent new ways of educating students?

The most important lessons learned:

- Collaboration/partnerships between education and service are essential to promoting competence of new graduates and experienced nurses.
- Clinical imagination and practice situated in context are the foundations for integrated learning and competency development.
- Competency assessment is complex but not impossible.
- A paradigm shift is in process, and nurses must champion the change in our circles of influence.
- The importance of treating one another with respect and finding new ways to be together, such as students and faculty being part of the team in the agency.
- Faculty development is a must.

Some of the questions arising from the Conference included:

- How will Nursing move forward with the needed changes and will we be effective?
- How do we get other administrators in the organization to participate in the discussions?
- How do we get faculty buy-in?
- How do we incorporate these new concepts and methodologies in our nursing education programs?
- How do we accurately measure competency?

- How do we move practice and education closer?
- How do we integrate the information with all levels of nursing students?
- How do we integrate this information into the practice environment?
- Why do we not show more respect for one another?
- How does certification fit into competency assessment?
- How do we keep nurses engaged and competent in practice?
- How do we know that clinical instructors (and faculty?) remain competent?
- How to best weave the IOM recommendations into curricula – benchmark with whom?

Conclusion and Next Steps

The main areas of foci for a 'go forward' plan are:

1. Work with development of 3 pilot simulation centers in Texas to focus on the competency of "working in interdisciplinary teams", with particular attention to "communication". Team leaders for this goal are Joyce Batchelor, Sharon Decker and Susan Sportsman.
2. Develop a "student friendly" program in the Texas schools of nursing with the goals to move to a national level. Team leaders for this goal are Paulette Burns and Elizabeth Poster.
3. Continue competency movement, refocusing TNCC to the national level and hosting a national conference. Team Leaders for this goal are Pat Yoder-Wise, Alexia Green, Mary Beth Thomas and Clair Jordan.

As Pam Ironside reflected in her "Epilogue" in the *Journal of Continuing Education in Nursing* (2008) "by focusing on continuing competence, the discourse is reframed from an issue just for those entering nursing practice or just for those with practice deficiencies to one that is at the heart of health professionals everywhere – continuing competence is an ethic shared among those working together to safeguard patients."

"Our work has been a learning community" (Alexia Green, May 2008).