Evidence-Based Competency Management System

Toolkit for Validation and Assessment

EBP
This product is evidence based

SECOND EDITION

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hcPro

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Preface

Before you use any methodology for validating and assessing the competency of your nurses to deliver safe patient care, it is essential that you have a system in place for verifying that your nurses are who they say they are prior to allowing them on your units.

This might sound obvious, but stories of nurses faking credentials, hopping from job to job in various states, and harming patients are stark reminders that you must be diligent in verifying any nursing applicant's licensure, criminal background, education, and employment history.

Nurse-credentialing processes at some facilities may be inadequate. Nurses who have had action taken against them by another state nursing board, have a criminal history, or have incomplete education may slip by and end up working in direct contact with your patients, making those patients vulnerable and your facility liable. You should examine your organization's policies to make sure they protect your patients, and sufficiently screen applicants for dangerous nurses or imposters.

Credentialing nurses falls to the HR department in most facilities, and the medical staff office handles physician and advance-practice RN credentialing. For advice on credentialing nurses, HR administrators can consult their colleagues in the medical staff office, who most likely already have an established credentialing process in place.

Here are some steps you can take to verify nurses' credentials and to ensure your patients' safety and your facility's integrity.

Step 1: Gather applicant information

The application for employment should be thorough and should obtain the information needed to ensure patient safety in your facility. Ask for the following:

- The applicant's name and any other names he or she has used (e.g., a maiden name)

- Education, the degree obtained, and the name and location of the educational institution

- Professional licensure, the state in which the license was issued, the date issued, the license number, and the expiration date

- Disciplinary actions on the license

- Specialty certification

- Employment history

With many new nursing schools starting up, the organization needs to determine whether it requires nursing applicants to be graduates of an accredited school of nursing. New programs cannot apply for National League for Nursing Accreditation Commission accreditation until after their first class has graduated, which means that organizations that require graduation from an accredited school cannot hire any graduates of these programs.

That also requires that the accreditation status of all schools from which a potential applicant graduated must be verified prior to hire. Is licensure to practice as a nurse in that state sufficient? Whatever policy the organization decides to follow must be followed consistently, and must be reflected in the job descriptions.

It is also important to determine whether the applicant has even been convicted or pleaded guilty or no contest to the following:

- Criminal charges (other than speeding violations)

- Drug- or alcohol-related offenses

If either one of these situations applies, ask the applicant to specify the charges and the dates on which they occurred. Finally, inquire whether he or she has ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., Medicare or Medicaid) or similar federal, state, or health agency.

Step 2: Verify the applicant's information

Verify to the best of your ability the information you obtained on the application. Even if you don't find anything, document each verification step to further reduce your hospital's liability.

Some facilities hire a third party to verify this information, but most often the HR department performs this task. Either way, make sure a specific, established process is in place.

The best method of checking an applicant's qualifications is to use primary source verification, including education, licensure, and past employment. For the most accurate and up-to-date information, you should check the state board in every state that the applicant nurse has worked. Most state licensing boards post licensure information on their Web sites.

Many organizations require criminal background checks on all applicants, even if the state nursing board runs checks on its own. Nurses may have committed a crime after receiving their licenses. In most states, the responsibility is on nurses to notify the state board it they are convicted of a crime, but they may or may not do so, which puts your facility at risk.

Another important part of the process is to check federal sanctions lists. If you hire a nurse who has been sanctioned by the Office of Inspector General or General Services Administration, you could be fined thousands of dollars. Reasons for sanctions include everything from defaulting on student loans to Medicare fraud.

Here are some other potential "red flags" to consider:

- **Gaps in job history:** HR professionals are well aware of this red flag, but be sure to ask about the gaps. Understand that there could be a perfectly good explanation, such as the birth of a child or a family emergency.

- **Moving from state to state:** When an applicant moves around a lot, his or her licensure information could be buried or lost. Therefore, be sure to check the status of the license in each state in which the applicant practiced.

- **Job hopping:** HR professionals are well aware of this pattern as well, and they will look twice at any applicant with evidence of it. But be sure to call each employer and verify that no disciplinary actions were taken against the applicant.

Step 3: Continually verify the employee's license after the hire date

Most facilities check nurses' licenses when they are up for renewal to make sure they are current and active. However, it is crucial that you institute a process to verify licensure status more often as well.

Ensure that your policy spells out that it is the nurse's responsibility to report any disciplinary action taken against his or her license over the course of his or her employment. If your nurses do not report such action, they could be working on your unit with a suspended or inactive license and you would have no idea. Many boards of nursing post disciplinary actions against nurses in that state, which can be used as another method to ensure that all employees have a current license with no restriction.

Creating a new credential-verification process or updating your current process is a very important prerequisite to the competency assessment process.

How to use this book

Evidence-Based Competency Management System: Toolkit for Validation and Assessment, Second Edition, will help you understand the basics of competency validation and assessment and discuss the steps you need to take to develop a process for performing these assessments at your organization.

In addition, this book provides you with evidence-based sample tools that will help get you started.

The appendix contains 206 evidence-based sample competency validation skill sheets. Tabbed for easy navigation, the skill sheets are organized into six sections: General, Medical-Surgical, Intensive Care Unit, Emergency Department, Obstetrics, and Operating Room. In addition, the appendix contains 29 role-related checklists, which can be used for orientation, training, or review purposes. The first page of each section contains a table of contents, which lists the name and page number of each skill sheet included in that section.

All of the content in the skill sheets was contributed or updated by Summa Health System Hospitals in Akron, OH. This content has been reprinted with the permission of this organization.

Customizable, electronic versions of all the skill sheets can be found on the CD-ROM accompanying the book. We have also included a copy of the "Competencies Analyzer" on your CD-ROM. This easy-to-use spreadsheet will help your unit or department managers organize their competency assessment program. A complete list of tools included on the CD-ROM can be found in the "How to use the CD-ROM section."

Putting your skill sheets to work

The template used to standardize the appearance of these skills sheets appears on your CD-ROM. Save this blank template to your computer and use it to create additional skill sheets for your organization.

Duplicate this blank sheet as many times as needed. Type in content as you would into any table created using Microsoft's word-processing software to customize the sheets to fit your organization's needs, using the information discussed in this manual.

Here is a quick look at one of the skill sheets:

Name, date, skill – the section includes a space for the name of the employee whose competency is being validated, the date the validation is taking place, and the name of the skill being validated. Consider adding a second identifier, such as the employee number, to this section.

We have already provided the name of the skills for each of the skill sheets included in the manual. As we discuss in Chapter 2, however, all the competencies validated by your organization will not be technical or skill-based competencies, such as using a blood-glucose meter. Therefore, when customizing these sheets for validation on an interpersonal competency or a cultural competency, consider changing the term "skill" to "behavior" as a more accurate way to incorporate the elected required of these competencies.

Steps, completed, comments – This section is set up in a typical checklist format. After each step is successfully completed, the validator would add a check to the "completed" column. Consider changing the term "steps" to "performance criteria" when creating sheets for competencies that may not conform to a step-by-step format. The validator can use the "comments" column to record statements such as "needs reinforcement for steps" or "reteaching required."

Self-assessment – The validator should ask the employee to do a self-assessment of his or her competence on the skill being validated. Use this section to check off the appropriate response.

Evaluation/validation methods – This box contains some of the more common methodologies used to validate competencies. The validator should note which method was used in association with the skill sheet to validate the competency.

Levels – Consideration for the level of proficiency should be made when validating competencies (refer to Chapter 2). The level of proficiency (i.e., beginner, intermediate, expert) should coincide with the experience level of the employee. Should the level not coincide, then remediation should be planned to achieve the desired level of competence.

Type of validation – In this section, the validator can specify whether this competency validation tool was used during orientation, during an annual competency assessment, or at another point during the competency validation process.

Employee observer signature – Have both the employee and the validator (i.e., observer) sign the completed tool. This helps ensure the employee was an active participant in the process and that he or she understands and acknowledges this piece of the competency validation process.

How to use the files on your CD-ROM

The following file names correspond with figures listed in the book, *Evidence-Based Competency Management System: Toolkit for validation and assessment.*

sstemp.rtf	Blank skillsheet template
analyze.xls	Competencies Analyzer
Fig3-1.rtf	Figure 3.1: Essential functions
Fig4-1.rtf	Figure 4.1: Successful completion of competency assessment training form
Fig5-1.rtf	Figure 5.1: New competency assessment checklist
Fig6-2.rtf	Figure 6.2: Competency-based orientation checklist
Fig6-3.rtf	Figure 6.3: Nursing assistant orientation checklist

General:

General1.rtf	ABG Interpretation
General2.rtf	Annual Competency Performance—Quality of Instruction
General3.rtf	Arjo Ceiling Lift
General4.rtf	Assessment/Validation of Competencies
General5.rtf	Assisting Adult with Feeding
General6.rtf	Blood Glucose Meter
General7.rtf	Blood Pressure Measurement – Automatic
General8.rtf	Blood Pressure Measurement – Manual
General9.rtf	Digital Holter Hookup (Diagnostic Cardiology)
General10.rtf	Emergency Preparedness
General11.rtf	Falls Prevention (Get Up and Go)
General12.rtf	Fit Testing for N-95 Respirator Mask
General13.rtf	Intake and Output
General14.rtf	Medication Administration
General15.rtf	Oxygen Administration
General16.rtf	Presentation Skills
General17.rtf	Regulating and Monitoring IV Rate
General18.rtf	Service Excellence
General19.rtf	Thrombolytic Therapy
General20.rtf	Thrombus, Chronic versus Acute
General21.rtf	Use of Automated External Defibrillator (Heartstream FR2)
General22.rtf	Venipuncture with Winged Needle

Emergency Department:

Ed1.rtf	12 Lead Electrode (Modified Limb Leads) Prep and Placement
Ed2.rtf	Aircast Splint Application
Ed3.rtf	Airway Management
Ed4.rtf	Arterial Blood Gas (ABG) Interpretation
Ed5.rtf	Brace Application – Ice Corset
Ed6.rtf	Brace Application – L-S Binder
Ed7.rtf	Brace Application – TLSO Brace
Ed8.rtf	Bronchoscopy Set-up and Equipment Use
Ed9.rtf	Buck's Traction
Ed10.rtf	Contrast Reaction Management
Ed11.rtf	Defibrillator Monitor (Heartstream XL)
Ed12.rtf	Electrocardiologram (EKG) Interpretation
Ed13.rtf	EKG 12 Lead
Ed14.rtf	Foreign Body Removal
Ed15.rtf	Heartstream XL AED Mode
Ed16.rtf	Monitoring Lead Placement
Ed17.rtf	Triage – Diarrhea
Ed18.rtf	Triage – Upper Respiratory Infection

Intensive Care Unit:

Icu1.rtf	Arterial Duplex Graft
Icu2.rtf	Arterial Line Monitoring
Icu3.rtf	Barthel and Rankin Scores
Icu4.rtf	Bipolar ECG Identification – Cardiac Rehab
Icu5.rtf	Camino Intracranial Pressure Monitoring
Icu6.rtf	Code Management – Critical Care
Icu7.rtf	Codman External Drainage System II
Icu8.rtf	Dialysis Fistula Duplex
Icu9.rtf	Discontinuing Esophagogastric Tamponade Tube
Icu10.rtf	Echocardiogram – Cardiology
Icu11.rtf	Electroencephalogram (EEG) – Routine
Icu12.rtf	Excel Care ES Bariatric Bed
Icu13.rtf	Femostop Application
Icu14.rtf	Hemaquet Removal Post Catheterization
Icu15.rtf	Identification of Pseudoaneurysm
Icu16.rtf	Lead Placement for Stress Testing
Icu17.rtf	Mechanical Ventilation
Icu18.rtf	Medtronic Pulse Generator
Icu19.rtf	Miami J Cervical Collar
Icu20.rtf	Nasopharyngeal/Tracheal Suctioning
Icu21.rtf	Neurological Exam
Icu22.rtf	Preparing for Intubation
Icu23.rtf	Pulmonary Artery Pressure Catheter

Icu24.rtf	Spinal Cord Monitoring
Icu25.rtf	Thrombolytic Therapy
Icu26.rtf	Ventricular Drain
Icu27.rtf	Versacare Bed

Medical-Surgical Unit:

Ms1.rtf	Accessing Implantable Access Devices
Ms2.rtf	Adding IV Solution, Priming Tubing, Changing Tubing
Ms3.rtf	Adding IV Solution to Central Line
Ms4.rtf	Administration of Blood
Ms5.rtf	Applanation Tonometry
Ms6.rtf	Appointment Scheduling – Clinic
Ms7.rtf	Atrium Ocean
Ms8.rtf	Barthel Index
Ms9.rtf	Bed Bath
Ms10.rtf	BICAP and Cautery
Ms11.rtf	Bladder Scanner
Ms12.rtf	Blood Culture Collection
Ms13.rtf	Braden Scale
Ms14.rtf	CADD Pump
Ms15.rtf	Care of Patient with Central Venous Catheter
Ms16.rtf	Central Venous Catheter – Application of Sterile Occlusive Dressing
Ms17.rtf	Central Venous Catheter – Obtaining Blood Samples
Ms18.rtf	Central Venous Catheter Removal
Ms19.rtf	Chemotherapy Administration
Ms20.rtf	Chemotherapy Teaching
Ms21.rtf	Chest Drainage Autotransfusion – Atrium Unit
Ms22.rtf	Chest Tube Dressing Change
Ms23.rtf	Code Management – Med/Surg
Ms24.rtf	Conscious Sedation
Ms25.rtf	Conversion to Intermittent Infusion of Continuous IV
Ms26.rtf	Crutch Walking and Use of Walker
Ms27.rtf	Discontinuing Intravenous (IV) Therapy
Ms28.rtf	Drug Testing (Blood and Urine)
Ms29.rtf	Flex Pen Patient Self-Administration
Ms30.rtf	GemStar Pump
Ms31.rtf	Homegoing Instructions
Ms32.rtf	Hypodermoclysis
Ms33.rtf	Infusion Intravenous Piggyback Administration (IVPB)
Ms34.rtf	Inline Tracheobronchial Sunction
Ms35.rtf	Insertion of Dobbhoff Feeding Tube
Ms36.rtf	Insulin Administration
Ms37.rtf	Insulin Administration Instruction
Ms38.rtf	Intramuscular Injections

Ms39.rtf	Intravenous Catheters – Declotting
Ms40.rtf	IV Dressing Changes
Ms41.rtf	IV Site – Drawing Blood From
Ms42.rtf	IV Start – Hemodialysis Catheter
Ms43.rtf	IV Starts and PRN adapter
Ms44.rtf	IV Therapy Documentation
Ms45.rtf	Lab Specimen Labeling Compliance
Ms46.rtf	Lidocaine for Insertion of IV Catheter
Ms47.rtf	Maintenance of Hickman Catheter
Ms48.rtf	Metered Dose Inhaler (MDI)
Ms49.rtf	Nasogastric Tube Maintenance
Ms50.rtf	Nasopharyngeal Suctioning
Ms51.rtf	Neurological Assessment and Documentation
Ms52.rtf	Neurovascular Status
Ms53.rtf	Neutropenic Precautions
Ms54.rtf	NIH Stroke Scale, Completing the National Institutes of Health
Ms55.rtf	Normal Saline Wet to Dry Dressing
Ms56.rtf	Ocular Medication Administration
Ms57.rtf	Ophthalmic Medication Administration
Ms58.rtf	Oral Care of the Cancer Patient
Ms59.rtf	Patient Controlled Analgesia (PCA) Infuser
Ms60.rtf	Peripheral Blood Draw
Ms61.rtf	PICC Line – Applying a PRN Adapter
Ms62.rtf	PICC Line – Obtaining Blood samples
Ms63.rtf	PICC Line – Removing the PICC
Ms64.rtf	PICC Lines – Starting and Discontinuing an Infusion
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Ms75.rtf	Skin Burn – Care of
Ms76.rtf	Skin Prep Using Tincture of Iodine
Ms77.rtf	Staple.Clip Removal
Ms78.rtf	Sterile Gloves, Applying
Ms79.rtf	Sterile Technique
Ms80.rtf	Subcutaneous Needle Placement
Ms81.rtf	Tenckhoff Catheter
Ms82.rtf	Tissue Therapy

Ms83.rtf	Tracheal Suctioning
Ms84.rtf	Tracheostomy Care
Ms85.rtf	Tracheostomy Tube Dislodgement, Emergency Intervention
Ms86.rtf	Transfer of Patient with Cervical Surgery and Patient with Shoulder Surgery
Ms87.rtf	Transfer Patient with Lumbar Surgery
Ms88.rtf	Transfer, Transport, Ambulation
Ms89.rtf	Transportation of Postcatheterization Patients
Ms90.rtf	Tuberculosis Skin Test
Ms91.rtf	Urinary Catheterization
Ms92.rtf	VAC: Negative Pressure Wound Therapy
Ms93.rtf	VACD (Vacuum Assisted Closure Device for Negative Pressure Wound Therapy)
Ms94.rtf	Venous Reflux Exam
Ms95.rtf	Ventilator , Assessment and Troubleshooting
Ms96.rtf	Vital Signs (Observation Room)
Ms97.rtf	Weights/ Height – Digital
Ms98.rtf	Wound Culture
Ms99.rtf	Wound Photography
Ms100.rtf	Zoladex, Subcutaneous Injection of

Obstetrics:

Ob1.rtf	Breastfeeding - Initiating
Ob2.rtf	CRIES Score
Ob3.rtf	Electronic Fetal Monitoring Placement
Ob4.rtf	Fetal Scalp Electrode Placement
Ob5.rtf	Flourescein
Ob6.rtf	Gestational/Pregnancy Diabetes Education
Ob7.rtf	Infant Oxygen Administration
Ob8.rtf	Intrauterine Pressure Catheter Placement
Ob9.rtf	Kick Count Records, Instruction Patient on Keeping
Ob10.rtf	Labor and Delivery Labor Support
Ob11.rtf	NEO Crash Cart
Ob12.rtf	Neonatal Echocardiographyy
Ob13.rtf	Nursing Care of Patient on Bedrest
Ob14.rtf	PIH Routine (Retroscpective Chart Review)
Ob15.rtf	Prenatal Risk Assessment
Ob16.rtf	Rhythm – OB
Ob17.rtf	Scrubbing for Ceasarian Section and Tubal Ligation
Ob18.rtf	Special Care Nursery Pulse Ox Monitor
Ob19.rtf	Speculum Exams – L&D Triage
Ob20.rtf	State Metabolic Screen
Ob21.rtf	Suctioning of the Neonate RN/RT
Ob22.rtf	Vaginal Examination
Ob23.rtf	Weight Scale

Operating Room:

Or1.rtf	Assisting with Flexible Sigmoidoscopy
Or2.rtf	Autoclave Biological Gravity
Or3.rtf	Autoclave Biological PREVAC
Or4.rtf	Cryotherapy
Or5.rtf	Cusa Cavitron Use of on Surgical Procedure
Or6.rtf	Electro-Surgical Unit
Or7.rtf	Identification of Blood in Operation Room
Or8.rtf	Intraoperative Echocardiography
Or9.rtf	Proper Movement in OR (Nonsterile Person)
Or10.rtf	Safe Patient Positioning
Or11.rtf	Scope Cleaning: Endoscopy
Or12.rtf	Setting Up and Troubleshooting Electronic Controlling Devices (ECD)
Or13.rtf	Steris Biological, Competency Test for
Or14.rtf	Transesophageal Echocardigraphy
Or15.rtf	Transporting Inpatients to OR
Or16.rtf	Vital VUE

Role Related:

Role1.rtf	Acid Mixing
Role2.rtf	Adding Toner to Fax
Role3.rtf	Administrative Associate Accurate Charging
Role4.rtf	Admission to the Special Care Nursery
Role5.rtf	Appointment Scheduling – Diabetes Center
Role6.rtf	Age-Specific Competency Checklist RN/LPN
Role7.rtf	Age-Specific Competency Checklist SA/AA
Role8.rtf	Behavioral Health Associate Skills Assessment/Evaluation
Role9.rtf	Bicarb Mixing
Role10.rtf	Charge Entry
Role11.rtf	Charge Nurse Assessment/Evaluation
Role12.rtf	Defibrillator Function — Daily Check (Lifepak 9)
Role13.rtf	Discharge Bed/Bassinette Cleaning for Environmental Associates
Role14.rtf	EMS Phone Orientation
Role15.rtf	Handling Contaminated Delivery Instruments – Support Associates
Role16.rtf	Hospital Outpatient Profile (HOP) Charges
Role17.rtf	Insurance Precertification Authorization
Role18.rtf	LPN Skills Assessment/Evaluation
Role19.rtf	Nursing Assistant Orientation Skills Assessment/Evaluation
Role20.rtf	Nursing Student Technician Competency Checklist
Role21.rtf	Private Duty RN/LPN Competency Evaluation
Role22.rtf	Protocol for Cleaning Delivery Rooms
Role23.rtf	Registration
Role24.rtf	RN Skills Assessment/Evaluation
Role25.rtf	Sitter Guidelines

Role26.rtf	Telephone Skills
Role27.rtf	Telephone Skills (Problem Solving)
Role28.rtf	Unit Secretary Skills Assessment/Evaluation
Role29.rtf	Women's Health Infant Safety Abduction Code Pink

To adapt any of the files to your own facility, simply follow the instructions below to open the CD.

If you have trouble reading the forms, click on "View," and then "Normal." To adapt the forms, save them first to your own hard drive or disk (by clicking "File," then "Save as," and changing the system to your own). Then change the information to fit your facility, and add or delete any items that you wish to change. Installation instructions

This product was designed for the Windows operating system and includes Word files that will run under Windows 95/98 or greater. The CD will work on all PCs and most Macintosh systems. To run the files on the CD/ROM, take the following steps:

1. Insert the CD into your CD/ROM drive.

2. Double-click on the "My Computer" icon, next double-click on the CD drive icon.

3. Double-click on the files you wish to open.

4. Adapt the files by moving the cursor over the areas you wish to change, highlighting them, and typing in the new information using Microsoft Word.

5. To save a file to your facility's system, click on "File" and then click on "Save As." Select the location where you wish to save the file and then click on "Save."

6. To print a document, click on "File" and then click on "Print."

Introduction

The focus on competence and evidence-based practice (EBP) is pervasive in healthcare today. Not only do the various regulatory agencies require assessment and documentation of competence of staff members, but the expectation is that organizations use evidence-based practice to provide quality care.

EBP is the process of making clinical decisions based on the most current and valid research and high-quality data available, with the goal of improving patient safety and decreasing the number of medical errors (Avillion 2007).

The second edition of this book includes the evidence for all the competencies that are provided. It should not be assumed that the competencies in the first edition were not based on current literature or evidence, but that information was not included on the competency itself. In this edition, the evidence base for each competency is included as part of the competency itself.

For the second edition, information in all the chapters has been updated to provide current resources on the competency management process. Chapter 1 outlines why competency validation is required, Chapter 2 defines competency validation, and Chapter 3 discusses including information on why competency validation should be a part of job descriptions and the performance-evaluation process. Chapter 4 focuses on the training needed for staff to perform competency validation, and Chapter 5 provides suggestions on keeping up with new competencies. How to use the skills checklists is described in Chapter 6.

There are 235 competency validation skills sheets included in this edition. Some of the skills in the first edition were deleted and others were added based on current practice and best evidence. In addition to the categories included in the first edition (general, medical-surgical, intensive care unit, emergency room, obstetrics, and operating room) there is another category added for general checklists that are role-related. These bonus checklists focus on specific skills required of various care providers, so these do not include references. The checklists can be adapted for the specific needs of your organization.

I hope you find the information in this second edition helpful whether you are developing a competency management program or refining ones you currently have in place.

REFERENCES

1. Avillion, Adrianne E. (2007). *Evidence-Based Staff Development: Strategies to Create, Measure, and Refine Your Program*. Marblehead, MA: HCPro, Inc.
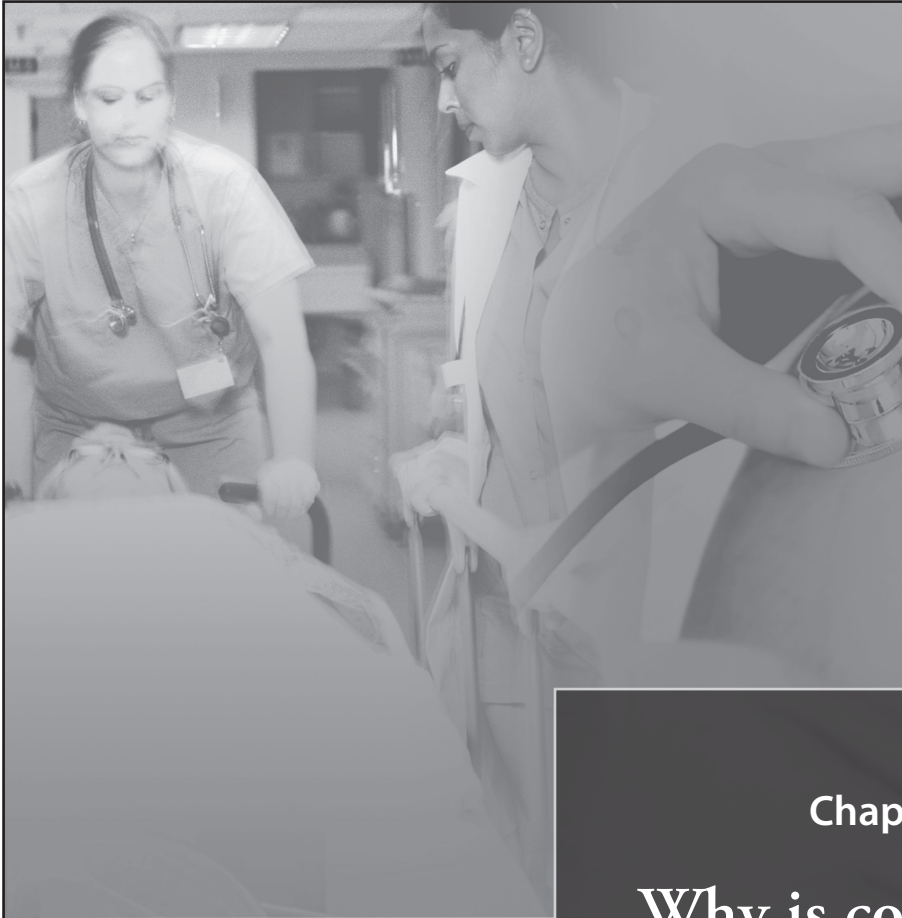
Chapter 1

Why is competency validation required?

> # Why is competency validation required?

Learning objectives

After reading this chapter, the participant should be able to:

- Design a competency plan to effectively assess employee competence

Regulating competence

Does it seem as though regulatory survey teams visit you every day? Sometimes the survey is announced and sometimes it's a surprise, but every time, the surveyors—regardless of whom they represent—are concerned about "competency."

The definition of this word is in the eye of the beholder. *Webster's New World College Dictionary*, for instance, defines *competent* as "well qualified, capable, fit" (Agnes 2006). The American Nurses Association (ANA) defines *competency* as "an expected level of performance that results from an integration of knowledge, skills, abilities, and judgment" (ANA 2007). In healthcare, however, it's not so simple. Your healthcare staff make decisions and carry out responsibilities and job duties that affect patients' lives. When the goal is to achieve positive patient outcomes—whether to cure or manage a chronic disease process, or to allow someone to die a dignified death—will "sufficient ability" be good enough? Should competency apply only to clinical bedside nursing? Should an RN case manager have to meet the same competency requirements as a critical-care staff nurse? No, no, and no.

Evidence-based practice involves supporting your actions with research and data, and basing competencies in evidence is becoming the standard in competency validation. Researchers have identified best practices for patient care based on evidence, so when assessing staff members' competence, they should be assessed based on their provision of evidence-based care. By instituting evidence-based practice in your competency assessment, you ensure the methods by which you are validating your staff members' skills are established and grounded in research. In this book, you are provided with references to the original research so you are able to institute evidence-based competency assessment at your facility.

Protecting the public

Regulatory agencies are rampant in the healthcare industry. Their purpose is to protect the public and to ensure a consistent standard of care for patients and families. Initially, there was only the Joint Commission on Accreditation of Hospitals (JCAH). Ernest Codman, a physician, proposed the standardization process for hospitals in 1910, and the American College of Surgeons developed the Minimum Standards for Hospitals in 1917 and officially transferred its program to the JCAH in 1952. A trickling of new agencies followed, and in 1964, the JCAH started charging for surveys. JCAH changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1987 and is now known simply as The Joint Commission (The Joint Commission 2007).

The list of regulators today now looks like an alphabet soup. Political debates regarding the effectiveness of these agencies have multiplied in recent years. In July 2004, for example, the Centers for Medicare & Medicaid Services (CMS) began to criticize the validity of Joint Commission accreditations. However, since its inception, The Joint Commission has never had federal oversight (Knight 2004). In some cases, criteria for federally mandated CMS regulatory standards may exceed those of The Joint Commission.

For acute-care facilities, the agencies that "oversee" patient care and thus require competency assessment may now include the following:

- The Joint Commission

- CMS

- National Quality Foundation

- The Leapfrog Group

- State departments of health and human services

- State medical foundations

- ANA

- State Board of Nurse Examiners (BNE)

- Health Quality Improvement Initiatives

- Occupational Safety & Health Administration (OSHA)

- College of American Pathologists (CAP)

- Office of Inspector General

- Quality improvement organizations

- Agency for Healthcare Research and Quality

- The U.S. Food and Drug Administration

- Centers for Disease Control and Prevention (CDC)

Add to this a list of your hospital's competency assessment initiatives. Most of these initiatives revolve around the mission, vision, and value statements for the organization. Indicators may include:

- Patient satisfaction

- Physician satisfaction

- Employee health and pride

- Fiscal responsibility

- Community involvement

- Risk management

Those of us working in healthcare started our careers wanting to improve human life, and it is frustrating at times when it seems that the bureaucracy of regulatory mandates keeps growing. But the business of healthcare must consist of personnel who are both caring and able to perform their jobs safely and correctly. Remember that the provision of quality care and services depends on knowledgeable, competent healthcare

providers. Every organization should have a competency plan in place to ensure that performance expectations based on job-specific position descriptions are consistently met.

You must design your competency plan with consideration given to:

- The mission, vision, and values of your organization

- The needs of patients and families served

- The extended community

- New services or technologies planned for future services

- Special needs required for particular healthcare situations

- Current standards of professional practice

- Applicable legal and regulatory agency requirements

- Organizational policies and procedures

In addition, the organization should foster learning on a continual basis. The CEO and nurse executive should mandate this learning environment and hold the leadership team and staff accountable for expected outcomes (Joint Commission Resources 2008). The entire organization must foster a work environment that helps employees discover what they need to learn for self-growth.

What's the return on this investment? A positive patient/family outcome. The outcome may be improved health, the ability to manage a chronic disorder, or even a dignified death.

A consistent process for competency assessment is essential throughout the organization for all job classes, contract personnel, and, when indicated, affiliating schools. There must be a centralized, organized approach that moves seamlessly throughout the continuum of care and ensures the same standard or practice for all of the patients and families it serves. If your main policies and procedures say one thing but certain departments or units develop their own policies and procedures that say something else, you are in trouble.

Generating tons of paperwork does not ensure competency in practice. Use the KISS method: "Keep it simple, smarty." Although documenting that standards are being met is important, regulatory surveyors are

moving away from looking at paper. The trend is to interview patients, staff members, physicians, vendors, and members of the leadership team to see evidence of compliance. And now more than ever, there are expectations to move beyond merely verifying whether nurses are "competent." Thanks in part to advances in technology, nurses have been catapulted into more advanced and specialized care. Entire nursing divisions in hospital settings may now apply for American Nurses Credentialing Center (ANCC) Magnet Recognition Program® designation. Designations such as this and the Malcolm Baldrige National Quality Award are raising the bar for practice by empowering nurses to demand excellence in delivering care.

Instead of telling you months in advance the date on which it will arrive at your hospital, the regulatory agency may show up at your door at any time without advance notice. In fact, Joint Commission surveyors began doing so in 2006. Therefore, it is vital for you and your organization to be survey-ready every day. Ongoing performance must be measured and assessed. If individual members of your healthcare organization do not meet the standards you've established, individuals and the leadership team must develop a system for ongoing validation and assessment of personnel based on those standards. Remember: Competency assessment would be necessary even if it were not an accreditation standard.

It is worth framing this discussion on the expectations of regulatory agencies, because understanding their motivations and complying with their recommendations will result in a better understanding of what an effective competency assessment process should look like. What do these regulatory agencies want? In our upcoming discussion of The Joint Commission, we will also introduce the concepts of other state and federal agencies.

The Joint Commission

The Joint Commission is still considered to be the leader in healthcare accreditation. Standards devoted to competency are woven through The Joint Commission's accreditation manual, from the leadership chapter to the environment of care chapter. It uses elements of performance (EPs) to determine hospitals' compliance with standards. The Joint Commission's 2008 HR standards listed in the following section summarize its expectations for competency (Joint Commission Resources 2008).

Standard HR.1.20

A staff member's qualifications are consistent with his or her job responsibilities.

This requirement pertains to staff members, students, and volunteers who work in the same capacity as staff members who provide care, treatment, and services. This also includes contract staff members.

It seems simple enough, doesn't it? Steve Doe applies to be an emergency department (ED) staff RN. HR representatives compare what Steve Doe put on his application to the RN job description for an ED staff nurse to determine whether he meets the qualifications for the position. The criteria on the job description state, "Licensed RN in the state of Texas. Minimum of two years recent clinical experience in an ED required. Current card in basic life support for healthcare providers, advanced cardiac life support, and pediatric advanced life support required. Certified emergency nurse preferred." Steve Doe had better meet these requirements.

As we indicated in the Preface, the process for verifying these credentials is of utmost importance to the safety of your patients. Your organization needs a system to ensure that your nurses are who they say they are and have the experience and documentation to back it up. A surveyor may ask an ED nurse (who happens to be Steve Doe), "What is required to work in this department?" The nurse tells the surveyor what was required for his position. The surveyor may then ask for an ED staff RN job description as well as Steve's file to see whether the hospital did indeed verify that all the screening requirements were met and that there is a record indicating that the requirements are still being met.

Standard HR.2.10

The hospital provides initial orientation.

The EPs establish that this standard applies to each staff member, student, and volunteer at your facility. The EPs encompass the following:

- Key elements of orientation that must occur before staff members provide care

- Orientation of the staff to identified key elements prior to providing care

- The hospital's mission and goals

- Organization- and relevant unit-, setting-, or program-specific (e.g., safety and infection control) policies and procedures

- Specific job duties and responsibilities and unit-, setting-, or program-specific job duties related to safety and infection control

- Cultural diversity and sensitivity

- Patient rights and ethical aspects of care, treatment, and services and the process to address ethical issues

In addition, the forensic staff (i.e., police who bring in prisoners) must know how to:

- Interact with patients

- Respond to life safety codes

- Communicate through appropriate channels

- Define their roles in clinical seclusion and restraint

It is expected that, during orientation, the hospital assesses and documents the competency level of the new hire so that by the end of orientation the person is deemed competent (sample orientation competency assessment tools for an RN and nurse assistant appear in Chapter 6). This standard highlights the fact that competence in nursing is not a one-size-fits-all arrangement. Although your ability to synthesize your competency assessment practices across your entire organization will ultimately determine your success, you must be able to customize your tools and process to their intended audience. However, keep in mind that the organization is not expected to shoulder this responsibility alone. Provision 5.2 under the ANA's Code of Ethics 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" (ANA 2001).

As a result, state BNEs' rules and regulations may dictate competency expectations. These regulations vary, but many discuss competency pertaining to:

- Role delineation for "respondent superiors" (i.e., adult nurse practitioners, licensed practical nurses, licensed vocational nurses, new grads, and unlicensed personnel)

- Scopes of practice for patient care

- Peer review

- Informed consent

- Medication administration

- Pain management (including epidurals)

- Conscious sedation/analgesia

- Patient/family education

- Blood administration

- Population-specific care

Standard HR.2.20

Staff and licensed independent practitioners, as appropriate, can describe or demonstrate their roles and responsibilities relative to safety.

The EPs for this standard include:

- Risks within the hospital environment

- Actions to eliminate, minimize, and report risks

- Procedures to follow in the event of an adverse event

- Reporting processes for common problems, failures, and user errors

This standard coincides with the introduction of the National Patient Safety Goals (NPSGs) and new requirements by The Joint Commission. The NPSGs are derived from a sentinel event advisory group, and the requirements are generally more prescriptive than other Joint Commission requirements. They are based upon aggregate data following national trends of sentinel patient events. As of January 1, 2005, The Joint Commission began to incorporate NPSGs into the accreditation survey (Joint Commission 2007). The NPSGs highlight the link between competent patient care and safety. To fulfill your hospital's mission of delivering safe patient care, there is significant value in validating healthcare professionals' competencies associated with these goals.

Also note that licensed independent practitioners (LIPs) have been included in HR.2.20. An LIP is some-one who is authorized by law and the hospital to "provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges" (Joint Commission Resources 2008). LIPs give medical orders for patient care. The individual is credentialed through the hospital medical staff committee.

2008 National Patient Safety Goals

Goal #1. Improve the accuracy of patient identification.

- Use at least two patient identifiers when providing care, treatment, or services

Goal #2. Improve the effectiveness of communication among caregivers.

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read back" the complete order or test result

- Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization

- Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical tests and critical results and values

- Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions

Goal #3. Improve the safety of using medications.

Look-alike, sound-alike names for medications and concentrated electrolyte drug concentrations are sentinel events waiting to happen. Studies have been initiated regarding the advent of computer-based medication administration to improve the safety of such medications. For example, bar code scanning, the latest technological advance, may decrease medication errors. But with this new technology comes a new set of competencies. These competencies must be validated before care is initiated with the new technology, and your assessments must be ongoing. In addition, this goal expects you to:

- Identify and review at least annually look-alike, sound-alike drugs used in the organization

- Label all medications, medication containers (e.g., syringes, medicine cups, and basins) or other solutions on and off the sterile field

- Reduce the likelihood of patient harm associated with anticoagulation therapy

Goals #4–6. Not applicable.

Goal #7. Reduce the risk of healthcare-associated infections.

This includes:

- Compliance with World Health Organization or CDC hand hygiene guidelines

- Managing all cases of unanticipated death or loss of function from a healthcare-associated infection as a sentinel event

OSHA mandates competency in maintaining health requirements for those working in healthcare facilities. These OSHA competencies must be validated. Tuberculosis testing, use of personal protective equipment, use of needless systems, latex allergy requirements, and so on stress the need for those involved in direct patient care to be competent in delivering that care to your patients.

Goal #8. Accurately and completely reconcile medications across the continuum of care.

A process must be developed for obtaining and documenting a complete list of current patient medications—with the involvement of the patient—upon admission. The process includes a comparison of the medications the organization provides to those on the list. This list is communicated to the next provider of service upon transfer or referral within or outside of the organization and is provided to the patient on discharge from the organization. Goal #8 requires interpersonal communication and listening skills, competencies that are challenging but not impossible for your organization to validate.

Goal #9. Reduce the risk of patient harm resulting from falls.

For this goal, the organization must implement a fall reduction program, including an evaluation of the effectiveness of the program. Staff members, patients, and families must be educated on the fall reduction program.

Goals #10–12. Not applicable.

Goal #13. Encourage patients' active involvement in their own care as a patient safety strategy.
The organization must define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. When patients know what to expect, they are more aware of possible errors and choices. Patients can be an important source of information regarding potential adverse events and hazardous conditions.

Goal #14. Not applicable.

Goal #15. The organization identifies safety risks inherent in its client population.

- The organization identifies clients at risk for suicide

Goal #16. Improve recognition and response to changes in a patient's condition. (Note: this requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing ["milestones"] at three, six, and nine months in 2008, with the expectation of full implementation by January 1, 2009.)

- The organization selects a suitable method that enables healthcare staff members to directly request additional assistance from one or more specially trained individuals when the patient's condition appears to be worsening

- Formal education for urgent response policies and practices is conducted with the people who may request assistance and the people who may respond to those requests

Many organizations have implemented Rapid Response Teams to meet this standard. Early response to changes in a patient's condition may reduce cardiopulmonary arrests and patient mortality.

The list of NPSGs will probably lengthen with time. However, using evidence-based practice and benchmarking, facilities with the best-practice data to reduce risk and enhance patient safety will continue to drive competency in practice in the future.

Standard HR.2.30

Ongoing education, including inservices, training, and other activities, maintains and improves competence.

With this standard, The Joint Commission expects that measuring competency at your organization is an ongoing process. In other words, it isn't enough for you to assume that your system for validating competencies at orientation will cover your employees for the length of their employment. EPs for this standard expect:

- Training to occur when job responsibilities and duties change (e.g., when an ED nurse transfers to the neonatal ICU [NICU] but has never worked in a NICU setting).

- That participation in ongoing training will increase staff, student, or volunteer knowledge of work-related issues.

- Ongoing education to be appropriate to the needs of the population(s) served, safety, and infection prevention and control, and to comply with laws and regulations.

- Staff members to know how to manage and report unanticipated events.

- Inservices and staff education to incorporate methods of team training, when appropriate.

- That learning needs to be identified through performance improvement findings and other data analysis. Education is planned, implemented, and evaluated for effectiveness.

- Documentation of ongoing staff education.

Most state boards of nursing mandate continuing education requirements for nurses who apply for relicensure. Hospitals striving for recognition through the ANCC Magnet Recognition Program® are required to foster an environment of continual learning for their nursing staff or risk losing their designation. This standard underlines the need for ongoing education and competency validation at your organization.

Standard HR.3.10

Staff competence to perform job responsibilities is assessed, demonstrated, and maintained.

Once again, this standard stresses that competency assessment be an ongoing process. An EP for this standard may be point-of-care testing (POCT) for the CAP. For example, for CAP accreditation to be main-

tained, staff members must be competent to perform POCT (CAP Web site). This testing goes beyond knowing how to do a fingerstick test for blood-glucose testing. CAP wants to know who is allowed to do POCT. Are staff members involved in quality control testing and documentation as defined by hospital policy? What tests are allowed to be performed outside of the main hospital laboratory, and what areas are allowed to do what? Examples of POCT that may need to be validated include (but may not be limited to):

- Hemacult

- Urine dipstick

- Nitrazine pH

- Blood glucose

Competency and litigation

Regulatory agencies and legal issues are conjoined in HR.3.10. What is the link? Competency assessment is "systematic and allows for a measurable assessment of the person's ability to perform required activities" (Joint Commission Resources 2008). The EPs do not say that you have to use a certain form or have a certain methodology, but you do have to use a systematic measurable process.

In addition, whoever assesses competency must be qualified to do so. The leadership team must know the qualifications of the staff members caring for the patient population served and is accountable and responsible for maintaining a competent staff. For example, an ED nurse cannot deem another ED nurse competent in managing an overdose patient if the "assessor" has managed only one overdose patient. Peer review is critical to competency assessment, but careful consideration must be given to the process.

Plaintiffs' attorneys in legal cases use expert witnesses to verify issues related to competency. For example, the expert ED nurse called on the case of an overdose patient may manage several overdoses every day. This credible witness likely embodies the standard for excellence and competency in practice. If the patient had a negative outcome following a gastric lavage, the expert may be able to dispute the defendant organization's method used to measure competency of ED staff nurses caring for overdose patients.

Case study
Surveyors tracing for competent care

The staff members at Healthcare Hospital are in their second day of a four-day Joint Commission survey. Wanda, the nurse surveyor, is in the critical-care unit (CCU) focusing on a tracer patient named Mrs. D., who was admitted from the ED. Mrs. D. tried to commit suicide in the ED. She was lavaged for her overdose, intubated, and transferred to the CCU.

The Joint Commission's tracer methodology strives to ensure that the same standard of care is used throughout the facility by retracing the care delivered to sample patients (or tracers), so Wanda asks the nurse manager to gather three caregivers associated with this patient's case. She also requests that she pull their personnel files because Wanda wants to first ask these nurses various questions regarding the care the patient received and their competency to deliver that care. Then she'll verify whether accreditation standards have been met by reviewing their files. The three employees are:

- A new graduate who is going through a critical-care internship

- An RN with 25 years of experience in critical care

- A certified nursing assistant (CNA) who is a foreign nurse preparing to sit for the boards in the United States

Wanda also wants to review the nurse manager's file to verify that she meets the competency standards required of her as a member of the leadership team at this facility; she wants to know what training she has had to become a leader. Wanda then proceeds to walk around the unit and delves further into the standards for hospital accreditation.

Based upon federal and state regulatory requirements discussed in this chapter, can you think of some of the important questions Wanda will ask the staff, physician, patient (if this vented patient can participate), and family?

Wanda may ask whether the new graduate is competent to take care of a ventilator patient. If so, how was that validated? If she is not competent, what is the action plan? If the nurse with 25 years of experience is her preceptor, how was she deemed competent? Can the CNA, who is a nurse in her country of origin, interpret the monitor strips correctly?

How would Wanda ensure the timely and accurate assessment of competencies for these personnel? Could she pull job descriptions? Performance evaluations? Competency checklists, or skill sheets? Is your organization ready for that?

Your organization must ask itself, "Are the right people taking care of the right patients for the right reasons?" Consider the following:

> **The decline of standards**
>
> A big-city school system requires a student in the seventh grade to be able to read as well as a fifth grader, who must be able to read as well as a fourth grader, who, in turn, must be able to read as well as a third grader. What's wrong with demanding that a seventh grader be required to read like a seventh grader? How would you like to be operated on by a brain surgeon who graduated from a school that allowed its students to be a year and a half behind in their skills?
>
> —*Author unknown*

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