Continuing Competence In Certified Practice

April 2016

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One of the biggest shifts in the credentialing of nurses is the shift from a focus on continuing education to a focus on the broader issue of continuing competence. The shift has been spurred by the focus on quality and safety following the release of the Institute of Medicine (IOM) report *To Err is Human: Building a Safer Health System* (2000). Since the publication of the report, many national calls have been made for the health professions, including nursing, to address continuing competence (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine (IOM), Robert Wood Johnson Foundation & Institute of Medicine (IOM), 2011; Institute of Medicine (IOM), 2001; Greiner, Knebel, & Institute of Medicine (IOM), 2003; Swankin, LeBuhn, & Morrison, 2006). The National Council of State Boards of Nursing (NCSBN) identified continuing competence as a critical challenge for regulatory boards in the 21st century and declared that "it is time to address that challenge" (National Council of State Boards of Nursing (NCSBN), 2005, p. 1). Swankin, LeBuhn, and Morrison (2006) concluded that most boards that license healthcare professionals in the United States have continuing competence requirements; however, most of these are requirements for continuing education (CE). They suggested that a new model of regulation is required that goes beyond mandatory CE. Smith (2004) concluded that "while CE has frequently been used as a means of ensuring continued competence, no link has been established between mandatory CE and the development of professional competence" (p. 23). Kendall-Gallagher, Aiken, Sloane, and Cimiotti (2011) concluded improved patient outcomes are associated with specialty certification of nurses with baccalaureate and higher educational preparation.

Review of the Literature

To Err is Human: Building a Safer Health System (2000) contained several recommendations aimed at improving the safety of the healthcare system. One of the report's recommendations called for standards and expectations that place a greater emphasis on patient safety for health professionals. This broad recommendation was followed by a more specific recommendation for those bodies that license health professionals to:

1) Implement periodic re-examinations and re-licensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practice; and
2) Work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action (Kohn, Corrigan, & Donaldson, 2000, p. 12).

Continuing competence is viewed as a professional nursing responsibility. This responsibility is laid out in one of the foundational documents of the profession of nursing. Provision Five of *The Code of Ethics for Nurses with Interpretive Statements* (2001) states that "the nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth" (American Nurses Association, 2001).

In a subsequent report *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), the IOM concluded that licensure laws function to assure the public that licensed professionals have the minimum competencies and qualifications required for practice (IOM, 2001). In 2003 the IOM issued another report, *Health Professions Education – A Bridge to Quality*, which concluded that considerable variation in the requirements for health professionals to maintain licensure exists, and that linkages between accreditation, certification, and

licensure should exist to achieve the ultimate outcome: professionals who provide the highest quality of care. The IOM committee which issued this report also concluded that all health professional boards should require demonstration of continued competence. This IOM report also made recommendations for health professional licensing boards and certification bodies:

> Recommendation 4: All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care…through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods (Greiner et al., 2003, p. 128).
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> Recommendation 5: Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care (Greiner et al., 2003, p. 129).

Another related IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004), acknowledged that "prelicensure or pre-employment education cannot provide sufficient frequency and diversity of experiences…in the performance of every clinical nursing intervention needed for every clinical condition found in patients, especially as the breadth of knowledge and technology expands" (Page, 2004, p. 203).

In their systematic review of the literature on clinical competence assessment in nursing, Watson, Stimpson, Topping, and Porrock (2002) found : "considerable confusion about the definition of clinical competence and most of the methods in use to define or measure competence have not been developed systematically…"(p. 241). Bryant (2005) concluded that "the link between continuing competence and requirements for it is not well articulated" (p.25). She also indicated that "the [nursing] profession, as a whole, has clearly seen the need for

continuing competence but has grappled with how this can be universally accepted by all nurses" (p. 25). She contended the issue has become urgent with the heightened focus on quality and safety in health care. Scott Tilley (2008) concluded that "a common understanding of what competency is does not exist" (p. 58).

The NCSBN (2005) used the following definition of continued competence: "the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health" (p. 1). The NCSBN indicated that continuing competence initiatives have been undertaken by boards of nursing; however, it also identified several reasons that no comprehensive regulatory scheme for evaluating continuing competence exists. Among the reasons the NCSBN identified were:

- Competence is multifaceted and may be difficult to measure;
- The sheer volume of nurses in practice makes it difficult to identify feasible and meaningful yet cost-effective regulatory approaches; and
- Nursing careers take widely divergent paths, varying by professional role, settings, clients, therapeutic modalities and other professional criteria… (pp. 1-2).

In addressing questions about continuing competence, the NCSBN (2005) stated:

> Talking about continued competence makes professionals feel singled out and vulnerable. The concept of continued competence is intended to encourage practitioners to maintain their practice. But it is threatening to many. There is fear of the licensing board. There is fear of losing one's livelihood. There is fear of failure (p. 3).

The Citizen Advocacy Center (CAC), an organization that focuses on supporting public members of health care credentialing, governing, and regulatory boards by providing networking, research and training opportunities, has been active in calling for continuing

competence to be addressed by licensing authorities and certifying organization. The CAC in its report, *Implementing Continuing Competency Requirements for Health Care Practitioners* (2006), issued findings that new laws were needed to require health care professionals to demonstrate that they continue to be competent (Swankin et al., 2006). These authors also maintained that new regulatory models have to go beyond requiring mandatory continuing education to requiring a "model that includes periodic assessment of knowledge, skills, and clinical performance; development, execution, and documentation of an improvement plan based on the assessment; and periodic demonstration of current competence" (Swankin et al., 2006, p. 7).

The IOM issued another landmark report focused on the nursing profession, *The Future of Nursing: Leading Change, Advancing Health* (2011), that concluded the knowledge required for nurses to deliver safe and effective care should result in an essential expectation of lifelong learning for nurses (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the IOM, Robert Wood Johnson Foundation & IOM, 2011). This IOM report also included the following recommendation:

> Recommendation 6: Ensure that nurses engage in lifelong learning. Accrediting bodies, schools of nursing, health care organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan (p. 13).

Two of the specific items following this recommendation were: "all health care organizations and schools of nursing should foster a culture of lifelong learning and provide resources for interprofessional continuing competency programs" and "health care organizations

and other organizations that offer continuing competency programs should regularly evaluate their programs for adaptability, flexibility, accessibility, and impact on clinical outcomes and update the programs accordingly" (p. 14).

In 2008 the National [Australia] Cancer Nursing Education (EdCaN) Project, a project focused on the development and education of the cancer nursing workforce in Australia, published its report, *Competency Assessment in Nursing: A Summary of Literature Published Since 2000*. The basis of the report was a review of 54 articles published between 2000 and 2007. The report highlighted the wide range of definitions and concepts of competence, and identified the following common indicators used to assess competence: continuing education, portfolios, examination, peer review, direct observation, self-assessment, interview, and patient outcomes (Evans, 2008). The report outlined key aspects of each of the listed indicators; however, the report pointed out a lack of evidence supporting the effectiveness of the indicators in measuring competence (p. 5). The report concluded that "competencies for professional nursing should reflect the multifaceted nature of nursing practice, the broad range of practice settings, and cultural differences with the population" (p. 42).

Globally, the profession of nursing has undertaken efforts to address continuing competence; however, the goal of ensuring continuing competence has been hindered by many factors. These factors include questions about the best term to describe the goal. Henderson (2008) pointed out that "continued competence, continuing competence, licensure maintenance, maintenance of certification, maintenance of competency, lifelong learning, and even simply relicensure appear in the literature" (p. 6). The diverse practice settings of nurses, broad functional practice areas, and the sheer size of the nursing workforce (NCSBN, 2005) are additional factors that have thwarted continuing competence efforts.

In 2011 the Hospice & Palliative Credentialing Center (HPCC) published the work of its Continuing Competence Task Force (CCTF) in its *Statement on Continuing Competence for Nursing: A Call to Action*. In the statement, the CCTF clarified the difference between competency and competence using language developed by Kathryn Schroeter and published in the Competency and Credentialing Institute's (CCI) Competence Literature Review (2008). Schroeter wrote:

> Although they may sound similar, competence and competency are not necessarily synonymous. Competence refers to a potential ability and/or 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 (Schroeter, 2008, p. 2).

The CCTF settled upon the following definition of continuing competence: "continuing competence is the ongoing commitment of a registered nurse to integrate and apply the knowledge, skills, and judgment with the attitudes, values, and beliefs required to practice safely, effectively, and ethically in a designated role and setting" (NBCHPCN, 2011, p. 4).

The CCTF also set forth beliefs that underpin the definition of competence. The beliefs clarified that competence is:

- A professional and ethical obligation to safe practice;
- A commitment made to the individual, the profession, and to consumers;
- A responsibility shared among the profession, regulatory bodies, certification agencies, professional associations, educators, health care organizations/workplaces, and individual nurses,

    - Healthcare organizations/workplaces accept responsibility for measuring, documenting, and supporting competency, and for addressing any deficiencies in staff members' competency;
- Evolutionary, in that it builds on previous competence and integrates new evidence;
- Dynamic, fluid, and impacted by many factors as the individual enters new roles and situations (NBCHPCN, 2011, p. 4).

Case Di Leonardi and Biel (2012) wrote that the interchangeable use of the terms continuing competence and continued competency had served as an impediment to reviewing the literature regarding competence. The CCTF concluded that a common definition would allow accountability to be clarified, decision-making to be specific, and meaning to be communicated (NBCHPCN, 2011).

The American Board of Nursing Specialties (ABNS) is among the entities that have endorsed the HPCC CCTF statement, and it has encouraged its member organizations to use the statement and definition as a starting point to evaluate and enhance their assessment and recertification programs (American Board of Nursing Specialties (ABNS), 2012). Other organizations that have adopted the statement include: the Citizen Advocacy Center , the Accreditation Board for Specialty Nurse Certification, the American Association of Colleges of Nursing, the Council on Graduate Education for Administration in Nursing, the Association of Nursing Professional Development, formerly known as the National Nursing Staff Development Organization.

The CCTF's definition of continuing competence is broad enough to encompass the diverse practice settings of nurses and their broad functional practice areas. The beliefs the

CCTF articulated included a statement on shared responsibility that suggests spreading the burden for ensuring continuing competence among the profession, regulatory bodies, certification agencies, professional associations, educators, health care organizations/workplaces, and individual nurses.

Improving outcomes and protecting patients from harm requires a shift to demonstrating continuing competence (Ironside, 2008). In light of the calls for the health professions, including nursing, to address continuing competence (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the IOM, Robert Wood Johnson Foundation & IOM, 2011; IOM, 2001; Greiner et al., 2003; Swankin et al., 2006), nursing must respond. Using a common definition of continuing competence will begin to address the issues that have impeded efforts to address continuing competence for nurses. The beliefs and definition presented in the NBCHPCN statement provide a framework for the common ground that is necessary.

In a survey designed to explore and describe the current continuing competence requirements of nursing specialty certification boards oganizations that are members of ABNS were asked, among other things, whether their organization had reviewed *The Statement on Continuing Competence: A Call to Action*. These organizations have made a commitment to improving patient outcomes and protecting consumers by promoting specialty nursing certification.

Results

Data were collected between December 2012 and February 2013. A total of 19 of the 32 specialty certification board participants completed the survey, representing a response rate of 59%.

Most of the specialty certification boards that responded, 82% (*n* = 14), had reviewed *the Statement on Continuing Competence for Nursing: A Call to Action* (HPCC, 2011), and 56% (*n* = 10) had adopted or endorsed the statement. Most, 77% (*n* = 13), also responded that their organization does not have a formal definition of continuing competence, and 71% (*n* = 12) responded that their organization does not use a conceptual or theoretical framework for continuing competence.

The specialty certification boards were asked about the use of a formal definition of continuing competence and whether their organizations use a conceptual framework for continuing competence. The respondents indicate that there is no widely agreed upon definition or conceptual framework in use. This was despite more than half of the respondents indicating that they had adopted or endorsed the *Statement on Continuing Competence for Nursing: A Call to Action*. Further action is required to explore the resistance to the use of a consistent formal definition of continuing competence in nursing.

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Table 1

State and Territorial Boards of Nursing Continuing Competence Requirements

	License Renewal	
Strategy	RN (n = 29)	APRN (n = 28)
Provide continuing education to others	10%	4%
Examination	3%	4%
Portfolio review	0%	0%
Peer review	0%	4%
Certification in a specialty	17%	75%
Continuing education	79%	54%
Publication	14%	4%
Simulation	3%	4%
Hours of practice/work in a given time	28%	14%
Self-assessment	0%	4%
Other	24%	21%

Note: Respondents could check all that apply, and not all participants answered all items.

Table 2

Nursing Specialty Certification Board Continuing Competence Requirements

Strategy	Initial (n = 18)	Recertification (n = 18)
Provide continuing education to others	0%	56%
Examination	94%	72%
Portfolio review	0%	22%
Peer review	6%	11%
Continuing education	33%	100%
Publication	6%	67%
Simulation	0%	6%
Hours of practice/work in a given time	72%	78%
Self-assessment	6%	22%
Other	6%	17%

Note. Respondents could check all that apply, and not all participants answered all items.