

The development of a pre-registration nursing competencies assessment tool for use across Australian universities

Final Report 2010

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The *Pilot guidance package: competency assessment tool – nursing* is available on the ALTC's website, <www.altc.edu.au>



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Executive Summary

Debate about the lack of consistency in the competency of nursing graduates has gained momentum in recent years. In part, this stems from disparities in clinical assessment tools in use across Australia's 39 nursing schools to evaluate graduates' readiness for nurse registration. But it has also thrown up issues around the nursing profession's expectations of new graduates and how prepared they are for practice.

The following report is the culmination of a project to address some of these issues by developing a new nationally-agreed competency assessment tool for nursing graduates. The tool applies to Australian universities with nursing programs that lead to eligibility for nurse registration in all states and territories.

Project outcomes and impacts

The tool will have three important impacts on the profession by:

- clearly articulating the competencies and assessments of the Australian Nursing and Midwifery Council (ANMC) to promote quality of care and public safety
- providing a standardised tool that enables benchmarking and evaluation to embed robust, valid and reliable work-based learning in practice
- reducing the plethora of competency assessment tools in current use, with concomitant reductions in confusion and workloads for assessors.

The skill areas and competency assessments identified in the report will facilitate ongoing skills development for nurses. These will provide a framework for universities to structure theory, theory-simulation and practice in a consistent way across nursing programs.

The project outcomes enable tools to be embedded in nursing programs to develop competence and clinical skills throughout the duration of those programs. It also provides a lifelong learning framework or schedule for nurses to use throughout their careers as they acquire and apply new competencies.

Approach and methodology

The project team undertook an analysis of curriculum documents, competency assessment tools and skills taught within universities in Australia (n=36) and a review of the relevant literature. The information from these analyses formed the basis of two key approaches. An expert group reviewed the sampling frame. The skills list from the universities was refined using their expertise. The Modified Delphi rounds were then used to refine and clarify the skills areas circulated to nearly 800 nurses over two rounds. Both the literature and the ANMC National Competencies for the Registered Nurse (2006) were used to refine the data down to the final 21 skills areas.

The modified nominal groups explored and refined exemplars of the ANMC competencies. This was undertaken to enable an agreed approach to their interpretation that can readily be used for assessment by clinicians in practice.



This project has advanced existing knowledge through:

- the development of a number of exemplars and supportive guidance for assessors of clinicians in practice with regard to the interpretation of the ANMC National Competencies for the Registered Nurse (2006)
- the identification of skills that an entry level practitioner could reasonably be expected to demonstrate in clinical areas.

Thirty-nine universities delivered eligibility to practice nursing programs in Australia in 2010. That number suggests there are likely to be variations in the curricula delivered, the range and complexity of skills taught and the assessment of practice tools used. The findings in this study support that view. The challenge therefore is to identify a set of clinically-based skills and a competency assessment schedule that are readily transferrable to all institutions.

The profession: the Council of Deans of Nursing and Midwifery (Australia and New Zealand) (CDNM); the ANMC Professional Reference Group; the chief nurses of states and territories; and practitioners in the field; has been, and continues to be, very positive about this work. There are, however, variations in the way institutions have developed skill sets and assessment tools. Their comments on the tools illustrate a number of concerns which will be explored during the piloting and benchmarking process.

Dissemination of the resources developed

The tools were shared with the key stakeholders in nurse education and practice across Australia, namely the CDNM, the ANMC Professional Reference Group and the chief nurses of Australia and New Zealand. The project team has undertaken a series of roadshows in a number of states and territories.

The project team is aware that the tools developed through this project are yet to be benchmarked. However, a pilot by the initial reference group will provide clarity on the use of the tools as well as guidance on how to facilitate their implementation and operation. The resolution of some of these issues will be identified once the reference institutions pilot the tools alongside their existing tools. More thorough benchmarking is intended to be undertaken using an Australian Learning and Teaching Council (ALTC) funded project which, if funded, will facilitate validation across institutions in Australia. Interest from some international partners may expand the work further afield.



1.0 Introduction

Each Australian university nursing school has its own clinical assessment tool for evaluating the competency level of pre-registered nursing students (although the title of this report indicates undergraduate students, it is more appropriate to refer to pre-registered nursing students). This lack of parity creates the potential for different outcomes for newly registered nurses within and between programs. The current project presents a nationally-agreed competency assessment schedule for pre-registered nursing students across Australia. The schedule encompasses the regulatory competencies mandated by the Australian Nursing and Midwifery Council (ANMC) – the ANMC National Competencies for the Registered Nurse (2006) – as well as employer competencies (Allen, 2000). The tool has the potential to be implemented in Australian universities to assess pre-registration nurses.

2.0 Background and Rationale

The nursing profession's expectations of newly registered nurses (RNs) has been a topic of debate in recent years. Some clinically-based nurses have asserted that graduates are not competent in key areas. To some degree this view stems from the shift in 1985 from hospital-based nurse education to the education of nurses in universities, one of the aims of which was to give nurses the same professional status as other tertiary-educated healthcare professionals. At this time the curriculum changed to accommodate the academic structure and accreditation of higher education nursing programs as well as state and territory nursing boards. It also led to a reduction in the amount of time nursing students spent in practice. This appears to have led to the notion that a newly registered university-educated nurse is therefore less able in practice.

Experienced nurses cite a lack of work readiness and lack of technical nursing skills such as drug administration and wound care among their newer colleagues. In other words they believe that many new nurses do not 'hit the ward running' and cannot therefore be relied upon as fully-fledged members of the RN team from day one, to carry a patient load in the typical patient allocation model of care. It is important to note that these critics refer to "employer competencies" not "regulatory competencies" (Allen 2000).

The Australian Nursing and Midwifery Council (ANMC) is the peak national nursing and midwifery organisation. The ANMC National Competency Standards for the Registered Nurse (subsequently referred to as the ANMC Competencies in this report) are the requirements for RNs to obtain and retain their licence to practice (see Appendix 1). For an operational definition of competence the project uses the following statement from the ANMC Competencies:

The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.

ANMC 2006:8

A further common complaint is that new nurses do not have adequate time management skills and have difficulty managing the competing priorities of a complex patient load as effectively as their more experienced colleagues. Although



time management is often referred to as a basic skill, the project leaders contend that managing a patient load (particularly if not guided by more senior colleagues) is anything but basic. Rather, time management is complex and requires insights into the many personal and clinical needs of the patient group and their relatives. It also requires an understanding of the routines and expectations of the clinical area in which the care is being delivered.

It is not surprising, therefore, that newly registered nurses are seen as lacking in competence – not only by others, but sometimes by themselves – because expectations are too high. These high expectations could be the result of two major factors: 1) the roles of new RNs and those of experienced RNs are not adequately defined and 2) entry level practitioners are found in all areas of clinical practice. These two factors combined make it virtually impossible for new registrants to ‘hit the wards running’. It would be difficult for even an experienced RN to be able to do this, let alone a novice one. For example, specialist delivery units, such as critical care, have competency frameworks (ACCCN 2002) to enable entry level nurses and experienced nurses new to that area to develop focussed skills in a specific clinical setting.

The problem is compounded by the fact that each university nursing program in Australia has a unique clinical assessment tool for the skills and competencies of its pre-registered nursing students. While these are based on the ANMC Competencies they can focus on different technical nursing skills, thus providing scope for different graduate outcomes within and between programs. This lack of parity is difficult for clinical colleagues who are often called upon to take part in the clinical assessment of pre-registered nursing students from different universities. Ultimately the situation could lead to nursing students from different universities being in a clinical area at the same time but being assessed differently, a time-consuming and inefficient system.

The above factors indicate an urgent need for the development of a single nationally agreed competency tool for pre-registered nurses that builds on the ANMC Competencies and encompasses both regulatory and employment competencies (Allen, 2000). A systematic review of the literature (Crookes and Inoue, 2006) indicates a plethora of literature exists in relation to the nature of competencies and the history of the competency movement internationally. In recent years an increasing number of papers on competencies in specialist areas of nursing have been published. However, there has been limited work examining what newly graduating nurses should be able to do. Some work has been conducted in the UK (Royal College of Nursing, UK, 2005) and Canada (eg The College of Registered Nurses in Ontario, 2005; The College of Registered Nurses of British Columbia, 2006), but this tends to focus on the skills set aspect of the role or to retain the problems of the ANMC Competencies outlined above.

Interestingly, material from the UK’s Royal College of Nursing indicates that the basic grade of nurse in the UK, the Competent Nurse, is a newly qualified RN or an RN who has moved to a new area and will take up to 12 months to become experienced. In contrast, the materials from organisations in Canada are slightly unclear as they seem to imply that entry level nurses are in the midst of consolidating competencies.



2.1 Project Aims and Anticipated Outcomes

The current ANMC Competencies are in a form that makes consistent assessment difficult. There is no agreed skills repertoire to assess the competencies of new nursing graduates. Australian universities also use a variety of tools to assess nursing skills and competencies. Thus, the purpose of the present project is to design and develop a competency assessment tool (CAT) that can be used to assess nursing students across Australia, and to identify a skills list that can reasonably be expected of an entry level practitioner. The development of the assessment tool is based on:

1. the 2006 ANMC National Competency Standards for the Registered Nurse (see Appendix 1)
2. extensive consultations with nursing clinicians, managers and educators across Australia
3. the creation of a set of skills areas that could reasonably be expected of an entry level practitioner.

The project clarifies competencies in the context of nursing in Australia and identifies skills deemed essential to new RNs. The generic CAT schedule will be made available to all nursing schools across Australia and will encompass both the ANMC Competencies (Appendix 1) and employer competencies (Allen, 2000). The tool could also be used to underpin the assessment of overseas qualified nurses seeking registration in Australia or RNs returning to work after a significant break in service. With further evaluation and refinement, future curricula may be developed to complement this tool.

2.2 Project Team

Lead Institution: University of Wollongong

Partner Institutions:

- Curtin University
- Queensland University of Technology
- University of Technology Sydney
- University of South Australia

Other Organisations

- The Council of Deans of Nursing and Midwifery
- Australian Nursing and Midwifery Council Professional Reference Group
- Australian and New Zealand Council of Chief Nurses (ANZCCN)



Project Leaders

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Reference Group Members

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Curtin University
- Professor Denise Dignam
University of Technology Sydney
- Professor Helen Edwards
Queensland University of Technology
- Professor Helen McCutcheon
University of South Australia
- Professor Patrick Crookes
University of Wollongong
- Mr Roy Brown
University of Wollongong



3.0 Methodology

The methodology for this project comprised the following phases:

- | | |
|----------|--|
| Phase 1a | developing a set of employer competencies (technical skills) to be expected of all newly registering RNs |
| Phase 1b | more clearly articulating the ANMC Competencies as the basis for more consistent assessment in clinical areas (regulatory competencies). |
| Phase 2 | developing the Clinical Assessment Tool (CAT) based on the results from Phases 1a and 1b |
| Phase 3 | disseminating the tool. |
| Phase 4 | piloting the tool at partner institutions |

There is a longer-term vision beyond the scope of this project to further refine and evaluate the tool so that it can be successfully integrated into universities. This could proceed with a future ALTC grant or with the support of the National Health Workforce Taskforce/Health Workforce Australia.

Ethical approval for the project was obtained from the University of Wollongong's Human Research Ethics Committee (HE08/142).

The specific methodological approach for each phase of this project is described in detail below.

3.1 Phase 1a – Employer Competencies

3.1.1 Literature review and documentary analysis

Phase 1a was initially led by researchers at Curtin University and subsequently by the University of Wollongong team. This phase involved a two-pronged approach comprising:

1. a literature review of technical skills in nursing practice
2. an analysis of nursing curriculum documents from Australian universities.

The documentary analysis involved an audit of the lists of clinical skills outlined in the various curriculum documents of nursing schools in Australia. The documents were sought from the universities from late 2007 to June 2008 by direct email to the head or dean of school. The list of contacts was derived from the most current information from the Council of Deans of Nursing and Midwifery; the Chair and Executive reiterated to the membership that this request had the full support of the council. The email invited the contact information to be forwarded to the most appropriate individual within that organisation who could comply with our request. Shortfalls in submissions to the project team were followed up firstly by email, then via telephone if necessary. Most universities were helpful and compliant. A number of minor concerns were raised which were often resolved by email or by a telephone conversation. Initial analysis indicated a few shortfalls in data and so additional requests were made to those institutions. Compliance was excellent.



All curriculum documents were reviewed after which an inclusive list of clinical skills was developed by comparing the lists. Data regarding how and when these skills were taught and how and when they were assessed was also collected.

3.1.2 Modified Delphi rounds

The project then reviewed and aggregated the lists of clinical skills obtained through the documentary analysis into a single skills list. This was done by reducing repetition and grouping similar skills.

The initial plan was to use a Delphi survey, a technique that enables systematic and controlled refinement of expert opinion to arrive at consensus (Bowles, 1999). Delphi surveys ensure responses are anonymous, thereby reducing pressure on respondents to conform to dominant group attitudes (Bowles, 1999, Zhou, et al., 2001). Furthermore, because the aim of this project was to obtain input from all areas of nursing (experts in practice and academic settings, as well as students), the Delphi technique was considered to be ideal in effectively building bridges between participants from different fields within nursing (Bowles, 1999). An expert panel consisting of nurse educators and clinicians across Australia was therefore formed to identify an agreed list of reasonable expectations of clinical skills for newly registering nurses.

However, preliminary analyses indicated that the initial list of skills obtained from the documentary analysis was too large to be subject to a Delphi survey or to be reviewed by the expert panel. As a consequence, the initial methodological approach was revised and an expert group was instead convened to work on refining the skills areas using a theoretical framework (Anderson, 1991; Meretoja, 2004; Utley-Smith, 2004) and the ANMC Competencies. (Please see section 4.1.2 under Key Findings for how this was undertaken).

Once the list was refined to a manageable number of skills areas, the Delphi Survey was conducted on the refined list of skills areas. A diverse range of respondents and stakeholders were invited to participate in the Delphi surveys to ensure that the results were representative of, and applicable to, nursing across different settings in Australia (Henderson et al., 1990). Partnering institutions were asked to identify the relevant professionals in their respective jurisdictions, and to invite and encourage them to participate in the Delphi survey as a member of the expert panel. This role of in-state liaisons, incorporating existing contacts and initiating and developing new links, was essential to the success of the project and to the future use of the tool. As such, our survey was administered by an expert panel from a range of backgrounds, including nursing academics/educators, managers, clinicians, and newly registered nurses (RNs).

The Delphi process involved contacting people via email and inviting them to participate in an online survey. The Delphi process consisted of the following two rounds:

Round 1:

In this Modified Delphi round, the list of skills areas identified through the documentary analysis and refined by the expert group was circulated to relevant clinicians and academics throughout Australia using an online survey tool. For each skill, participants were asked to indicate whether they believed:

1. The skills area was grouped in the correct category (ie clinician, manager,



- communicator, researcher, educator)
2. The skills area was appropriate for a newly registering RN

Round 2:

In this Modified Delphi round, participants were again invited to participate in an online survey. In this round, participants were again presented with the list of skills areas and were asked to state the level of competency they would expect from a pre-registered nursing student in each year of their course. Participants provided their responses for each skill according to the modified Bondy Scale (1983) outlined below:

Dependent:	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.
Marginal:	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues required.
Assisted:	Refers to being safe and knowledgeable most of the time; skilful in parts, however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues.
Supervised:	Refers to being safe and knowledgeable; efficient and coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Independent:	Refers to being safe and knowledgeable; proficient and coordinated and appropriately confident and timely. Does not require supporting cues

The work of Bondy (1983) is used in 46 per cent of the assessment documents within entry to practice nursing programs surveyed. There are variations in some institutions, however, of those surveyed in the initial documentary analysis. The variations are minor in that the range is from Dependent (D) to Independent (I) above. A number of universities had used numbers to replace the initial examples being 0=dependent and 4=independent whereas others used 1 as independent and 5 as dependent. A number of universities used a simplified version similar to the one above. The original work of Bondy is lengthy which is why this shortened; revised version is suggested as an accurate alternative.

3.2 Phase 1b – Regulatory Competencies

Phase 1b was led throughout by the research team at the University of Wollongong (UOW) and was supported by each partnering institution. This phase involved the UOW research team updating an existing systematic review of the literature on competencies and competency assessment (Crookes and Inoue, 2006 unpublished).

An audit of the current (pre-registered nursing) clinical assessment tools used across Australia and New Zealand was then undertaken and expanded to include



other relevant disciplines, such as speech pathology and physiotherapy (Dalton, Keating and Davidson, 2009; Ferguson, 2008). This included:

- defining 'what' competency is
- examining 'how' competency is assessed
- investigating the tools used to drive (or measure) the assessments.

The project team members then developed a draft ANMC assessment tool, annotated with potential means of assessment. This tool was refined based on consultations with an expert panel using a modified Nominal Group Technique (NGT). The NGT was considered an appropriate approach as it is designed to facilitate collaborative and democratic decision making (Delbecq, Van de Ven & Gustafson, 1975) using a structured meeting format to generate information and opinions about a predetermined topic from a group of experts.

Other benefits of the NGT (Nelson et al. 2003; Waddell and Stephens, 2000) include:

- balanced participation, which avoids issues caused by dominant individuals
- participants feeling less pressure to conform to a specific view
- the results are known at the end of the NGT meeting
- the approach is very flexible and can be used in a variety of situations.

The purpose of the NGT was for the groups to identify ways of assessing the ANMC Competencies (see appendix 1). To achieve this participants were asked to produce a list of exemplars based on their own experiences for each ANMC Competency, indicating how an assessor could be assured that a student has achieved competency for each ANMC competency. Participants were asked to consider the following in their responses:

- Observations: what would you need to see in practice?
- Questioning: what questions might you ask and what type of response would you expect?
- Measurement: is there anything that you are able to measure and record?

Participants were also asked whether the observations, questions or measurements would be most appropriately assessed through simulation, practice or a combination of both. Participants were also told that a 'good' exemplar should:

- signpost a clear direction that is competency related
- be a clear statement of specific desired competence
- contain no potential confusion
- encourage different pathways to solutions
- provide clear criteria to judge value of achievement
- galvanise professional thinking/activity across the competencies.

The NGTs were conducted in each jurisdiction of the partnering institutions and most states and territories within Australia (see Appendix 2) to reach a national consensus on relevant exemplars for the ANMC Competencies in a manner that allowed all participants to actively participate. The role of the group was to identify,



clarify, evaluate, and prioritise each exemplar.

Based on the process identified by O'Neil and Jackson (1983), this phase of the project involved:

1. Briefly reviewing the intended outcomes of the meeting and ensuring that the process was followed to achieve those outcomes.
2. Participants generating a list of exemplar assessments for a number of the ANMC Competency Standards for the Registered Nurse.
3. A strategy where each participant was asked to identify to the facilitator (by writing on post-it notes) his/her response to the exemplars for the first competency. The respondent then placed their response onto butchers paper; there was no discussion at this point.
4. After all participants had an opportunity to state their ideas through this method, a discussion was facilitated for each competency that incorporated:
 - clarifying the comments
 - reaching consensus on whether the exemplar did indeed assess the competency
 - discussing each idea that was not considered to be assessing the competency to determine how it could be modified to do so.
5. The results were organised along themes by the group with support from the facilitator, and the final outcome was discussed.

It is our view that via an amalgamation of the literature and reported best practice, plus the use of modified NGT groups, our approach produced a tool and a process that provided an accurate, reliable and valid assessment of the ANMC Competencies.

3.3 Phase 2 – Linking Phases 1a and 1b Together

Phase 2 was led by Roy Brown (UOW) and comprised:

- Sending reference group members the skills areas and inviting them to discuss how the skills areas might inform the ANMC Competencies and vice versa.
- Editing the final tool, based on input from the project team and expert groups.

The responses from the partnering institutions enabled discussion about the skills areas and how they informed the ANMC Competencies and vice versa. The topics included, for example, addressing care planning skills (listed in the ANMC Competencies) as these need to be overtly assessed in practice. The project reference group then discussed and edited the final tool based on this input.

The results of phases 1a and 1b were linked to form one assessment tool, with the phases feeding into one another. For example, some of the skills areas formed the basis of the ANMC Competency assessment, while some of the exemplars informed the list of skills areas.

In essence the ANMC Competencies can be seen as an articulation of 'how we do things' in nursing (eg legally, safely, ethically) rather than 'what the nurse does'. The purpose of this project was to join the two through the development of an



assessment tool. In this way we are articulating a scope of practice for newly registering nurses. At present there is no distinction made between the expected skills and knowledge sets of any RN – beginner or expert, or any place in between (Benner, 1984).

The support of members of the CDN (ANZ) and the ANMC professional reference group ensured we had input from all states and territories – either by their direct participation in the Delphi/NGT or by their identifying credible clinicians to participate. Furthermore, the Council aided the project team in the dissemination of the final tool. This support maximises the probable uptake of the tool once fully developed.

The project uses a strong theoretical framework as the tool is based on the ANMC competency framework, an audit of clinical skills currently in programs and a Delphi component seeking input from clinicians and educators. The above approach aligns with the commitment of the ALTC to enhance learning and teaching in higher education and, specifically, research and development focussing on an issue of emerging and continuing importance. In this case it is performance indicators for work integrated learning and teaching. It also supports the current move towards establishing benchmarking standards for graduates in the same discipline across the higher education sector.



4.0 Key Findings

4.1 Phase 1a – Employer Competencies

4.1.1 Literature review 1

One of the key challenges of the study was to identify the range and extent of the skill set that a newly registered nurse should reasonably be expected to perform. A review of the relevant literature provided a coherent and robust means of identifying those skills. On the whole the literature review identified skills ranging from the 73 areas identified in the Finnish work of Meretoja et al (2004) to literature that either explored how a skill was assessed in simulation, or how skills learned in simulation could be transferred to practice and the students' perceptions of that experience. Alavi et al. (1991) explored the notion of “skills required” from the perspective of health service professionals, and which skills were most commonly undertaken in practice. This led to 63 skills being identified.

Overall, the skills identified range from what the literature terms “fundamental skills” (Alavi et al 1991) such as patient hygiene, mobility and vital signs, to “basic skills” (Lee et al 2002) or “essential clinical skills” (Boxer and Kluge, 2000). The latter cites 14 areas such as patient assessment, hygiene, patient nutrition, patient activity, patient education, medicine administration and wound management. Each of these areas comprises subsets. For example, the “medicine administration” list comprises administration routes (oral, subcutaneous injections, etc).

4.1.2 Audit of curriculum documents

The second stage of Phase 1a comprised an audit of the lists of clinical skills outlined in the curriculum documents of nursing schools. A total of 39 universities were contacted, with 36 responses received in the specified time frame.

An initial review of the curriculum documents revealed about 550 skills. However, when the repeat mentions of skills were taken into account the number rose to more than 1300. This relatively simple tally gave the team some indication of the way that particular skills areas were being delivered and where the emphasis within programs lay. Further, on discussing the issue of the requisite skills for nurses there was considerable debate. This centred on how the art and science of nursing could be reduced to a simple list of skills to be performed. The two peak bodies for nursing and midwifery in Australia (the ANMC PRG and the CDNM) supported the notion of avoiding this reductionist approach, as did many of the respondents in the Delphi survey and in the nominal groups. The project team thus constructed skills areas to reflect the complexity of what nurses do on a day to day basis.

A number of sources within the literature explored a conceptual framework for reducing the number of skills to a manageable size while still retaining their meaning. In particular, Anderson (1991), Meretoja et al (2002), Meretoja et al (2004) and Utley-Smith (2004) established frameworks that identified the roles of nurses. Anderson's work asserted that nurses “work” encompassed the following roles:

- clinician
- educator



- communicator
- researcher
- manager.

These five roles provided the first filter through which to view the data. By modifying the work of Benner, Meretoja, Eriksson & Leino-Kilpi (2002) identified seven areas:

- organisation and work role competencies
- administering and monitoring therapeutic interventions and regimens
- the teaching and coaching role of the nurse
- effective management of rapidly changing situations
- the helping role of the nurse
- diagnostic and monitoring functions
- monitoring and ensuring the quality of health care practices.

In 2004 Meretoja reduced the seven to six areas with 73 sub categories. The six areas were:

- helping role
- managing situations
- diagnostic functions
- work role
- teaching-coaching
- therapeutic interventions.

The above six 'roles' enabled the identification of any missing areas of practice that could be used. Two final areas of work were considered – that of Utley-Smith (2004) and the primary vehicle for this work, the ANMC Competencies themselves. Utley-Smith identified what she termed six derived factors:

- Health promotion Competence
- Supervision Competence
- Interpersonal Communication Competence
- Direct Care Competence
- Computer Technical Competence
- Caseload Management Competence.

These were identified as “top level” competencies. Each one of the competencies contained up to six psychomotor skills or technical skills, including areas such as “organises care for patients”; “demonstrates computer literacy”; “administers medication”; “supervises staff” etc.

The final analysis of skills areas was undertaken by coding each one under the headings of the five key roles. This formed the basis of the groupings listed below under five roles/headings used in the first round of the Delphi survey. Thirty sub-headings were created under the initial five key roles, and 30 skills areas encapsulated the 550 from the documentary analysis – seven from Meretoja et al



(2002) and Utley-Smith (2004). The 30 skills are listed below under the five key roles (see table 1):

Table 1 – Thirty skills areas

<i>Clinician</i>	
1	Planning nursing care (eg range of varied settings/client needs)
2	Understanding the different roles of RNs in different treatment or care settings (eg aged care, rural and remote, acute, mental health)
3	Medications and IV products (eg safe and appropriate administration of medications)
4	Clinical monitoring and management – use of assessment tools (eg hemodynamic/respiratory assessment, etc)
5	Technology and Informatics (eg IVI management systems, patient information systems, etc)
6	Personal care – ability to assess, plan implement and evaluate care of clients across a range of settings using a holistic, comprehensive nursing model
7	Mental health nursing care (eg application of assessment tools and care strategies and interventions)
8	Knowledge of key nursing implications of common medical/surgical patient presentations
9	Clinical interventions - preparing, assisting after care (investigations/surgery/diagnostic)
10	Professional nursing behaviours – includes collaborative approaches to care (eg advocacy, scope of practice, being aware of ones self, etc)
11	Privacy and dignity (eg culturally acceptable practice, personal space, respectful)
12	Dealing with emotional and bereaved people (eg breaking bad news, dealing with anger, etc)
13	Dementia related skills (eg managing behavioural and psychosocial symptoms of dementia)
<i>Manager</i>	
14	Coordinating skills regarding the nursing process – uses a range of appropriate assessment strategies and skills across a range of settings
15	Leadership skills
16	Preventing risk and promoting safety – duty of care (eg strategies for reducing risk, risk assessment, etc – promoting self care)
17	Case manager (eg coordination of care, crisis/emergency situation management, etc)
18	Teamwork and multidisciplinary team working
19	Supervisory skills
<i>Communicator</i>	
20	Cultural competence (eg cross-cultural care, culturally safe and appropriate practice)
21	Therapeutic nursing behaviours/respectful of personal space
22	Efficient and effective communication (eg with professionals in other disciplines)
23	Communication and documentation ie verbal including handovers and non-verbal including documentation
<i>Researcher</i>	
24	Learner/evidence-based practitioner (eg appropriate application of practice evidence)
25	Critical analysis and reflective thinking (eg using reflection and critical incidents, evidence of linking theory to practice)
<i>Educator</i>	
26	Demonstrated teaching/educator skills (eg using appropriate teaching and learning strategies in practice)
27	Resource to others
28	Promotes self care (eg specific gender and lifespan related information and strategies)
29	Demonstrates behaviour conducive to learning (eg participates in the creation of a positive, approachable and supportive environment)
30	Learning and developmental culture – learning environment (eg relates to an environment conducive to learning and personal and professional growth as a new graduate)



4.1.3 Modified Delphi: Round 1 (Phase 1a – employer competencies/skills)

In this Modified Delphi round, the 30 skill areas were presented to participants grouped under the five headings above. An electronic web-based survey tool enabled these to be randomly presented to each respondent. The randomisation was performed to reduce the effect of factors such as fatigue or loss of concentration when completing a survey. Participants were asked to indicate whether they felt each particular skill was:

- grouped under the appropriate heading
- applicable to new graduates.

A total of 495 clinicians and educators participated in the Modified Delphi: Round 1. Key participant characteristics are summarised in Table 2. The sample included a diverse mix of clinicians and educators of varying levels of experience, with good representation from states and territories across Australia.

Table 3 presents the percentage of participants who believed each of the 30 skills was:

- accurately grouped with other skills in each category
- applicable to new graduates.

For the 13 skills listed under *Clinician*, the majority of participants indicated that these were appropriately listed together and were applicable to new graduates. Similarly, the majority of participants indicated that supervisory skills, case management and leadership skills were accurately grouped together under the heading of *Manager*. However, a substantial proportion of participants (32.7 per cent) believed that 'preventing risk and promoting safety' (37.2 per cent), 'teamwork and multidisciplinary team working' (38.9 per cent) and 'coordinating skills regarding nursing process' (21.3 per cent) were relevant to all categories. Furthermore, 19.8 per cent of participants believed that 'coordinating skills regarding the nursing process' should be moved under the heading of *Clinician*.



Table 2 Characteristics of participants in Round 1 of Delphi (N = 495)

	<i>n</i>	%
Primary Role		
<i>Nursing academic</i>	137	27.9
<i>Clinical nurse consultant/manager/specialist</i>	123	25.1
<i>Clinical/Nurse Educator</i>	100	20.4
<i>DoN/DoN's Assistant/Deputy DoN</i>	54	11.0
<i>Other</i>	77	15.7
Time in current role		
<i>< 1 year</i>	65	17.1
<i>1 – 2 years</i>	68	17.9
<i>3 – 5 years</i>	97	25.5
<i>6 – 10 years</i>	62	16.3
<i>> 10 years</i>	89	23.4
Job Location (state)		
<i>New South Wales</i>	205	41.8
<i>Victoria</i>	88	17.9
<i>Queensland</i>	62	12.6
<i>South Australia</i>	58	11.8
<i>Western Australia</i>	32	6.5
<i>Tasmania</i>	22	4.5
<i>Northern Territory</i>	14	2.9
<i>ACT</i>	10	2.0
Job Location (area)		
<i>Metropolitan</i>	315	64.3
<i>Regional</i>	98	20.0
<i>Rural</i>	64	13.1
<i>Remote</i>	13	2.7
Years as a Registered Nurse		
<i>≤ 10 years</i>	67	13.6
<i>11 – 20 years</i>	118	24.0
<i>21 – 30 years</i>	180	36.7
<i>> 30 years</i>	126	25.7

Participants believed that most skills listed under *Manager* were applicable to new registrants. However, only 38.1 per cent believed that leadership skills were applicable to a new RN.

About half the participants agreed that the four skills listed under *Communicator* were accurately grouped. A substantial proportion of respondents (36.2 per cent to 43.4 per cent) indicated these skills were relevant to all categories. The overwhelming majority of participants indicated that these skills were applicable to new RNs.

About half the participants agreed that the two skills listed under *Researcher* were accurately grouped. And more than two thirds believed these two skills were relevant to all categories. More than 90 per cent of participants believed each skill was applicable to new registrants.

The majority of participants indicated that the skills listed under *Educator* were accurately grouped and were applicable.



Table 3 Results from the Modified Delphi: Round 1

<i>Skill Area</i>	<i>Skill Grouping</i>	<i>Accurately grouped</i>	<i>Applicable</i>
1. Planning of nursing care (eg range of varied settings/clients needs)	Clinician	85.5%	97.8%
2. Understanding the different roles of RNs in different treatment or care settings (eg aged care, rural and remote, acute, mental health, etc)	Clinician	67.1%	85.7%
3. Medications and IV products (eg safe and appropriate administration of medications)	Clinician	88.3%	98.2%
4. Clinical monitoring and management – use of assessment tools (eg hemodynamic/respiratory assessment, etc)	Clinician	90.2%	95.5%
5. Technology and Informatics (eg IVI management systems, patient information systems, etc)	Clinician	64.2%	82.4%
6. Personal care – ability to assess, plan, implement and evaluate care of clients across a range of settings using a holistic, comprehensive nursing model	Clinician	88.3%	97.6%
7. Mental health nursing care (eg application of assessment tools and care strategies and interventions)	Clinician	86.7%	88.8%
8. Knowledge of key nursing implications of common medical/surgical patient presentations	Clinician	88.1%	97.6%
9. Clinical interventions – preparing, assisting after care (investigations/surgery/diagnostic)	Clinician	91.6%	95.9%
10. Professional nursing behaviours – includes collaborative approaches to care (eg advocacy, scope of practice, being aware of one's self, etc)	Clinician	62.4%	98.4%
11. Privacy and dignity (eg culturally acceptable practice, personal space, respectful)	Clinician	71.0%	98.8%
12. Dealing with emotional and bereaved people (eg breaking bad news, dealing with anger, etc)	Clinician	67.5%	92.6%
13. Dementia related skills (eg behavioural and psychosocial symptoms of dementia)	Clinician	85.1%	90.0%
14. Coordinating skills regarding nursing process – uses a range of appropriate assessment strategies and skills across a range of settings	Manager	55.6%	88.3%
15. Leadership skills	Manager	62.8%	38.1%
16. Preventing risk and promoting safety – duty of care (eg strategies for reducing risk, risk assessment, etc – promoting self care)	Manager	51.7%	95.7%
17. Case manager (eg coordination of care, crisis/emergency situation management, etc)	Manager	68.5%	58.3%



18. Teamwork and multidisciplinary team working	Manager	50.7%	98.0%
19. Supervisory skills	Manager	70.4%	57.5%
20. Cultural competence (eg cross-cultural care, culturally safe and appropriate practice)	Communicator	53.6%	97.1%
21. Therapeutic nursing behaviours/respectful of personal space	Communicator	58.5%	94.7%
22. Efficient and effective communication (eg with professionals in other disciplines)	Communicator	55.2%	98.6%
23. Communication and documentation ie verbal including handovers and non-verbal including documentation	Communicator	56.9%	99.0%
24. Learner/evidence based practitioner (eg appropriate application of practice evidence)	Researcher	57.7%	92.0%
25. Critical analysis and reflective thinking (eg use of reflection and critical incidents, evidence of linking theory to practice)	Researcher	52.6%	93.9%
26. Demonstrates teaching/educator skills (eg utilising appropriate teaching and learning strategies in practice)	Educator	75.9%	68.3%
27. Acts as a resource	Educator	65.2%	67.5%
28. Promotes self care (eg specific gender and lifespan related information and strategies)	Educator	62.8%	90.4%
29. Demonstrates behaviour conducive to learning (eg approachable and supportive)	Educator	66.5%	90.6%
30. Learning and developmental culture – learning environment (eg relates to an environment conducive to learning and personal and professional growth as a new graduate)	Educator	72.0%	89.6%

Participants were also asked to provide any additional comments in this Delphi round. The comments within this section were often elaborating on a particular point of view. Many comments related to the three scores that were much lower than the rest of the 30 skills areas. These were “Leadership” (38.1 per cent), “Case manager” (58.3 per cent) and “Supervisory skills” (57.5 per cent). “Acts as a resource” (67.5 per cent) and “Demonstrates Teaching/Educator skills” (68.3 per cent) were also commented on. The comments on the whole suggested that the entry to practice RN would need these skills but that they would develop them further once they undertook their transition programs and/or when they were in their substantive posts.

4.1.4 Modified Delphi: Round 2 (Phase 1a – employer competencies/skills)

A total of 295 participants completed Round 2 of the Delphi survey in March 2009 and some basic demographic characteristics of this sample are presented in Table This again demonstrates that the expert panel included a diverse range of nurse educators and clinicians with varying levels of experience.

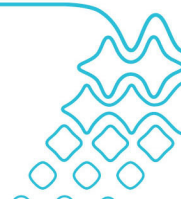


Table 4 Characteristics of participants in the Modified Delphi: Round 2 (N = 295)

	N	%
Primary Role		
Nursing academic	80	27.2
Clinical nurse consultant/manager/specialist	73	24.8
Clinical/nurse educator	64	21.8
DoN/DoN's assistant/deputy DoN	28	9.5
Other	49	16.6
Time in current role		
< 1 year	31	13.0
1 – 2 years	36	15.0
3 – 5 years	67	27.9
6 – 10 years	35	14.6
> 10 years	71	29.6

In this Delphi round, participants were asked to indicate the level of competency they expected from students after one, two and three years of study for each of the 30 skills areas. Participants provided their responses by using the following modified Bondy (1983) scale:

Dependent:	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.
Marginal:	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues required.
Assisted:	Refers to being safe and knowledgeable most of the time; skilful in parts, however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues.
Supervised:	Refers to being safe and knowledgeable; efficient and coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Independent:	Refers to being safe and knowledgeable; proficient and coordinated and appropriately confident and timely. Does not require supporting cues

Table 5 shows an example of the detailed responses for three selected areas (a summary of the results for all 30 skills areas is provided in Appendix 3). This indicates the percentage of participants who rate the competency at each level (ie Dependent to Independent) for each skill area at each year of study. The results demonstrate a clear shift in expectations across the three years from Dependence to Supervised/Independence.

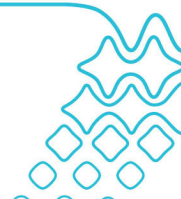


Table 5 Expected skill level of pre-registered nurses at the end of each academic year

	Clinical monitoring and management – use of assessment tools (eg haemodynamic/ respiratory assessment, MMSE, RUDAS etc).			Personal care – provision and coordination of care – the ability to assess, plan, implement and evaluate care of clients across a range of settings using a holistic, comprehensive nursing model			Clinical interventions – preparing, assisting during and after care, (such as investigations/ surgery/diagnostic)		
Percentages	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
Dependent	28%	1%	0%	21%	0%	0%	41%	3%	0%
Marginal	32%	11%	0%	27%	7%	0%	31%	16%	1%
Assisted	32%	41%	6%	39%	29%	4%	23%	47%	8%
Supervised	8%	42%	41%	10%	50%	27%	5%	31%	55%
Independent	0%	5%	53%	2%	13%	69%	0%	2%	35%

The data demonstrates clear and firmly-held views: the student progressing through an entry to practice program moves towards achieving independence in all competencies. But the expectation of early achievement is higher in some skills areas than in others. The following two examples encapsulate the two points of the continuum.

Medication and IV products ←-----→ Privacy and dignity

The expectation is that students who are early in their entry to practice program have an intrinsic understanding of the need for protecting and being sensitive to a client/patients privacy and dignity. This is illustrated by the data suggesting that 37 per cent are above “assisted” (so nearer to the *Independent*) end of the continuum, whereas for Medication and IV Products 74 per cent are below the *Assisted* level making them closer to the marginal/dependent end of the continuum.

This would appear to indicate that the skills areas in the main relate to the areas of practice where the safety of the client/patient is at risk due to that particular activity, or that the skill area is one where a greater level of experience would be expected to meet the requirements of that skill. Respondents held the view that first year students are less able to carry out those skills areas. These are listed below:

- medications and IV products (eg safe and appropriate administration of medications)
- clinical interventions – preparing, assisting during and after care (eg in investigations, surgery, diagnostic)
- dealing with emotional and bereaved people (eg conflict management, resolution, breaking bad news, dealing with anger).

There is a greater expectation that the first year student has an intrinsic appreciation of the need to maintain the client/patient’s privacy and dignity (37 per cent); that they behave professionally (18 per cent); and that they can deliver personal care (12 per cent).



4.1.5 Finalising the skills areas (Phase 1a – employer competencies/skills)

On closer re-inspection of the original skills list and the Delphi round results, we re-examined the skills areas to see if any might be combined or whether the expert group believed there were particular skills areas that required a much more overt presentation in the findings. This led to a further refinement of the skills list and to highlighting of particular skills areas deemed important. The justification for these modifications was centred on the panel's expertise, the Department of Health and Aging National Health Priorities and the quality and safety agenda. The final skills list of 21 is presented below in alphabetic order:

1	Clinical interventions – preparing, assisting during and after care (such as investigations/surgery/diagnostic)
2	Clinical monitoring and management – use of assessment tools (eg haemodynamic/respiratory assessment, MMSE, RUDAS). All forms of assessment are included here
3	Communication and documentation such as verbal (including handovers) and non-verbal (including documentation such as communication of care, appropriate and accurate use of documentation)
4	Community/primary care to include health education and promotion strategies
5	Coordinating care as an entry level practitioner within a reasonable time frame to include urgent and non-urgent clients
6	Cultural competence, for example, cultural diversity or trans cultural care, culturally safe and appropriate practice
7	Dementia-related skills such as managing behavioural and psychosocial symptoms of dementia and the ability to differentiate other causes of confusion such as delirium
8	Demonstrated teaching/educator skills that promote a learning and development culture by acting as a resource and role model, for example, using appropriate teaching and learning strategies in practice
9	Evidence-based practice such as clinical reasoning and ability to incorporate findings from assessments into care delivery
10	Management and leadership, supervisory skills, for example, conflict management resolution and acknowledging this is an entry level practitioner
11	Medications and IV products (eg safe and appropriate administration of medications); legal and safe medication administration storage and disposal
12	Mental health nursing care: application of assessment tools, care strategies and interventions
13	Personal care-provision and coordination of care – the ability to assess, plan, implement and evaluate nursing care of clients across a range of settings and across the lifespan using a holistic, comprehensive nursing model such as Roper, Logan and Tierney.
14	Professional nursing behaviours: includes collaborative approaches to care such as advocacy, scope of practice, being aware of one's self
15	Promotion of self care eg specific gender and lifespan-related information and strategies
16	Respect for privacy and dignity of clients/patients
17	Teamwork and multidisciplinary team: working in a team (eg team member and leadership roles, conflict management, resolution, negotiation skills)
18	Technology and informatics: incorporating standards (eg IVI management systems, patient information systems)
19	Therapeutic nursing behaviour/respectful of personal space/dealing with emotional people such as other professionals, clients, relatives, nurses – psychotherapeutic skills/therapeutic communication
20	Understanding the different roles of RNs in different treatment or care settings (e.g. aged care, rural and remote, acute, mental health and child)
21	Uses opportunities for learning such as the experiences of the client/patient by listening to their stories/experiences



4.1.6 Summary of Phase 1a results

Step 1: 550 skills identified in curriculum documents



Step 2: Project leaders reduced to 275 skills



Step 3: 275 skills grouped into 30 areas under five banners



Step 4: Modified Delphi rounds reduced the list to 19



Step 5: Consultations with relevant expert groups increased the list to 21

Review of the documents identified
1300 including duplicates



4.2 Phase 1b – Regulatory Competencies

4.2.1 Literature review: competencies and competency assessment

The area of competence and competency assessment in the workplace has been explored on numerous occasions by a variety of authors, not only in health care and nursing, but in many areas of the world of work where competency to undertake a work-based role has been problematic. The main reason the assessment of competence for nursing practice is important is to ensure the safety of patients in the care of a registered nurse. This is quite a complex issue as nursing programs do not prepare nurses to work in one specific clinical area. Rather, they focus on nurses' "eligibility to apply for a licence to practice" in a wide range of clinical settings.

In recent years there has been a plethora of literature, particularly in nursing, that explores the competence of the experienced practitioner in specific clinical settings such as critical care, mental health or oncology (Chiarella et al 2008). However, literature exploring the assessment of competence in the developing nursing student has been less notable. Runciman (1990) and Eraut (1998) debated definitions of nursing competence. Bradshaw (1997, 1998) noted that competence was fraught with "uncertainty and fragmentation". She cited a lack of clarity regarding the teaching and assessment of nursing competence in nurse education at that time. Bradshaw went on to define competence as a set of minimum standards that must be achieved. Most importantly she said that as practice and technology advanced any definition of competence and its assessment would need to be redefined over time. Later Redfern et al (2001) highlighted the work of Schon (1983) and attempted to illustrate that nursing was a complex activity, as did Benner and Tanner (1987). Redfern et al (2001) suggested that any assessment systems needed to comply with the particular authority who "set the standard for the regulatory competencies".

Meretoja & Isoaho (2004) developed and psychometrically tested a "nurse competence scale" which was subsequently piloted in Australia (Cowan et al 2008). The tool has correlations with the Finnish Nurse Competency scale. However this work was undertaken in 2005 and has not been repeated with the ANMC Competencies of 2006.

There are interesting connections between these studies and the skills areas component of this study. Assessors and students need to be aware, therefore, of the range of knowledge, skills and attitudes (or behaviours) being assessed in order to make sense of the competencies that are being tested and considered. Students' reflections on their practice, their knowledge base and their observations of the expert clinician's demonstrated skills should come together in a consistent and coherent way.

The ANMC stipulates that assessment of competency standards is necessary to determine the eligibility for registration of individuals who want to become nurses in Australia. This encompasses all new graduates, those returning to the workplace after an absence, those with international qualifications and the assessment of qualified nurses who are required to show their ability to continue practising.

The need for validity and reliability of assessment is of vital importance. Assessment should not be viewed as a one-off event but an opportunity for the experienced clinician (and possibly the patient) to work with the student and to evaluate his or her



ability to meet the needs of a diverse range of patients, acknowledging a range of safety and quality standards or benchmarks (ie best evidence utilisation, appropriate and coherent communication). Preparation of the individuals who are to assess and report on a student's competence must be adequate, appropriate and refreshed periodically to ensure they are aware of the study program needs and the location and level expected for a student within a specific program.

4.2.2 Audit of the current nursing clinical assessment tools (Phase 1b – Regulatory Competencies)

The support of the Council of Deans of Nursing and Midwifery (Australia and New Zealand), the ANMC and the profession as a whole led to excellent response rates from universities and individuals for this study. More than 35 competency assessment tools (CATs) were received by the team – more than 90 per cent of the tools used in Australia.

The tools audit revealed that the majority of CATs used the ANMC Competencies. There were however considerable variations on how the student was assessed. In addition, guidance for the assessor was unclear and the outcome measures often varied across programs. Most universities used the ANMC domains examples:

1. Practises in accordance with legislation affecting nursing practice and health care
4. Participates in ongoing professional development of self and others
5. Conducts a comprehensive and systematic nursing assessment

In a number of instances lower level descriptors that differed from those of the ANMC were used. For example, in relation to competency number 4 - "Participates in ongoing professional development of self and others" – the following descriptors were used:

Provides appropriate evidence to the preceptor of clinical performance and knowledge application (eg documentation in client's chart, completed assessment forms, skills signed as competent in Tollefson)

Seeks and critically reflects on feedback from Preceptor and/or Registered Nurses on clinical performance

Provides the Preceptor with a Student Portfolio upon request

Reflects (written or verbally) on own clinical performance on practicum (ie identifies weaknesses and strengths, and strategies to improve).

Sixteen of the 35 respondents – approximately 46 per cent of the universities' clinical assessment tools – used Bondy's (1983) dependent to independent scales. However, others used "competent/not competent" or "needs further development" while others used a "satisfactory" or "unsatisfactory" category. Some universities used a portfolio framework that tested specific skills at specific times within the program, within both a simulation setting and practice setting. Many used the "Clinical Skills Competency" assessment sheets from Tollefson's (2007) text as a template for the assessment of psychomotor skills. Common assessment tools were used for "Administration of Medicines" such as oral and intramuscular, and a range of "Wound Management" skills such as "drain removal", "clip removal" and so on..



The work of Tollefson (2007) appears in a number of skills assessment tools. This has provided a level of consistency even though many universities modified the work and used variants of it across their programs. In most cases the “clinical skills competency” sheets were seen as an assessment of a specific psychomotor skill.

4.2.3 Development of a draft ANMC Assessment Tool **(Phase 1b – Regulatory Competencies)**

The development of the ANMC tool is acknowledgement that universities need to ensure all nursing students, on completion of a program, are eligible to register as nurses and thus meet the ANMC Competencies. That stated, most universities already use the higher level descriptors against which their assessors/facilitators/clinicians assess whether students meet those competencies. In an effort to create minimum of disruption, and as means of unifying assessment tools, the use of the ANMC Competencies have been offered as the core document in this study along with the use of the modified Bondy (1983) scale. Many universities (46 per cent) were using the Bondy (1983) scale. However other universities were using different clinical assessment strategies and different tools. The latter group would need to consider a time frame for implementation that acknowledges their approval and accreditation processes.

The competency assessment tool package (*Pilot guidance package: competency assessment tool – nursing*) is in a separate document. There are two components to the tools. The first part is designed to be used on each clinical placement the student attends throughout their course. It is anticipated the student will demonstrate growth in terms of their ability to demonstrate developing clinical competence during their program of study. The document has shaded portions to show the expected minimum level the student will achieve during that part/year of the program on that placement. Validity and reliability will be assured through a benchmarking process once the tools are accepted and piloted. The eight competency assessments will be completed by the student over the duration of the program. Their locations within the course of study will be different for each university depending on the structure of their curriculum. The roll out and benchmarking process will assist university academic and clinical teams locate the assessments within their programs.

4.2.4 Nominal Group Technique **(Phase 1b – Regulatory Competencies)**

Nominal group meetings were conducted in two phases: Phase 1 was conducted between 7 November and 10 December 2008; and Phase 2 was conducted between 25 May and 29 May 2009. A total of 66 participants were involved in the nominal groups, providing a representative sample of nurses, practitioners and academics from across Australia.

In the first stage of each, NGT participants were given a presentation on the project and were invited to share their experience of the assessment documents they currently use. The following issues were raised in these groups:

- a wide variation exists across the documents used to assess practice
- some are more helpful than others



- students attend from a range of institutions and at different points in their programs of study
- different skills and competencies are explored by students from different institutions
- no documents specifically highlight the nature of nursing practice.

Participants provided their responses on post-it notes and placed these on large sheets of paper for each ANMC competency. Responses were then grouped into the following themes (ranked from highest to lowest frequency):

- scope of practice (eg ability to 'do' and to be aware of limitations)
- communication and documentation (eg verbal and nonverbal, between nurses and inter-professionally)
- use of tools (eg accepted and appropriately validated tool utilisation)
- critical thinking (eg clear evidence of)
- cultural understanding (eg safety and competence expected as clear evidence in activities)
- knowledge (eg clear evidence of appropriate anatomy, physiology and patho-physiology)
- patient education (eg clear evidence of ability to teach/educate clients/patients)
- reflection (eg on and in practice)
- further and shared learning (eg evidence of knowledge and checking information, helping others to learn too)
- leadership and time management (even as a new RN)
- involves others, team working and inter-professional working
- active participation (eg willingness to engage and learn)
- advocacy, respect and valuing
- emotive debriefing/clinical feedback (eg respects individuals and upholds their rights and wishes)
- initiative (eg willingness to engage and to take the initiative, being aware of scope and limitations)
- client/patient focus (eg engages in a process of care over a span of duty or over an incident/situation)
- skill performance (eg demonstrates ability to perform and to learn)
- supervision/boundary relationships (eg willingness to engage and to learn).

The above themes indicated that a number of clinical competency areas were used to assess nurses. These included:

- wound management
- medicine management/administration
- nursing assessment
- infection control and management
- caring for a client/patient – relating to the skills of caring for one client as opposed to the team leadership and coordination skills required to manage a group of



clients/patients

- appropriate methods of communication/documentation to be considered in these practices.

Using a round robin strategy, each participant was asked to indicate their practice priorities to the facilitator. These were tallied and the results were as follows (listed from most frequent to least frequent):

- demonstrated skills (psychomotor and therapeutic ie appropriate communication strategies)
- documentation
- medicine administration (including IVI and blood)
- patient monitoring and response to changes in patient condition
- nursing assessment, planning and establishing attainable goals
- patient care over a span of duty/period of care in any setting
- patient safety
- wound management.

4.2.5 Phase 3 – dissemination

(Phase 1b – Regulatory Competencies)

This section deals with the dissemination of the project findings through the project reference group, to conferences and through direct invitation to a range of organisations throughout the duration of the study. Section 5 of the report identifies how the competency and assessment tools have been (and will be) distributed to the wider nursing community (ie health services and universities).

The tools, in the form of a pack (*Pilot guidance package: competency assessment tools - nursing*), were distributed via meetings at the partner universities in December 2009 to enable the lead member from the reference group at each institution to discuss the tools with colleagues and consider their implementation strategies. It also enabled them to identify issues that might arise from the implementation and operation of the tools.

The purpose of this was twofold: to establish the tool's use and enable each institution to consider the impact on their curriculum, assessment practice strategies and skill delivery; and, secondly, to enable the project team to identify an outline strategy to assist other institutions with implementation and operation.

Some of the initial feedback is outlined below:

Concept of a national, standardised, ANMC-based clinical competency assessment tool is excellent and long overdue

A feature is the student reflection – one that is lacking in the current document (university was named)

Clinical assessment form agreed student component most important – liked that it was more than psychomotor skills



Need to consider policies and guidelines with regard to terms such as unsafe and how that differs from incompetent

Overwhelming when you first see it

Will need extensive education of facilitators

*Corresponding map of skills to competency assessments
Would need to be piloted.....*

How does Bondy take into account the context of practice?

Reliability and validity data of the tools and of Bondy (that's recent)

Perhaps "dependent" wording could be structured in developmental terms rather than unsafe or unskilled or inefficient

The project group anticipated the feedback on a number of factors, key areas of which were the need to prepare facilitators/mentors/registered nurses when different support and assessment models were being used across universities; and the preparation of academic and clinical staff and students for the introduction of new methods and tools.

Issues relating to terminology can be addressed by structuring the evaluation in a way that explores the development of those terms and the overall structure and shape of the tools. Reliability and validity can be achieved through an initial pilot followed by a cross institutional benchmarking exercise. This exercise would enable significant evaluative research to be undertaken for the first time in Australia into the use of a standardised competency assessment tool for nursing.

A number of respondents referred to the lack of evidence regarding the reliability and validity of Bondy's (1983) assessment tool (interestingly, 46 per cent of universities are using this tool, and among the remaining 54 per cent, there is no published evidence of the robustness of the tools they are using). The examination of the use of Bondy will be an important aspect of the pilot.

The following presentations to relevant organisations were made:

- CDNM – through the Council a number of presentations have been undertaken, raising awareness of the project among the heads and deans of schools.
- ANMC PRG – the ANMC group and members were informed of the progress and outcomes of the project through six-monthly updates.
- Australian and New Zealand Chief Nurse Meeting: by presenting the research and the competency assessments tools.

The project team has also been invited to several chief nurse forums in states and territories to present the tool and deliver workshops on its use and implementation.

Other publications/presentations/conferences:

- Brown, R. A. & Crookes, P. A. (2010). 'Nursing competence – not just a skills list'. *3rd International Nurse Education Conference, Nurse Education in Practice/Nurse Education Tomorrow* (p. 209). 11-14 April; Sydney, Elsevier.
- Brown, R.A., Crookes, P.A., Dignam, D.M., McCutcheon, H., Della, P. &



Edwards, H (2009) 'Developing a competency assessment process in professional healthcare practice (nursing)', ATN Conference, RMIT, November 2009.

- Brown, R. A. & Crookes, P. A. (2008). 'The identification of a newly graduating nurses' technical skill set and the development of competency assessment tool (II) – project progress and preliminary findings from the analysis'. *Leadership and Practice Development in Health* Tasmania: Conference Design.
- Crookes, P. A. & Brown, R. A. (2008). 'The development of an undergraduate nursing competencies assessment tool for use across Australian universities'. Global Alliance for Nursing Education and Science, Toronto, September 30.
- Brown, R. A. & Crookes, P. A. (2008). 'The identification of a newly graduating nurses' technical skill set and the development of competency assessment tool' (I). *Clinical Professions Education* (pp. 60). Sydney: ConLog.

The implementation and operation of the tools were discussed with:

- partner institutions
- the expert groups
- clinical and academic leads in states and territories.

These discussions have highlighted a high degree of commitment from key stakeholders regarding the implementation and robust piloting and benchmarking of the tools in most, if not all, states and territories. It is acknowledged that the tools will require a gradual phase-in, with associated strategies and time frames to guide their management and implementation.

Preparation of the final tools and supporting resource materials are vital. During the piloting and benchmarking phases the refinement of the student and facilitators guides will be completed. This will support the implementation. To date most senior managers in healthcare provision and the senior academics attending the roadshows have been supportive. They are looking to contribute to the development and roll out of the tools. This continues the significant contribution of key stakeholders across Australia to the development and operation of the tools.

At the time of writing this report, eight institutions and one state said they would pilot the tools. The state includes all universities within that state and a significant number of the healthcare providers who place students in programs leading to eligibility to register in that state or territory. Some of the other institutions cross state and territory boundaries; and others comprise universities in a particular geographic location. This range of institutions will help to maximise input in relation to implementation and operational issues arising during the pilot process.

4.2.6 Phase 4 – pilot of the tool at partner institutions

Partner institutions will undertake an informal pilot of the tool as soon as practicable (hopefully some time spring 2010). A guidance pack will be developed jointly by the piloting institutions. This will be made available to universities to establish the tool. A common evaluation framework is being developed to capture both clinical educator/facilitator feedback as well as student evaluation/feedback. The evaluation tools will be agreed and used to ensure consistency in the information given to the facilitators and in the interpretation of the data gathered.



It is anticipated that the partner institutions will operate the new system alongside their existing system for a number of students in each year so that they can evaluate the impact of implementation and operation. Student demographics will also be collated to identify differences with regard to a student's position in a program. A sampling framework will be developed across institutions to ensure an acceptable representative sample of students in each part of the corresponding courses is used.



5.0 Dissemination

A key aspect of the original submission to the ALTC centred on sharing the project's findings as they unfolded. Our intention to maintain a high level of inclusivity and involvement of key stakeholders, namely the Australian Nursing and Midwifery Council and the Council of Deans of Nursing and Midwifery, was achieved through regular feedback to their meetings. The newly-formed Australian Nursing and Midwifery Board is also aware of the project via its Chair, Ms Anne Copeland. A briefing paper was submitted to the March meeting of the board. Health Workforce Australia and the ALTC Discipline Scholars also expressed a keen interest in the outcomes of the project.

The dot points below identify the key bodies with whom we have met to share the findings. We have also tapped into the experience of these groups as experts in nursing. The competency assessment tools were presented in the final meetings and their implementation and operation discussed.

The following presentations were made to relevant organisations:

- CDNM: through the council a number of presentations have been undertaken so heads and deans of schools are aware of the project. Professor Crookes has updated the council and the executive on numerous occasions during the project (six to eight times).
- ANMC PRG: through six-monthly updates to the ANMC group, the members have been made aware of the progress and outcomes of the project (four or five times).
- Australian and New Zealand Chief Nurse Meeting: by presenting the research and outcomes of competency assessments and tools (once).
- Invitations to chief nurse forums in states and territories to present the tool and deliver workshops on its use and implementation (see overlreaf).
- The National Health Workforce Taskforce Executive Director was present at the ANZCCN meeting when the findings and tools were presented.

The key areas of dissemination are through the peak nursing bodies, the CDNM and the ANMC, as well as the body about to replace the ANMC, the Nursing and Midwifery Board of Australia, whose appointed Chair and Practitioner member for nursing and midwifery (from Queensland) received an information pack outlining the tools and their future use. This material was presented at the meeting of the NMBA in March 2010.

The tool will be rolled out via roadshows as requested by chief nurses and heads of schools in the states and territories. These have been completed and regular feedback has been given through CDNM meetings. The project team has undertaken workshops and presentations in the New South Wales, the Northern Territory, Tasmania, Victoria, South Australia, Queensland, the ACT and Western Australia; presenting the tools and exploring issues associated with their implementation and operation at events established by the chief nurse's offices and the heads/deans of schools at local universities.



Events undertaken:

February 2010 – New South Wales

The Nursing and Midwifery Leadership Collaborative is an event organised by the Chief Nurse for New South Wales. The deans/heads of schools and the directors of nursing services in NSW attend. This event was used to present the tools and to discuss implementation issues.

March 2010 – Northern Territory

The Chief Nurse for the Northern Territory invited the team to run a three hour workshop with academic staff and directors of nursing services from across the territory. This workshop was used to present the tools and to consider local implementation challenges/issues across the territory.

April 2010 – Tasmania

This forum is held bi-monthly in Launceston, Tasmania. The project team were invited to present and discuss their work. Directors of nursing services from the different areas of Tasmania as well as the academic leads were present.

April 2010 – Victoria

This was one of the highest attended events with nearly 70 participants who ranged from clinicians to 'area' Director of Nursing and facilitators to heads of schools. The three hour presentation and discussion explored some critical aspects concerning the implementation of the tools.

April 2010 – South Australia

The Chief Nurse of South Australia and the Head of one of the Schools invited the team to present the tools in an open forum event. There were senior academics and clinicians present at the forum.

May 2010 – Queensland

The Chief Nurse's Office of Queensland Health holds a Nursing and Midwifery Alliance meeting four times a year. There were 16 participants who represented the universities within Queensland and the area directors of nursing.

May 2010 – ACT

There were 24 participants at this forum held in the Department of Health office in Canberra. The two universities and the directors of nursing were present at the presentation.

July 2010 – Western Australia

Curtin University (a partner institution) invited the team to present to the academic and clinical team at the university. This was a three hour workshop examining the operational issues of implementing the tools.

July 2010 – South Australia

A follow up event was held in South Australia, as universities and the Chief Nurse in this state were keen to pilot the tool across Adelaide and then to roll out it across the state. The event included over 80 participants from facilitators to senior clinicians.



Events yet to be undertaken:

Following the adoption of this report by the ALTC it is envisioned that a new proposal will be submitted to extend this work across a number of universities and states and territories. Fourteen universities have expressed a wish to be a part of this 'primary roll out'. This coupled with the many clinicians and directors of nursing services who are willing to be involved in the first piloting phases for the tools is encouraging.

A website will be developed at the University of Wollongong. This will provide ongoing support for the roll out, so that colleagues who cannot attend have the opportunity to explore some of the tools. This will be carefully managed in the initial stages to ensure appropriate document management and control prior to implementation and operationalisation.

Impact on the sector

Gauging the impact on the sector is a challenge as the tool is not fully operational. However, a number of factors illustrate the value that the nursing profession and academics attach to this research. These include an exceptionally high degree of involvement in the project, the level of responsiveness to requests for information and contribution to the research (documentary analysis/Delphi rounds/nominal groups), excellent attendance at conference presentations and roadshow events, and significant connections to other projects underway.

All respondents stated that the study was "not before time" or "long overdue". Comments such as these, as well as calls and emails from many organisations wanting to be involved in the pilot phase, illustrate the likely high impact through consistent use of the tools.

Another, and somewhat challenging, aspect of the project's impact will be the variation in the level of ease with which institutions move to the new tools. For example, it will be relatively easy for institutions that:

- already use the ANMC competency statements
- already use Bondy (1983)
- have thorough facilitator preparation
- already have e-portfolio resources
- have clinical partners who are keen to move forward with the new tools.

It will be more difficult for institutions that:

- do not use the ANMC competencies overtly
- do not use Bondy (1983)
- have differing supervision models
- do not have developmental plans ready for using e-portfolios.



Maximum impact will occur where:

1. Consistent use of the tool is supported by well structured systems such as:
 - academic team preparation that uses the Leading Professional Development for Teaching staff work (ALTC 2009 LE9-1212)
 - coherent and consistent RN/facilitator preparation exists
 - integrated approaches are adopted to embed the tools within the curriculum so that students' expectations are clear.
2. Institutions learn from best practice by examining and evaluating the ongoing impact of the tools.
3. There is opportunity to build a profession and institution-wide e-portfolio system.
4. There is large-scale evaluation of the data from the use of the tools with targeted institutional-level feedback.

These 'communities of interest' will need to phase in the introduction to their programs. Finally, some institutions will need to revalidate programs. However, with the delay in establishing the accreditation body, this may create some additional delays and challenges.



6.0 Linkages

A number of projects by health professionals have explored the competencies of practitioners, competency standards and their veracity. The project team has contacted colleagues undertaking (or who have undertaken) these projects during the course of our project and found the cross fertilisation extremely beneficial.

Among them are:

‘COMPASS™ directions: leading the integration of a competency based assessment tool in speech pathology learning and teaching’

Dr Sue McAllister

‘Development of the APP (Assessment of Physiotherapy Practice) instrument: a standardised and valid approach to assessment of clinical competence in physiotherapy’

Ms. Megan Dalton

‘Development of a computer-generated digital patient for teaching and assessment in pharmacy’

Dr David Newby

‘Examining the impact of simulated patients and information communication technology on nursing students’ clinical reasoning’

Associate Professor
Tracey Levett-Jones

Speech Pathology

At the inception of the project the project leaders met with Dr Sue McAllister (speech pathology) to explore the design and structure of the project brief and the specifications. This was invaluable and helped shape the project proposal and methodology. One of the key differences between the disciplines at this point was the number of programs being taught – nine in speech pathology and 39 in nursing. Critically maintaining our inclusive approach was highlighted as a key aim.

The speech pathology assessment of competence tool known as COMPASS™ – Competency Assessment in Speech Pathology – is a complete package delivered as a commercially-available hard-bound folder containing a range of items including: an assessment booklet; assessment resource manual; technical manual; and three-part training modules (CD-based to prepare assessors) for introducing the tools, assessing students and working with marginal students.

Occupational Therapy

The ALTC report, ‘Mapping the future of occupational therapy education in the 21st century’ (February 2009) noted two key aspects in relation to competencies. First, the competency standards, originally published in 1994, needed revising. Thus, part of the report focused on the “utility, relevance, appropriateness and currency” of the competencies to gauge the extent of the revision necessary. With 13 institutions delivering entry to practice occupational therapy programs in Australia, consultation



was more challenging for this group than in the speech pathology work. The critical challenge highlighted in the report was that when introducing nationally-agreed competencies, there was a clear need for an inclusive approach that captured a wide critique of existing competencies from “a diverse range of practice areas, work settings and professional roles”. This is not dissimilar to the need to capture a diverse range of practitioners and geographical locations within the nursing competency study.

Physiotherapy

The physiotherapy study, ‘Development of the APP (Assessment of Physiotherapy Practice) instrument: a standardised and valid approach to assessment of clinical competence in physiotherapy’ was completed in March 2009. The project was funded by the ALTC and undertaken by Griffith, Monash and La Trobe Universities. It set out to identify a clinical practice assessment tool that could be used by all universities delivering physiotherapy programs in Australia. Thirteen institutions deliver entry to physiotherapy practice programs in Australia. These, including the three institutions directly involved in the project’s management, and two institutions in New Zealand, made up the reference group.

Key messages from the ‘Assessment of Physiotherapy Practice’ project identify the need for simplicity in the tools produced. They also identify the need for clear guidance to clarify the interpretation of the competencies. The physiotherapy standards are not dissimilar to the nursing ANMC Competencies. They relate to nine higher level descriptors for physiotherapy and compare with the 10 nursing competencies such as communication, planning and use of evidence. In the physiotherapy tools the lower level descriptors are not used but, as with the nursing tool guidance, can be located in the information. The physiotherapy tool does not overtly use the nine standards. This is not a position we have adopted as the nursing competency assessment tool overtly uses the 10 higher level descriptors in the tool.

Pharmacy

The ALTC-funded ‘Development of a computer-generated digital patient for teaching and assessment in pharmacy’ by Dr David Newby looks at the development of competency in teaching and assessment in pharmacy. It uses a technological solution to explore and create situations that can be controlled and revisited. Key lessons from this work relate to the notion of standardised clients/patients that can be used to explore nursing skills, how these skills can be developed and then robustly, reliably and validly assessed. It is an area the project team intends to explore after completion of this study.

Overview

The above ALTC-funded projects are excellent models. And as a model of best practice, the project team can readily complement additional models such as the online resources used in Canada for Preceptor Education Preparation (PEP) for health professionals and students. The guidance packs that have been generated from the speech pathology, occupational therapy and the physiotherapy work can lend themselves to materials for the roll out of preparation resources for students, facilitators and educators as well as academics supporting work integrated learning.



Core information relating to communication skills – giving feedback and critical appraisal skills – are essential for assessors in any situation.

Finally, the linkages with other organisations are identified throughout the report. The number of presentations requested by stakeholders suggests the high regard in which this project is held:

- Australian Nursing and Midwifery Council Professional Reference Group
- Council of Deans of Nursing and Midwifery for Australia and New Zealand
- Australian and New Zealand Chief Nurses
- Global Alliance for Leadership in Nursing Education and Science
- American Nurses Association, USA
- National League for Nursing, USA
- ALTC – Discipline Scholars, Aus
- ALTC – Leadership events, Aus
- Health Workforce Taskforce – facilitated by Christine Ewan, Aus
- Council of Deans of Nursing, UK



7.0 Evaluation

An external independent evaluation was undertaken by the Centre for Health Initiatives led by Professor Sandra Jones. This can be found at Appendix 4. Section 7.1 is a reflection by the project leaders on behalf of the team.

7.1 Evaluation by the Project Team

The overall project brief was developed with an open and honest understanding that there would be significant challenges that would need to be clearly and transparently addressed. No one project in the field of nursing in Australia has attempted such an ambitious study – that of reaching consensus on a competency assessment tool that all universities could use to assess students undertaking eligibility to practice programs. That openness and inclusivity has enabled the team to be as responsive as we could be to the expert group's advice and guidance and to the comments from all involved. We have made every attempt to reflect on those comments and viewpoints. And even if they have not directly influenced the current position, note has been made so they will be included in the structuring of the evaluation of the pilots the and benchmarking process.

Factors critical to success of the approach: the key factors for the success of this project were:

- Early identification and agreement of the purpose and intention of the research.
- Inclusivity – the way the project team shared the various stages of the project at every opportunity, not only with the key stakeholders, but individuals who had contributed to the project.
- Initial and ongoing responsiveness to feedback through the use of expert groups.
- Regular dissemination through national and international conferences.

Factors which may have impeded success: these are few; however they include:

- difficulty in establishing the website which slightly slowed the ongoing communication of the project's progress
- the sheer size of the nursing community both nationally and internationally is always challenging in terms of capturing views and maintaining good two-way communication.

Formative and summative evaluation:

These were carried out throughout the project in terms of exploring the micro- and macro-level decision processes. By seeking clarification of the underpinning decisions the team was clear on direction and purpose. The Interim reports capture a number of these points, such as the decision processes around the design of the sampling frame and the number of Delphi rounds ultimately used in Phase 1a and, more importantly, the need to refine the methodology surrounding the refinement of the skills lists.



Formative evaluation:

Feedback/discussion between the chief investigator, project manager and research assistants enabled a clear focus on the intended direction and time line of the project. Communication with the reference group through email and teleconferencing meetings, which coincided with the Council of Deans meetings, was useful in maintaining dialogue on project direction and time line. Key stakeholder feedback from the CDNMC and the ANMC, based on the team presenting the project's progress to date, was incorporated. This was undertaken for the duration of the project.

Process evaluation of the audit of the skills areas; clinical assessment tools; and evaluation of the systematic literature review were undertaken as the project progressed. Clearly this informed decisions regarding the recruitment of additional Delphi round participants.

One final aspect of formative evaluation was the work leading to the connection between the skills areas and the work undertaken for the modified nominal groups. This was possibly an unexpected connection. However, the strength of the relationship between the respondents' commentary on what they said they would observe students practising and the competency assessments was irrefutable.

Summative evaluation:

The content of the external evaluation provides significant information on this particular kind of evaluation in terms of outcomes and intention. However, a number of points are worth raising here.

First, the response of the profession and of key stakeholders was clear in terms of clarity of inclusion. As a team we were unequivocal on that point so this was not a challenge. Ongoing contact with the key stakeholders was vital for data gathering as well as two-way communication and the maintenance of the high profile of the project. The influences of those key bodies informed and shaped the project as well as maintained a high level of dissemination.

Second, the sampling methodologies employed were necessary due to the large population size – lead universities were used to identify key players in the states and territories, thus enabling state and territory representation, and going some way to capturing the diverse views of different areas. Finally, the analysis of the curriculum documents from almost all universities (95 per cent) enabled the project team to utilise virtually all universities in the analysis.

7.2 External Evaluation

This can be located in Appendix 4, however the conclusion from the report is highlighted below:

Overall, an analysis of documentation and an evaluation of the project conducted through a series of interviews indicate that:



- *The project remained consistent with the original goals*
- *The project achieved (and possibly exceeded) the desired outcome*
- *The small deviations in methodology from the original plan were undertaken in a systematic and thoughtful way*
- *Participants from varying groups and parts of the country were keenly interested and were invited to participate in the project*
- *Participants and staff (with various levels of involvement and differing roles in the project) all appeared to have a consistent view of the key project elements (ie aims, outcomes, rationale, etc).*



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Appendix 1 – National Competency Standards for the Registered Nurse



4th Edition
January 2006

NATIONAL COMPETENCY STANDARDS FOR THE REGISTERED NURSE

Introduction	Description of Registered Nurse	Domains	National Competency Standards	Glossary of Terms
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Introduction

The Australian Nursing and Midwifery Council Incorporated (ANMC) is a peak national nursing and midwifery organisation established in 1992 with the purpose of developing a national approach to nursing and midwifery regulation. The ANMC works in conjunction with the state and territory nursing and midwifery regulatory authorities (NMRAs) to produce national standards which are an integral component of the regulatory framework to assist nurses and midwives to deliver safe and competent care.

The standards include the national competency standards for registered nurses which were first adopted by the ANMC in the early 1990s. These have been reviewed and revised regularly since then. Other standards developed by the ANMC for implementation by the NMRAs include the competency standards for enrolled nurses, midwives and nurse practitioners, codes of professional conduct and ethics, and a range of position statements and guidelines. The full list of standards, position papers and guidelines produced by the ANMC can be viewed on the website.

In 2004/2005 the ANMC undertook a review of the national competency standards for the registered nurse to ensure that they remain contemporary and congruent with the legislative requirements of the NMRAs.

This review, which was undertaken by a team of expert nursing consultants, included extensive consultation with nurses around Australia. The resulting standards, whilst different in some areas from the previous competency standards, remain broad and principle based so that they are sufficiently dynamic for practicing nurses and the NMRAs to use as a benchmark to assess competence to practice in a range of settings.

What are the standards used for?

The national competency standards for the registered nurse are the core competency standards by which your performance is assessed to obtain and retain your license to practice as a registered nurse in Australia.

As a registered nurse, these core competency standards provide you with the framework for assessing your competence, and are used by your state/territory NMRA to assess competence as part of the annual renewal of license process, to assess nurses educated overseas seeking to work in Australia, and to assess nurses returning to work after breaks in service. They are also used to assess nurses involved in professional conduct matters. The NMRAs may also apply the competency standards in order to communicate to consumers the standards that they can expect from nurses.

Universities also use the standards when developing nursing curricula, and to assess student and new graduate performance.

These are YOUR standards — developed using the best possible evidence, and using information and feedback provided by nurses in a variety of settings. Included also are the principles of assessment which will assist you in understanding how these standards may be used to assess performance. We believe you will find them easy to understand, and user friendly.

ANMC would like to thank nurses throughout Australia for their willing input to the development of these standards.



Description of the registered nurse on entry to practice

The registered nurse demonstrates competence in the provision of nursing care as specified by the registering authority's licence to practice, educational preparation, relevant legislation, standards and codes, and context of care. The registered nurse practices independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care.

The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individual/s with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life.

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individual/s and the multidisciplinary health care team so as to achieve goals and health outcomes. The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately. The registered nurse provides care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings and modifies practice according to the model/s of care delivery.

The registered nurse takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. This includes appropriate referral to, and consultation with, other relevant health professionals, service providers, and community and support services.

The registered nurse contributes to quality health care through lifelong learning and professional development of herself/himself and others, research data generation, clinical supervision and development of policy and clinical practice guidelines. The registered nurse develops their professional practice in accordance with the health needs of the population/society and changing patterns of disease and illness.



Domains

The competencies which make up the ANMC National Competency Standards for the Registered Nurses are organised into domains.

Professional Practice

This relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

Critical Thinking and Analysis

This relates to self – appraisal, professional development, and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

Provision and Coordination of Care

This domain relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals /groups, planning, implementation and evaluation of care.

Collaborative and Therapeutic Practice

This relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to the nurse understanding their contribution to the interdisciplinary health care team.

National Competency Standards for the Registered Nurse

Professional Practice

Relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

1. Practises in accordance with legislation affecting nursing practice and health care

1.1 Practises in accordance with legislation affecting nursing practice and health care

- identifies legislation governing nursing practice
- describes nursing practice within the requirements of common law
- describes and adheres to legal requirements for medications
- identifies legal implications of nursing interventions
- actions demonstrate awareness of legal implications of nursing practice
- identifies and explains effects of legislation on the care of individuals/groups
- identifies and explains effects of legislation in the area of health
- identifies unprofessional practice as it relates to confidentiality and privacy legislation

1.2 Fulfils the duty of care

- performs nursing interventions in accordance with recognised standards of practice
- clarifies responsibility for aspects of care with other members of the health team
- recognises the responsibility to prevent harm
- performs nursing interventions following comprehensive and accurate assessments

1.3 Recognises and responds appropriately to unsafe or unprofessional practice

- identifies interventions which prevent care being compromised and/or law contravened
- identifies appropriate action to be taken in specified circumstances
- identifies and explains alternative strategies for intervention and their likely outcomes
- identifies behaviour that is detrimental to achieving optimal care
- follows up incidents of unsafe practice to prevent re-occurrence



National Competency Standards for the Registered Nurse (continued)

2. Practises within a professional and ethical nursing framework

2.1 Practises in accordance with legislation affecting nursing practice and health care

- accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
- ensures that personal values and attitudes are not imposed on others
- conducts assessments that are sensitive to the needs of individuals/groups
- recognises and accepts the rights of others
- maintains an effective process of care when confronted by differing values, beliefs and biases
- seeks assistance to resolve situations involving moral conflict
- identifies and attempts to overcome factors which may constrain ethical decisions in consultation with the health care team

2.2 Integrates organisational policies and guidelines with professional standards

- maintains current knowledge of and incorporates relevant professional standards into practice
- maintains current knowledge of and incorporates organisational policies and guidelines into practice
- reviews and provides feedback on the relevance of organisational policies and professional standards procedures to practice
- demonstrates awareness and understanding of developments in nursing that have an impact on the individual's capacity to practice nursing
- considers individual health and wellbeing in relation to being fit for practice

2.3 Practise in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups

- demonstrates respect for individual/group common and legal rights in relation to health care
- identifies and adheres to strategies to promote and protect individual/group rights
- considers individual/group preferences when providing care
- clarifies individual/group requests to change and/or refuse care with relevant members of the health care team
- advocates for individuals/groups when rights are overlooked and/or compromised
- accepts individuals/groups to whom care is provided regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
- ensures that personal values and attitudes are not imposed on others
- undertakes assessments which are sensitive to the needs of individuals/groups
- recognises and accepts the rights of others
- maintains an effective process of care when confronted by differing values, beliefs and biases
- provides appropriate information within the nurse's scope of practice to individuals/groups
- consults relevant members of the health care team when required
- questions and/or clarifies orders and decisions that are unclear, not understood or questionable
- questions and/or clarifies interventions that appear inappropriate with relevant members of the health care team



National Competency Standards for the Registered Nurse (continued)

2.4 Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures

- identifies when resources are insufficient to meet care needs of individuals/groups
- communicates skill mix requirements to meet care needs of individuals/groups to management
- protects the rights of individuals and groups and facilitates informed decisions
- identifies and explains policies/practices which infringe on the rights of individuals or groups
- clarifies policies, procedures and guidelines when rights of individuals or groups are compromised
- recommends changes to policies, procedures and guidelines when rights are compromised

2.5 Understands and practises within own scope of practice

- seeks clarification when questions, directions and decisions are unclear or not understood
- undertakes decisions about care that are within scope of competence without consulting senior staff
- raises concerns about inappropriate delegation with the appropriate registered nurse
- demonstrates accountability and responsibility for own actions within nursing practice
- assesses consequences of various outcomes of decision making
- consults relevant members of the health care team when required
- questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team

2.6 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective nursing care

- maintains a current knowledge base
- considers ethical responsibilities in all aspects of practice
- ensures privacy and confidentiality when providing care
- questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team

2.7 Recognises the differences in accountability and responsibility between registered nurses, enrolled nurses and unlicensed care workers

- understands requirements of statutory and professionally regulated practice
- understands requirements for delegation and supervision of practice
- raises concerns about inappropriate delegation with relevant organisational or regulatory personnel



National Competency Standards for the Registered Nurse (continued)

Critical Thinking and Analysis

Relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

3. Practises within an evidence-based framework

3.1 Identifies the relevance of research to improving individual/group health outcomes

- identifies problems/issues in nursing practice which may be investigated through research
- considers potential for improvement in reviewing the outcomes of nursing activities and individual/group care
- discusses implications of research with colleagues
- participates in research
- demonstrates awareness of current research in own field of practice

3.2 Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of nursing care

- uses relevant literature and research findings to improve current practice
- participates in review of policies, procedures and guidelines based on relevant research
- identifies and disseminates relevant changes in practice or new information to colleagues
- recognises that judgements and decisions are aspects of nursing care
- recognises that nursing expertise varies with education, experience and context of practice

3.3 Demonstrates analytical skills in accessing and evaluating health information and research evidence

- demonstrates understanding of the registered nurse role in contributing to nursing research
- undertakes critical analysis of research findings in considering their application to practice
- maintains accurate documentation of information which could be used in nursing research
- clarifies when resources are not understood or their application is questionable

3.4 Supports and contributes to nursing and health care research

- participates in research
- identifies problems suitable for research

3.5 Participates in quality improvement activities

- recognises that quality improvement involves ongoing consideration, use and review of practice in relation to practice outcomes, standards and guidelines and new developments
- seeks feedback from a wide range of sources to improve the quality of nursing care
- participates in case review activities
- participates in clinical audits



National Competency Standards for the Registered Nurse (continued)

4. Participates in ongoing professional development of self and others

4.1 Uses best available evidence, standards and guidelines to evaluate nursing performance

- undertakes regular self-evaluation of own nursing practice
- seeks and considers feedback from colleagues about, and critically reflects on, own nursing practice
- participates actively in performance review processes

4.2 Participates in professional development to enhance nursing practice

- reflects on own practice to identify professional development needs
- seeks additional knowledge and/or information when presented with unfamiliar situations
- seeks support from colleagues in identifying learning needs
- participates actively in ongoing professional development
- maintains records of involvement in professional development which includes both formal and informal activities

4.3 Contributes to the professional development of others

- demonstrates an increasing responsibility to share knowledge with colleagues
- supports health care students to meet their learning objectives in cooperation with other members of the health care team
- facilitates mutual sharing of knowledge and experience with colleagues relating to individual/group/unit problems
- contributes to orientation and ongoing education programs
- acts as a role model to other members of the health care team
- participates where possible in preceptorship, coaching and mentoring to assist and develop colleagues
- participates where appropriate in teaching others including students of nursing and other health disciplines, and inexperienced nurses
- contributes to formal and informal professional development

4.4 Uses appropriate strategies to manage own responses to the professional work environment

- identifies and uses support networks
- shares experiences related to professional issues mutually with colleagues
- uses reflective practice to identify personal needs and seek appropriate support



National Competency Standards for the Registered Nurse (continued)

Provision and Coordination of Care

Relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/groups, planning, implementation and evaluation of care.

5. Conducts a comprehensive and systematic nursing assessment

5.1 Uses a relevant evidence-based assessment framework to collect data about the physical socio-cultural and mental health of the individual/group

- approaches and organises assessment in a structured way
- uses all available evidence sources, including individuals/groups/significant others, health care team, records, reports, and own knowledge and experience
- collects data that relates to physiological, psychological, spiritual, socio-economic and cultural variables on an ongoing basis
- understands the role of research-based, and other forms of evidence
- confirms data with the individual/group and members of the health care team
- uses appropriate assessment tools and strategies to assist the collection of data
- frames questions in ways that indicate the use of a theoretical framework/structured approach
- ensures practice is sensitive and supportive to cultural issues

5.2 Uses a range of assessment techniques to collect relevant and accurate data

- uses a range of data gathering techniques, including observation, interview, physical examination and measurement in obtaining a nursing history and assessment
- collaboratively identifies actual and potential health problems through accurate interpretation of data
- accurately uses health care technologies in accordance with manufacturer's specification and organisational policy
- identifies deviations from normal, or improvements in the individual's/group's, health status
- identifies and incorporates the needs and preferences of individuals/group into a plan of care

5.3 Analyses and interprets assessment data accurately

- recognises that clinical judgements involve consideration of conflicting information and evidence
- identifies types and sources of supplementary information for nursing assessment
- describes the role of supplementary information in nursing assessment
- demonstrates knowledge of quantitative and qualitative data to assess individual/group needs



National Competency Standards for the Registered Nurse (continued)

6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team

6.1 Determines agreed priorities for resolving health needs of individuals/groups

- incorporates relevant assessment data in developing a plan for care
- determines priorities for care, based on nursing assessment of an individual's/group's needs for intervention, current nursing knowledge and research
- considers individual/group preferences when determining priorities for care actively in performance review processes

6.2 Identifies expected and agreed individual/group health outcomes including a time frame for achievement

- establishes realistic short- and long-term goals that identify individual/group health outcomes and specify condition for achievement
- identifies goals that are measurable, achievable, and congruent with values and beliefs of the individual/group and/or significant others
- uses resources to support the achievement of outcomes
- identifies criteria for evaluation of expected outcomes

6.3 Documents a plan of care to achieve expected outcomes

- ensures that plans of care are based on an ongoing analysis of assessment data
- plans care that is consistent with current nursing knowledge and research
- documents plans of care clearly

6.4 Plans for continuity of care to achieve expected outcomes

- collaboratively supports the therapeutic interventions of other health team members
- information necessary for continuity of the plan of care is maintained and documented
- responds to individual/group or carer's educational needs
- provides or facilitates an individual/group or carer's resources and aids as required
- identifies and recommends appropriate agency, government and community resources to ensure continuity of care
- initiates necessary contacts and referrals to external agencies
- forwards all information needed for continuity of care when an individual/group is transferred to another facility or discharged

PROFESSIONAL PRACTICE FRAMEWORK



National Competency Standards for the Registered Nurse (continued)

7. Provides comprehensive, safe and effective evidence - based nursing care to achieve identified individual/group health outcomes

7.1 Effectively manages the nursing care of individuals/ groups

- uses resources effectively and efficiently in providing care
- performs actions in a manner consistent with relevant nursing principles
- performs procedures confidently and safely
- monitors responses of individuals/groups throughout each intervention and adjusts care accordingly
- provides education and support to assist development and maintenance of independent living skills

7.2 Provides nursing care according to the documented care or treatment plan

- acts consistently with the predetermined plan of care
- uses a range of appropriate strategies to facilitate the individual/group's achievement of short and long term expected goals

7.3 Prioritises workload based on the individual's/group's needs, acuity and optimal time for intervention

- determines priorities for care, based on nursing assessment of an individual/group's needs for intervention, current nursing knowledge and research
- considers the individual/group's preferences when determining priorities for care

7.4 Responds effectively to unexpected or rapidly changing situations

- responds effectively to emergencies
- maintains self-control in the clinical setting and under stress conditions
- implements crisis interventions and emergency routines as necessary
- maintains current knowledge of emergency plans and procedures to maximise effectiveness in crisis situations
- participates in emergency management practices and drills according to agency policy

7.5 Delegates aspects of care to others according to their competence and scope of practice

- delegates aspects of care according to role, functions, capabilities and learning needs
- monitors aspects of care delegated to others and provides clarification/assistance as required
- recognises own accountabilities and responsibilities when delegating aspects of care to others
- delegates to and supervises others consistent with legislation and organisational policy

7.6 Provides effective and timely direction and supervision to ensure that delegated care is provided safely and accurately

- supervises and evaluates nursing care provided by others
- uses a range of direct and indirect techniques such as instructing, coaching, mentoring, and collaborating in the supervision and support of others
- provides support with documentation to nurses being supervised or to whom care has been delegated
- delegates activities consistent with scope of practice/competence

7.7 Educates individuals/groups to promote independence and control over their health

- identifies and documents specific educational requirements and requests of individuals/groups
- undertakes formal and informal education sessions with individuals/groups as necessary
- identifies appropriate educational resources, including other health professionals

7.8 Uses health care resources effectively and efficiently to promote optimal nursing and health care

- recognises when nursing resources are insufficient to meet an individual's/group's needs
- demonstrates flexibility in providing care where resources are limited
- recognises the responsibility to report to relevant persons when level of resources risks compromising the quality of care



National Competency Standards for the Registered Nurse (continued)

8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team

8.1 Determines progress of individuals/groups toward planned outcomes

- recognises when individual's/group's progress and expected progress differ and modifies plans and actions accordingly
- discusses progress with the individual/group
- evaluates individual/group responses to interventions
- assesses the effectiveness of the plan of care in achieving planned outcomes

8.2 Revises the plan of care and determines further outcomes in accordance with evaluation data

- revises expected outcomes, nursing interventions and priorities with any change in an individual's/group's condition, needs or situational variations
- communicates new information and revisions to members of the health care team as required

Collaborative and Therapeutic Practice

Relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to the nurse understanding their contribution to the interdisciplinary health care team.

9. Establishes, maintains and appropriately concludes therapeutic relationships

9.1 Establishes therapeutic relationships that are goal directed and recognises professional boundaries

- demonstrates empathy, trust and respect for the dignity and potential of the individual/group
- interacts with individuals/groups in a supportive manner
- effectively initiates, maintains and concludes interpersonal interactions
- establishes rapport with individuals/groups that enhances their ability to express feelings, and fosters an appropriate context for expression of feeling
- understands the potential benefits of partnership approaches on nurse individual/group relationships
- demonstrates an understanding of standards and practices of professional boundaries and therapeutic relationships

9.2 Communicates effectively with individuals/groups to facilitate provision of care

- uses a range of effective communication techniques
- uses language appropriate to the context
- uses written and spoken communication skills appropriate to the needs of individuals/groups
- uses an interpreter where appropriate
- provides adequate time for discussion
- establishes, where possible, alternative communication methods for individuals/groups who are unable to verbalise
- uses open/closed questions appropriately



National Competency Standards for the Registered Nurse (continued)

9.3 Uses appropriate strategies to promote an individual's/group's self-esteem, dignity, integrity and comfort

- identifies and uses strategies which encourage independence
- identifies and uses strategies which affirm individuality
- uses strategies which involve the family/significant others in care
- identifies and recommends appropriate support networks to individuals/groups
- identifies situations which may threaten the dignity/integrity of an individual/group
- implements measures to maintain dignity of individuals/groups during periods of self-care deficit
- implements measures to support individuals/groups experiencing emotional distress
- information is provided to individuals/groups to enhance their control over their own health care

9.4 Assists and supports individuals/groups to make informed health care decisions

- facilitates and encourages individual/group decision-making
- maintains and supports respect for an individual/group's decision through communication with other members of the interdisciplinary health care team
- arranges consultation to support individuals/groups to make informed decisions regarding health care

9.5 Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security

- demonstrates sensitivity, awareness and respect for cultural identity as part of an individual's/group's perceptions of security
- demonstrates sensitivity, awareness and respect in regard to an individual's/group's spiritual needs
- involves family and others in ensuring that cultural and spiritual needs are met
- identifies, eliminates or prevents environmental hazards where possible
- applies relevant principles to ensure the safe administration of therapeutic substances
- maintains standards for infection control
- applies ergonomic principles to prevent injury to individual/group and self
- prioritises safety problems
- adheres to occupational health and safety legislation
- modifies environmental factors to meet an individual's/group's comfort needs where possible
- promotes individual/group comfort throughout interventions
- uses ergonomic principles and appropriate aids to promote the individual/group's comfort



National Competency Standards for the Registered Nurse (continued)

10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care

10.1 Recognises that the membership and roles of health care teams and service providers will vary depending on an individual's/group's needs and health care setting

- recognises the impact and role of population, primary health and partnership health care models
- recognises when to negotiate with, or refer to, other health care or service providers
- establishes positive and productive working relationships with colleagues
- recognises and understands the separate and interdependent roles and functions of health care team members

10.2 Communicates nursing assessments and decisions to the interdisciplinary health care team and other relevant service providers

- explains the nursing role to the interdisciplinary team and service providers
- maintains confidentiality in discussions about an individual/group's needs and progress
- discusses individual/group care requirements with relevant members of the health care team
- collaborates with members of the health care team in decision making about care of individuals/groups
- demonstrates skills in written, verbal and electronic communication
- documents, as soon possible, forms of communication, nursing interventions and individual/group responses

10.3 Facilitates coordination of care to achieve agreed health outcomes

- adopts and implements a collaborative approach to practice
- participates in health care team activities
- demonstrates the necessary communication skills to manage avoidance, confusion and confrontation
- demonstrates the necessary communication skills to enable negotiation
- demonstrates an understanding of how collaboration has an impact on the safe and effective provision of comprehensive care
- establishes and maintains effective and collaborative working relationships with other members of the health care team
- consults with relevant health care professionals and service providers to facilitate continuity of care
- recognises the contribution of, and liaises with, relevant community and support services
- records information systematically in an accessible and retrievable form
- ensures that written communication is comprehensive, logical, legible, clear and concise, spelling is accurate and only acceptable abbreviations are used
- establishes and maintains documentation according to organisational guidelines and procedures

10.4 Collaborates with the health care team to inform policy and guideline development

- regularly consults policies and guidelines
- demonstrates awareness of changes to policies and guidelines
- attends meetings and participates in practice reviews and audits
- demonstrates understanding of the implications of national health strategies for nursing and health care practice



Glossary

ANMC: Australian Nursing and Midwifery Council

Appropriate: Matching the circumstances, meeting needs of the individual, groups or situation

Attributes: Characteristics which underpin competent performance

Core Competency Standards: Essential competency standards for Standards registration or licensure.

Competence: The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.

Competent: The person has competence across all the domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed.

Competency Unit: Represents a major function/functional area in the total competencies of a Registered Nurse in a nursing context representing a stand-alone function which can be performed by the individual.

Competency Element: Represents a sub-function of the competency unit.

Competency Standards: Consists of competency units and competency elements.

Contexts: The setting/environment where competence can be demonstrated or applied.

Cues: Key generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist the assessor when using their professional judgement in assessing nursing practice. They further assist curriculum development.

Domain: An organised cluster of competencies in nursing practice.

Enrolled Nurse: A person licensed under an Australian State or Territory Nurses Act or Health Professionals Act to provide nursing care under the supervision of a Registered Nurse. Referred to as a Registered Nurse Division II in Victoria.

Exemplars: Concrete, key examples chosen to be typical of competence. They are not the standard but are indicative of the standard

Registered Nurse: A person licensed to practice nursing under an Australian State or Territory Nurses Act or Health Professionals Act. Referred to as a Registered Nurse Division 1 in Victoria.

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The ANMC acknowledges that the methods and processes in assessment of competencies will be further developed, and that the content of this document will be reviewed in three years. Comments should be addressed to:

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Appendix 2 – Participants and organisations represented in the Modified Nominal Groups

Job Description	Organisation	State
Clinical nurse educator	Department of Health and Human Services	Tasmania
Postgraduate and graduate course facilitator	Launceston General Hospital, Tasmania	
Training and development coordinator	Calvary Health Care Launceston Campuses	
Clinical nurse educator	Tasmanian Mental Health Services	
Academic(s)	University of Tasmania	
Registered nurse	Curtin University	Western Australia
Clinical nurse educator	Curtin University	
Academic	University of Notre Dame	
Academic(s)	Curtin University	
Nurse educator	Nurses and Midwives Board of WA	
Nurse educator	Curtin University	
Program coordinator	Child and Adolescent Health Service	
Staff educator	Fremantle Hospital and Health Service	
Registered nurse	South Eastern Sydney Illawarra Area Health Service (SESAHS)	New South Wales
Nurse educator	SESAHS	
Nursing unit manager	SESAHS	
Nurse educator(s)	Sydney South West Area Health Service (SSWAHS) and RPAH	
Clinical nurse consultant	SESAHS	
Academic(s)	Charles Darwin University	Northern Territory
Enrolled nurse and RN student	Charles Darwin University	
Clinical nurse consultant	Royal Darwin Hospital	
Clinical placement manager	Charles Darwin University	
Nurse educator	Mater Health Services	Queensland
Academic	Queensland University of Technology	
Academic	University of Southern Queensland	
Nurse educator	Royal Brisbane & Women's Hospital	
Nursing unit manager	Queensland Health	
Nurse educator	Princess Alexandra Hospital	
Nurse educator	Southside Health Service District	
Nurse educator	Royal Brisbane & Women's Hospital	
Nurse educator	University of Southern Queensland	
Nurse educator	Queensland Health	
New graduate RNs	Whyalla Hospital and Health Services	South Australia
RN – mental health	Division of Child & Adolescent Mental Health Service (CAMHS)	



RN – general surgery	Calvary North Adelaide Hospital	Victoria
RN – general medicine	Central Northern Adelaide Health	
Academic(s)	Victoria University	
Graduate nurse program coordinator	The Royal Melbourne Hospital	
Academic	Deakin University	
Academic(s)	University of Ballarat	
Education manager	East Grampian Health Service	
Clinical teacher	Wimmera Health Care Group	
Education manager	Wimmera Health Care Group	
Clinical coordinator	University of Ballarat	
	University of Ballarat	
Graduate nurse coordinator	Perth Hospital	Western Australia
Senior lecturer		
Associate Professor Teaching and Learning		
Lecturer		
Facilitator		
Programme director		
Clinician and facilitator		



Appendix 3 – Summary of Delphi Round 2

Skill Area	Year 1	Year 2	Year 3
1. Planning of Nursing Care (eg range of varied settings/clients needs)	Marginal = 30% Assisted = 32%	Assisted = 38% Supervised = 46%	Supervised = 44% Independent = 49%
2. Different roles of RNs in different treatment or care settings (eg aged care, rural and remote, acute, mental health, etc)	Dependent = 39% Marginal = 28%	Assisted = 45% Supervised = 29%	Supervised = 55% Independent = 29%
3. Medications and IV products (eg safe and appropriate administration of medications)	Dependent = 46% Marginal = 28%	Assisted = 46% Supervised = 30%	Supervised = 55% Independent = 35%
4. Clinical monitoring and management – use of assessment tools (eg hemodynamic/respiratory assessment, etc)	Marginal = 32% Assisted = 32%	Assisted = 41% Supervised = 42%	Supervised = 41% Independent = 53%
5. Technology and Informatics (eg IVI management systems, patient information systems, etc)	Dependent = 42% Marginal = 27%	Assisted = 46% Supervised = 31%	Supervised = 53% Independent = 32%
6. Personal care – ability to assess, plan implement and evaluate care of clients across a range of settings using a holistic, comprehensive nursing model	Marginal = 27% Assisted = 39%	Supervised = 50%	Independent = 69%
7. Mental health nursing care (eg application of assessment tools and care strategies and interventions)	Dependent = 46% Marginal = 30%	Assisted = 47% Supervised = 22%	Supervised = 53% Independent = 20%
8. Knowledge of key nursing implications of common medical/surgical patient presentations	Dependent = 43% Marginal = 31%	Assisted = 44% Supervised = 29%	Supervised = 49% Independent = 33%
9. Clinical interventions – preparing, assisting after care (investigations/surgery/ diagnostic)	Dependent = 41% Marginal = 31%	Assisted = 47% Supervised = 31%	Supervised = 55% Independent = 35%
10. Professional nursing behaviours – includes collaborative approaches to care (eg advocacy, scope of practice, being aware of one's self, etc)	Marginal = 28% Assisted = 33%	Assisted = 24% Supervised = 47%	Independent = 63%
11. Privacy and dignity (eg cultural care/transcultural practice, personal space, respectful)	Assisted = 39% Supervised = 24%	Supervised = 43% Independent = 38%	Independent = 84%



13.	Dealing with emotional and bereaved people (eg conflict management/resolution, breaking bad news, dealing with anger, etc)	Dependent = 39% Marginal = 29%	Assisted = 43% Supervised = 28%	Supervised = 52%
14.	Dementia related skills (eg behavioural and psychosocial symptoms of dementia and the ability to differentiate other causes such as delirium)	Dependent = 45% Marginal = 29%	Assisted = 45% Supervised = 25%	Supervised = 56% Independent = 24%
15.	Coordinating skills regarding nursing process – uses a range of appropriate assessment strategies and skills across a range of settings	Dependent = 37% Marginal = 26%	Assisted = 43% Supervised = 36%	Supervised = 42% Independent = 43%
16.	Leadership skills	Dependent = 40% Marginal = 40%	Marginal = 26% Assisted = 47%	Assisted = 27% Supervised = 52%
17.	Preventing risk and promoting safety – duty of care (eg strategies for reducing risk, risk assessment, etc – promoting self care)	Marginal = 25% Assisted = 37%	Assisted = 32% Supervised = 49%	Independent = 62%
18.	Case manager (eg coordination of care, crisis/emergency situation management, etc)	Dependent = 52% Marginal = 30%	Marginal = 28% Assisted = 43%	Assisted = 29% Supervised = 52%
19.	Teamwork and multidisciplinary team working	Marginal = 32% Assisted = 30%	Assisted = 45% Supervised = 35%	Supervised = 48% Independent = 41%
20.	Supervisory skills	Dependent = 45% Marginal = 33%	Marginal = 27% Assisted = 45%	Supervised = 53%
21.	Cultural competence (eg cross cultural care, culturally safe and appropriate practice)	Marginal = 27% Assisted = 36%	Assisted = 31% Supervised = 46%	Independent = 57%
22.				
23.	Therapeutic nursing behaviours/ respectful of personal space	Marginal = 25% Assisted = 34%	Assisted = 30% Supervised = 43%	Independent = 61%
24.	Efficient and effective Communication (eg with professionals in other disciplines)	Marginal = 29% Assisted = 37%	Assisted = 27% Supervised = 50%	Independent = 67%
25.	Communication and documentation ie verbal including handovers and non-verbal including documentation	Marginal = 27% Assisted = 37%	Assisted = 33% Supervised = 47%	Independent = 64%



26. Learner/evidence based Practitioner (eg appropriate application of practice evidence)	Marginal = 30% Assisted = 33%	Assisted = 39% Supervised = 40%	Supervised = 44% Independent = 45%
27. Critical analysis and reflective thinking (eg use of reflection and critical incidents, evidence of linking theory to practice)	Marginal = 26% Assisted = 38%	Assisted = 35% Supervised = 43%	Supervised = 40% Independent = 51%
28. Demonstrates teaching/educator skills (eg utilising appropriate teaching and learning strategies in practice)	Dependent = 37% Marginal = 31%	Assisted = 44% Supervised = 25%	Supervised = 47% Independent = 24%
29. Acts as a resource	Dependent = 38% Marginal = 33%	Marginal = 26% Assisted = 40%	Supervised = 49% Independent = 23%
30. Promoting self care (eg specific gender and lifespan related information and strategies)	Marginal = 29% Assisted = 36%	Assisted = 37% Supervised = 44%	Supervised = 40% Independent = 52%
31. Demonstrates behaviour conducive to learning (eg approachable and supportive)	Marginal = 20% Assisted = 34%	Supervised = 45% Independent = 27%	Independent = 76%
32. Learning and developmental culture – learning environment (eg relates to an environment conducive to learning and personal and professional growth as a new graduate)	Marginal = 33% Assisted = 31%	Assisted = 42% Supervised = 37%	Supervised = 48% Independent = 40%

Dependent: Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Marginal: Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues required.

Assisted: Refers to being safe and knowledgeable most of the time; skilful in parts, however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues.

Supervised: Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.

Independent: Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and time. Does not require supporting Cues.



Appendix 4 – Independent Evaluation Report

Undertaken by Professor Sandra Jones, Centre for Health Initiatives, University of Wollongong, New South Wales.

Documentary Analysis

Key project documents were examined to provide evidence that the project has been undertaken in a systematic way, and that any methodological changes have been undertaken in consultation with relevant parties. Documents are required to be internally consistent, and also consistent with the original aims of the project.

Documents reviewed included (but were not limited to):

- Literature reviews from stages 1a) and 1b)
- PowerPoint presentations given to promote and explain the project at different organisations
- Discussion guides for the nominal groups and Delphi survey materials
- Audit lists from the initial documentary analysis
- The draft Competency Assessment Tool (CAT).

Documents were analysed by a trained researcher, who is particularly experienced in the methods of literature reviews and survey development. A summary of the documentary analysis is included in the following sections.

Literature review- Phase 1a)

This literature review attempted to answer the research question: What clinical/practical skills should a graduate possess? The literature review provided a detailed background for the project in terms of the need for clarification of the roles and expectations of newly graduated nurses. It pointed to specific discrepancies between how competent new graduates felt upon completion of studies and how competent nurse educators and clinical nurses in their workplaces perceived them to be. Newly graduated nurses were generally seen as being less competent than expected by their more experienced counterparts. This was argued to be the need for such a review.

The literature search strategy was robust and key terms were appropriately used. However, only two databases were searched (one being “Google”) so a greater number of databases may have proven more fruitful. Nevertheless, a large number of studies were identified pertaining to the research question. Definitions and interpretations of the term “clinical skill” with respect to nursing were discussed in order to reduce conceptual ambiguity between studies reviewed. “Core practical skills” – skills that are used with a high level of frequency in clinical settings – were then appropriately identified in the literature. It was found that the scope of skills and the skills themselves varied widely from study to study and, furthermore, that the conceptualisation of skills and competencies often overlaps. To compound the matter, research indicated a marked disparity between graduates and more experienced nurses in the skills they considered “core skills”. The review concluded that there are numerous and widely varied sets of skills that are expected of new graduates, and that these have been poorly defined in the past. There is a lack of information available to ascertain which specific skills are essential and/or desirable for new graduates to possess, and exposure to more complex skills (e.g. catheterisation, tracheostomy care) may not be available - even for graduates.

While this literature review appeared to be restricted in coverage and contained some references more than 10 years old, the scope of the review was appropriate for the purposes of the project and was constructed in a systematic manner (with a clear structure, search



strategy, etc). The review makes a strong case that there is a need for a consistent and well-articulated definition of skills expectations for newly graduated nurses. The literature review was consistent with assumptions made in the initial project plan, and added significant detail to the emerging project.

Literature review- Phase 1b)

The literature review argues that clinical observation and assessment in practice using a valid and reliable competency assessment tool (CAT) is the most appropriate method for assessing student nurse competence. The literature review aimed to:

- a) Review literature surrounding definitions of “competency”;
- b) Discuss issues surrounding the “competency movement”;
- c) Determine from this “best practice” for developing a CAT.

A large number of varied databases were used to search the international and national literature, and a number of specific keywords gave the literature search credibility. The scope of the search was suitably wide, given the broad topic area, and allowed for teaching databases to be included, as well as articles published over a period of 28 years. The search strategy was systematic, the criteria for inclusion/exclusion of literature were well defined, and a large number of articles (n = 64) were reviewed. The results of the literature review suggested that the existing definitions of competency could be seen as both confusing and contradictory. The ANMC’s broad definition of competency, however, provided a more holistic view of nursing competency, and expanded the definition to cover the nurse’s “knowledge, skills, attitudes, values, and abilities”.

It is argued that a purely task-based assessment of competencies ignores the cognitive and humanistic components of nursing. However, measuring competencies such as critical thinking and interpersonal skills is a difficult task, as is deciding how these measurements are scaled. Furthermore, reliability and validity problems occur in that most competency documents are not tested in this way, and because of conceptual confusion surrounding the term ‘competency’, construct validity is threatened. Research emerging from Australia indicates that while technical skills are considered important to clinical nursing, personal, interpersonal, emotional, ethical, and time management skills also rate highly in terms of assessments of competence, and should not be ignored.

The review concluded with recommendations from the literature reviewed for: profile development (the development of a competency profile); scale and criterion development (applying a scale with a set criteria); validity/reliability testing; and administration of the tool. It is clear that this review of the literature has fed into the plan for the development of the CAT quite significantly. Recommendations made in the review were followed, and the tool reflects the specific concerns raised in previous research. For example, the Bondy Scale used in the final product was researched and alternatives to this were discussed; an empirically-based argument was made for the use of preceptor-based assessments rather than use of external examiners. Additionally, reliability and validity issues highlighted in the review will be addressed in the future through pilot testing and benchmarking subsequent to the conclusion of the project.

This literature review was of a high standard, comprehensive and served its purpose in informing the careful and systematic development of the CAT.



PowerPoint Presentations

PowerPoint presentations provided insights into the evolution of the project from start to finish. It is understood that these invited presentations were effective in generating discussion of, and participation in, the project from organisations with a stake in the outcome (such as the ANMC and CDNM). These were essential in creating an atmosphere where the project could be questioned, concerns could be raised in an open forum, and input from key organisations could be gathered through consultation. The slides indicated the level of change in staffing throughout the project and also allowed another layer of insight into how the (minor) changes to the methodology occurred.

Project slides commenced with a clear articulation of the problem and a rationale expressing the need for such a project, the intended outcomes of the project (the CAT), and a summary of project methodology (including the documentary analysis, literature reviews, Delphi surveys, nominal groups, and a dissemination plan). Earlier presentations also mention a fourth phase in which pilot testing of the tool was planned to occur.

Preliminary results and descriptive statistics were presented as they occurred. For example, while the first presentation (to the ANMC, 15/7/08) did not include a specific description of data already collected, the following presentation (23/7/08) included a breakdown of response rates from universities (regarding the documentary analysis), along with some examples of competencies being generated by the universities, and an estimate of how many “skills” had been listed by the various institutions (more than 550). Slides from later presentations (e.g. 24/11/08) show the conceptual framework which was then used to group these skills. From these presentations the progression of the project can be clearly seen, and reasons for some of the refinements to the methodology and extension of the timeline are apparent. An example of this might be the number of skills listed in the documentary analysis (approximately 550). Without having undertaken the analysis first, researchers could not have known that such a large number would be generated, and therefore had to take time to modify existing strategies in order to refine the list to a manageable number (for the Delphi surveys). Participants who consented to the Delphi survey on a volunteer basis would have been unlikely to be motivated to examine over 550 skills, so refinement using a recognised framework and an expert panel group was essential in this case.

Presentations routinely included a discussion of longer term goals beyond the scope of the current project - the “bigger picture” - where the tool is evaluated, refined and integrated into Australian universities. Presentations on the whole concluded with discussion of important or interesting issues from the perspective of the host group, and suggestions taken from the audience on what role their organisation might play in the project. This focus on inclusion and participation is a hallmark of the approach to this project.

The most recent presentation under review (7/12/09) displayed the draft CAT in addition to the structure of the project overall (how the project arrived at this point). In this way, CAT dissemination has also occurred via these presentations.

Overall, an analysis of the presentations has proven to be useful in demonstrating the sheer size of a project such as this, and how the project team has effectively managed this and other challenges.

Discussion guides for the nominal groups and Delphi survey materials

Interviews with key staff members on the project indicated that at first there was a low response rate for this Delphi process. In response to this, the research team used relevant contacts at key nursing organisations to promote (via email) participation in the Delphi



survey process. This led to increases in participation so that the target number of participants was reached.

Two rounds of Delphi surveys were conducted. In the first, participants were asked whether the 26 skills areas were grouped appropriately under headings (ie Clinician, Manager, Communicator, Researcher or Educator), and whether these skills were/were not considered necessary for a new graduate. The Delphi survey also included a qualitative section at the end of each heading where participants could list any omitted skills. At the conclusion of the survey there was an opportunity to record any comments at all about the survey. This mixture of quantitative and qualitative methodologies appeared to allow participants to both complete the survey in a timely fashion and to comment on any areas that they believed to be contentious. The skills list and framework for grouping of the skills list was theoretically derived, and was reviewed extensively by an expert panel to optimise objectivity and quality of the list.

The second round of the Delphi survey followed logically from the first. The response set was modified based on results from the first round so that only skills that more than 50% of respondents said were necessary for a new graduate remained as part of the survey. In this round participants were asked to use the Bondy Rating Scale to indicate the level of competence that an undergraduate nurse should have for each skill at each year of study. In this way, the survey incorporated relevant information from literature review 2, and the quantitative empirical results of the first round. Again, participants were invited to give qualitative feedback on any skills which they believed to be missing, but this time there was no opportunity to provide any other comments. Since some Delphi participants (interviewed) reported that they would have liked greater opportunity to give qualitative feedback, it may have been advantageous to include one extra question asking if participants would like to make any other comments in order to allow them to feel heard.

However, as noted earlier, the overall design and response sets for the survey were well organised, well-sequenced and user friendly, while still allowing participants to systematically consider the complex questions being asked. Furthermore, results of interviews with Delphi participants indicated that participants were satisfied with their involvement and felt that the surveys comprehensively covered a wide range of skills. While only two Delphi surveys were conducted (as opposed to the four initially proposed) other methods of refining the unmanageably large amount of data generated from the universities meant that only two Delphi surveys were necessary to answer the research questions, and allow collaborative input from academics, clinicians and students around Australia. Furthermore, given the initial problems with motivating participation in the two surveys, it might have been unrealistic to burden participants with four lengthy tasks as opposed to two. So while all four surveys were not conducted, other methods replaced the need for such a process.

Nominal group materials displayed the structure of these meetings. Warm-up activities commenced proceedings, followed by staff and participant introductions. The nominal groups continued with a presentation-style overview of the issues to be addressed by the project and in the nominal group itself, in order to orient the participants to the rationale for the tasks they would be asked to undertake. These PowerPoint presentations were modified slightly by the project team after the first few meetings to optimise their success in generating useful discussion. Notes were taken on butcher's paper on participants' own experiences with competency documents. Participants were then asked to provide exemplars of how they might assess particular competencies and, in particular, were asked to consider what they would need to observe to assess this, what they might ask to assess it, and what they would measure or record to assess it (if anything). Post-it notes were used to mark additional points on the butcher's paper.



The nominal groups were conducted in all states in Australia and were approximately equally represented by those from academic and clinical practice backgrounds. This sampling frame emphasised inclusion of participants from all facets of nursing, and also from rural and remote parts of Australia. Documentation of the guidelines from the meetings shows a consistent structure so that all participants were asked to consider the same issues and received equal input. Interviews with nominal group participants indicated a high degree of satisfaction with the process and with the facilitators themselves.

Audit lists and information from documentary analysis

In order to collect all curriculum documents currently in use at Australian universities, documentation was requested from 37 institutions around Australia. The institutions were contacted via email and asked to send both CATs and Skills lists currently in use at their institution. The response rate from universities was high, with 90% (35/39) of institutions agreeing to provide documentation. Three of the universities that agreed to provide documentation did not do so, and one other provided insufficient information. The response rate for CATs was high at 82% (32/39), and all of these universities provided sufficient documentation for the audit. The response rate for skills lists was lower with 65% (25/39) agreeing to provide skills lists, with 96% of these providing information on when these skills are taught, 88% providing information on the assessment of these skills, 56% providing information on *both* how and when these skills are assessed, and 36% providing *detail* on how and when the skills are assessed.

Although response rates were already high, the research team was diligent in following up non-responsive institutions over a number of months, and this is well recorded in the summary of the documentary analysis. The extensive summary document includes sections to note the name of the contact at that institution, the address and contact details, the relevant person to contact about the course materials, whether a response was received and the date of receipt (as well as the dates of any follow up emails/contact with that person), and a summary of the analysis of competencies provided.

Documentation of this process was very thorough and clear, and allows the reader to see exactly how competencies were assessed at each institution. The detailed process has a substantial positive impact on the reliability of the project, as the process used to collect data from each institution can be seen clearly, with a summary of each university's competency documentation making results easy to compare across institutions. Again, this approach is user-friendly and demonstrates the transparency of the research process.

The draft Competency Assessment Tool and the accompanying Guidance Package

The CAT itself is well structured and it is clear to see how project elements have fed into the approach used. As suggested by some in the "interactive" interview process, the CAT itself is relatively succinct and thus takes into account concerns about how long it should take RNs to complete for each student. Students and RNs are allowed reflection on their own performance in a qualitative manner, allowing for individual differences in nursing style to be taken into account, and for individualised feedback to be given to the student.

The CAT makes use of the ANMC competencies, and the empirically derived performance criteria for each are specific, to enhance ease of use by busy RNs. Detailed exemplars for each skill are also included in the final package. While the actual assessment of students should not be particularly time consuming, an orientation or brief training program for RNs on how to use the tool would be beneficial, so that ease of use is enhanced.

Overall, the resulting tool appears to have been successful in synergising project elements. Furthermore, a draft assessment schedule has been provided, rather than just a simple tool.



This acknowledges the wide and varied range of skills, knowledge and attitudes required for nursing practice, and sets it aside from simple 'skills based' lists. In this way, the resulting tool has exceeded what was agreed in the initial application to the ALTC.

Clarificative Evaluation

In this case, the clarificative component of evaluation was used to ascertain the consistency of goals across the different stakeholder groups and participants. Ensuring consistent representation of the project is central to the level of approval from the nursing community, and to the effective management of the project by the project team. The different stakeholder groups included project staff (who are likely to have an intricate knowledge of the project), randomly selected nominal group participants (who are likely to have a moderate knowledge base in regards to the project), and randomly selected Delphi survey participants (who are likely to have a varying level of knowledge about the project). Interviewees were selected on the basis of their representation of different nursing groups – academics, policy makers and clinical staff, as well as their locality. Efforts were made to constitute a representative sample of all the states of Australia. The focus on interviewees with different levels of involvement with the project, across different areas of the country, and coming from different nursing backgrounds, reflects the overall emphasis on broad community involvement which has been present throughout the course of the project. Sample selection was therefore heavily influenced by the pre-established aims of the project.

Potential interviewees were contacted via email and asked to indicate whether they would like to participate in the telephone interviews. Interviews were then scheduled over a two week period and were all undertaken by the same evaluator to ensure consistency. Notes were taken while interviews proceeded, and all interviews were taped using a digital voice recorder.

A series of structured interviews were undertaken to examine the perceptions of various stakeholders in terms of:

- a) The underlying rationale, or need, for the project
- b) The goals or outcomes they hoped the project would achieve (their expectations of the project)
- c) How the project had been designed to achieve these intended outcomes.

Additional open-ended questions were initiated for each sample group to examine their level of satisfaction with their involvement in the project, the appropriateness of methodology, and what they perceived to be the strengths and weaknesses of such a project. They were also allowed to comment freely about the project and to raise any issues or concerns they had about the project at this stage.

Project staff underwent more intensive questioning, as their level of experience with the project allowed more in-depth examination. They were asked additional questions such as how they thought the project had progressed at this stage, about challenges faced and how these were overcome, and about whether outcomes of the project had been satisfactorily completed.

While only four interviews for each stakeholder group were contracted to be undertaken, the high level of interest in the project allowed the CHI to conduct additional interviews. This allowed a more comprehensive evaluation of the project.



Interviews with Nominal Group Participants

Five interviews were undertaken with nominal group participants: two interviewees were lecturers (from Western Australia and Victorian universities), and three were involved in clinical nursing (Tasmania, Queensland and Melbourne).

Responses to open ended questions indicated great consistency in terms of their understanding of the rationale and need for the project. All responses emphasised the need to reach a *“consensus”* and *“consistency”* between universities and hospitals, and also nationally, about what can reasonably be expected of undergraduate nurses, and making sure *“we are all assessing the same things”*. Most responses mentioned that a *“standard”* needed to be set, and that having such a standard for assessing students would *“make it [the assessment process] more streamlined, especially for nurses on the floor”*. It was noted by one participant, who was a nurse coordinator, that they see *“over 120 grad nurses from up to 22 universities”* so they can have up to *“22 clinical assessment forms”* which vary in length *“some 1 page, some 10 pages”*. For this participant, the rationale for developing one agreed upon competency assessment tool was to make life *“easier for clinical teachers on the floor”*. One other participant particularly mentioned aligning this standard with existing ANMC competencies, indicating a broad and accurate understanding of the rationale for the project from all nominal group participants.

In terms of goals or outcomes of the project, most nominal group members expected the end product to be a tool, which would allow some level of *“confidence around what is expected”* of students, and the development of a *“National standard for assessing students”* or a *“valid tool”* which would assist in *“benchmarking”*. However, one participant did not know (or did not mention/recollect) that the outcome was to be a tool for practical use, and required an explanation of this point towards the end of the interview. Once prompted the participant did show a high degree of interest in this outcome. More specific goals within the nominal groups were also identified which were stated as *“to see where things aligned and where things didn’t [with ANMC competencies]”*

Overall, most participants were satisfied with their participation in the nominal groups, and felt that it was an *“open discussion”* in which *“everyone had an equal hearing”*. They generally felt the groups were *“run well”* that the *“facilitators were fantastic”* and that the discussions were *“thought provoking”*. One participant noted that while they all knew about the ANMC competencies *“looking at how they can be practically achieved was good”*. There was also enthusiasm about the fact that both clinicians and academics were invited to be involved, as they felt this approach was uncommon for this kind of research: *“it was great to have representatives from hospitals as well as academics”*.

One participant, however, felt that within the nominal group context, the project was *“not very clearly described”*, and felt *“unsure”* about what they were being asked to do within the groups. This participant felt that there was a division within the group whereby those who had prior knowledge of the project (*“who were part of the project from the outset”*) were confident with what they were being asked to do, but those with *“no prior knowledge”* of the project felt *“unsure of what was being asked of them”*. Regardless of this, the participant did feel the groups were of value, and showed enthusiasm about the project itself. So despite these initial reservations, the participant had a generally positive view of the experience. The value (or strength) of a project such as this was well recognised by nominal group participants. The move towards National registration was cited as an impetus for the development of a nationally recognised and well validated tool: *“it is essential that we are using the same assessment across Australia especially since we are heading towards National registration”*. The added value of the project was that it would theoretically produce graduates who are all at *“the same level or standard”*, and allow graduates to be *“all on*



equal footing". It was also thought that the project would *"give clarity to the people assessing them"*, particularly the RNs who are expected to undertake the assessments.

A few participants expressed concerns about some aspects of the project. These included that they felt their involvement had finished with the nominal groups, and that they had received no feedback or information about the project since. Others raised concerns about the implications of such a tool, and the danger of *"developing a list of skills"*. Their concerns stemmed from the idea that nursing is not simply *"just about doing skills"* and that the project staff *"needs to be careful in moving down that path"*. One participant noted the risk of the project being a *"step back for nursing"* in regards to going back to the days of the *"old blue book"*. There was also an emphasis on the researchers *"keeping it [the tool] simple as nurses don't have time on the floor"* and *"keeping it small"*. Given that none of the nominal group participants had actually seen the drafted CAT tool, and had not heard about the project since their involvement with it, these concerns may be alleviated once they are allowed the chance to view and comment on the tool.

Overall, the nominal group participants were competent at describing the aims and rationale for the project and their comments were consistent with one another, indicating that these stakeholders (all from different states, and areas of nursing) were satisfied with their part in the project. Their expectations of the project were similar. They expected that the project would develop a well-validated national tool to assess competencies, and that this tool would provide consensus across Australian universities and hospitals. Although potential risks were noted by participants, it was felt that the development of such a tool would be beneficial for nursing in the long term, particularly from the perspective of simplifying assessment for nurses *"on the floor"*. The nominal groups therefore served to demonstrate another layer of value for the project. While the project was initially discussed in terms of its usefulness for undergraduate and newly graduated nurses, the nominal group participants tended to feel that its main value would be lessening the load of already busy RNs who have to assess these students.

Interviews with Delphi Participants

Four interviews were conducted with Delphi survey participants. These participants represented a diverse array of roles in nursing, with one from an academic background, one who was a clinical nurse coordinator, one who was a clinical facilitator, and one who was involved in the teaching and development of nurses. These interviews were less time intensive than those for other groups as, in general, participants from the Delphi rounds had only participated minimally in the project, and so responses were considerably less complex. However, all Delphi participants were able to articulate the rationale and aims of the project as being to generate *"greater consistency in clinical assessment of students across a range of health services across Australia"*, and to *"come up with a competency assessment framework"*. While one participant could not articulate the intended outcome of the project, the other three participants understood that the outcome was to be a competency assessment tool or an *"appraisal form that can be utilised by universities and clinical placement organisations"*. Two of the four participants could describe elements of the project design that were aimed at reaching these outcomes, and both mentioned pooling of current assessment tools to generate a list of areas to assess, and then narrowing of this list into one coherent tool. As all but one Delphi participant interviewed had not heard anymore about the project following participation in the Delphi survey, it seems logical that they would only have knowledge of the initial project stages preceding the Delphi process (if they had any knowledge about the project design at all). When prompted, participants felt that the Delphi process was indeed the most time-efficient and effective way of generating such complex data from a National sample. It was considered *"easiest for people who are busy"*, and the best way to *"get involvement from others"*. The skill set presented in the survey was deemed by all participants to be comprehensive, and none felt that there were any glaring omissions.



All were satisfied with this aspect of the survey. However, some difficulties with the online survey format were mentioned including that more detailed qualitative comments could not be made for each skill area (e.g., *“there was some difficulty with the process being on the web.... somewhat restricted in how you could comment.... wanted to make more specific comments”*). Another participant felt the questions were *“too generic”* to answer in such a forum, but acknowledged the difficulties created by trying to ask complex questions to a large national sample which is geographically dispersed. While two participants could not think of an alternative way of asking these questions, the other two suggested use of focus groups or expert reference groups to collect the data in the future.

Consistent with the results of the nominal groups (and other interviewees) all Delphi participants reported that they felt this was a highly worthwhile project, and could not overstate the value of this process for streamlining and providing consistency to the assessment of student nurses (e.g., *“a most important project for achieving consistency”*; *“very worthwhile”*; *“quality control equals better practitioners”*).

In this way, it can be seen that participants with a lower level of involvement with the project had ideas consistent with other stakeholders on the benefit of the project for students, nurses, and the nursing profession more broadly; and they had a similar (but slightly more restricted) understanding of, and expectations for, the project.

Interviews with Project Staff

Five extensive interviews were undertaken with project staff. These interviews contained both clarificative and interactive components in order to provide a fuller examination of both their expectations of, and assumptions about, the project; and their perception of the development of the project and the resulting competency assessment tool itself.

Project staff all recognised the need for the project as being multifaceted. First, all staff mentioned that there is a misunderstanding or lack of agreement about what can reasonably be expected from newly graduated nurses, and nothing to adequately compare the performance of new graduates and/or undergraduate students, and also no definition of *“what skills should be required for a new graduate”*. They also cited *“concerns with the reliability and validity of varying [assessment] tools”*. A need to clarify what nursing programs should produce and to ensure *“quality control”* across universities was also widely mentioned. Furthermore the current situation of student assessment was considered *“anarchic”* in that schools all assess students in different ways using different tools, so a key part of the rationale for all staff members was to provide consistency across universities. Finally, the useful but rather non-specific nature of the current ANMC competencies was discussed by some as an impetus for developing a more specific elucidation of competencies using that same framework.

Project goals and expected outcomes were almost identically stated as being to use wide national consultation to develop a *“tangible piece of work”*, the CAT, which may be *“used by all universities in their assessment of student nurses”* and one staff member stated more specifically that the aim was the *“amalgamation of statutory competencies... with employment competencies”*. The long-term focus of *“pilot testing”* this tool at universities was also mentioned as a key expectation by two staff members.

There was even greater consistency in responses from staff regarding how the project was designed to achieve the desired outcomes. All mentioned that inclusivity – national consultation and feedback from academics and clinicians as well as key nursing bodies such as the AMNC and CDNM – was a key element to ensure satisfaction with the final product. In this way, the emphasis was on developing a *“symbiotic”* relationship between stakeholder



groups and the project team. This was achieved through the use of nominal group methodology, Delphi methodology, and through wide dissemination and presentation of the results of the project (eg *“we want them [other stakeholders] to influence the shape and structure of the tool”*, *“collaboration and involvement of all stakeholders including students”*).

More specific questioning about challenges faced during the course of the project, and how these were overcome, provided insight into the barriers and “speed-bumps” that were overcome. Changes in timelines and uncertainty about this was cited by two participants, and changes in staffing over the project period was also cited by three of the project staff as a challenge, as recruiting and orienting of new staff to the (large scale) project tended to add to the already tight timeline. One participant felt that the greatest challenge was the *“scale of the undertaking”*, and most commented that their determination to make the project as inclusive as possible meant that practical problems (such as coordinating participants and stakeholders from geographically dispersed areas) arose. The sheer number of people and organisations involved in the project also provided challenges as this brings *“lots of views to the table”*, and care must be taken to constantly *“incorporate that into what is being developed”*. Finally, one participant mentioned that there was often a misperception that the tool was going to be a simple “skills” list, and that countering resistance to this through reassurance and presentation of preliminary findings was particularly important. Challenges and barriers were resolved generally through a process of information giving (presentations), discussions with key individuals (such as Heads of Schools) and consultation with relevant nursing bodies. It was noted that a plan of action to counter these sorts of barriers existed prior to commencement of the project, so staff generally felt prepared to deal with challenges faced. The high level of communication between project team members was also cited as one of the means of tackling obstacles.

The small amount of methodological changes that occurred throughout the course of the project (eg the change from four Delphi survey rounds to two) were deemed to have had a positive rather than a negative impact on the project for all but one staff member (who stated they may have had a *“slight negative impact”*, but recognised that it was *“a dynamic project”* and so most *“changes were appropriate”*). Other staff members stated that the methodological changes were not a significant deviation from what was expected and resulted in the enhancement of the project, noting the need for them to be a *“responsive team”*. The addition of an “expert group” was felt to contribute a *“richness and value to the project”* and to have ultimately positive consequences in that these representatives allowed better dissemination of findings via their standing with various groups (eg CDNM). Some frequently noted strengths of the project were cited by the staff as:

- *“the potential of the tool to enhance teaching”*
 - the *“validity, reliability and benchmarking”* potential of the tool
 - the *“refinement of the competencies themselves”*
 - that the tool was *“developed by people with a passion for nursing as well as knowledge”* in the field
 - that the tool is a *“holistic assessment”* schedule - not just focussing on “psychomotor skills”
 - that it has been developed with *“ease of use”* in mind
 - that the project *“employed a comprehensive range of methodologies”*
 - that the project involved *“national collaboration”* and *“national consultation”* and will eventually allow universities to *“collaborate together”*.

Staff had very well articulated views on the usefulness and value of the project, and all indicated a multiplicity of reasons why they felt it was a methodologically and practically sound project.



Some weaknesses of the project were also noted (although there were fewer of these) including:

- that *“some organisations aren’t ready”* to implement such a tool and that it will take some institutions more time to implement than others (due to current differences in course structure)
- that the *“majority of the work for the project fell back on”* the University of Wollongong team and that the partner institution had little involvement towards the end of the project because of changes in staff at that institution
- that no *“implementation phase”* was included in the project, so pilot testing has not yet occurred
- that the geographical distance between the various stakeholders made it difficult to *“get the right people to participate”*.

All staff agreed, however, that these weaknesses were out of the control of the project team and/or outside the scope of the project. Furthermore, considerable effort was made to overcome any potential weaknesses by using a stringent and thorough methodology and by planning future testing of the tool.

Interactive Evaluation

In order to examine whether the delivery of the project has worked as planned, whether key individuals are satisfied with the project to date, and how consistent their perceptions are with those speculated in the original plan for the project, 10 interviews with key stakeholders were undertaken. Key stakeholders were those who had an active interest in and/or a more in-depth participation in the project. Representatives from key nursing bodies (such as the ANMC and CDNM) were interviewed, as well as a blend of academics and clinicians from across the country. In a similar manner to the previous interviews, the interviews began with allowing the stakeholders to display their understanding of the rationale, goals/outcomes, and methods of the project. They were then asked their opinion on how well they felt the project had progressed, how satisfied they were with the tool (if they had seen it), what they saw as the major strengths/weaknesses of the project and, finally, challenges/benefits of the implementation of the tool in practice.

Key stakeholders displayed a high level of understanding about the project and produced consistent responses, most similar to those given by the project staff. The primary rationale or reason for the project was understood to be that there is *“no common denominator”* or *“no common assessment tool”* to examine competencies as the interpretation of ANMC competencies *“varies from uni to uni”*, and so does the capability of newly graduated nurses. The research was seen to be needed to determine the *“core things required”* of newly graduated nurses. Two participants also noted the *“complaints from hospitals about having to use different tools to assess students”*, and the differing standards across states and across institutions.

Goals of the project were well recognised and responses were almost identical to (if somewhat less complex than) those of the project staff. The aim of the project was recognised as *“to get a competency tool that all nursing schools can use in the country”*, and to use *“representation from all states and universities”* to achieve this goal. The emphasis was again on gaining a national consensus on the *“knowledge, skills and attitudes”* that should be expected of new grads. Furthermore, these stakeholders thought that the project was adequately designed to achieve these goals and had engaged in a *“rigorous”* process, including literature reviews, analysis of curriculum documents, Delphi rounds, and nominal groups in order to inform the development of the tool.



All stakeholders interviewed stated that they were satisfied or very satisfied with the progress of the project from start to finish (*“great job”*; *“awesome job”*), elaborating that the project had indeed succeeded in reaching a number of individuals and being *“inclusive”*, and that *“these things are always going to take time”*. One participant noted that the timeframe had been extended by changes in staffing, but that the CIs and advisory committee had been very involved which allowed the project to continue to progress regardless of these changes. There was also praise for the large amount of the project time that was spent attempting to validate the competencies and the tool. One other stakeholder noted that the project was *“progressing well”* but seemed to have *“stopped and started”* at some stages. Another was very keen for the project to be completed as they wished to implement such a tool as soon as possible.

In terms of the tool itself, four of the 10 key stakeholders interviewed had not yet seen the tool and so could not comment on that aspect. Of those who had seen the tool, all stated that they were satisfied with it. It was deemed to be *“user friendly”*, *“rigorous”*, and they said that it *“looks good on paper”*. Three of the six participants added that they *“will have to look at it and trial it in context”* in order to assess their level of satisfaction with it. And, as one stakeholder commented, the trialing of the tool will depend on the uptake by schools of nursing. Overall, there was a high degree of enthusiasm surrounding the tool, but acknowledgment that pilot testing was still in order to see it work in practice.

Some frequently noted ‘strengths’ of the project cited by the stakeholders were:

- *“consistency in the assessment of competency”* and the potential for a *“nationally consistent way of assessing”* students especially given the move towards national registration
- having a tool which is *“not setting people [students] up to fail”*
- the *“inclusivity”* of the project
- that the project represents *“something that people want”*, and that is *“overdue in the sector”*
- that the project will not just benefit schools of nursing, but that it will benefit *“hospitals, clinical partners- they’re the ones that will benefit the most”*
- that it will provide a *“benchmark for all to use”*
- that it will *“negate complaints from hospitals about using different tools”*
- that hospitals may be re-assured that nurses from different schools produce the same quality nurses.

Weaknesses of the project were usually expressed as challenges that may be faced or concerns for where the project could take nursing, rather than concerns about the execution of the project. Some weaknesses of the project were thought to include:

- that the wide use of the tool may threaten the *“individuality”* of different universities’ nursing curriculum and that it may lead to a *“one size fits all approach”* and may *“stifle creativity”*
- that it may have some difficulty *“getting all schools to take it up [the tool]”*
- that the tool needs to remain current (*“keeping the work up to date”*), particularly since existing ANMC competencies are set to be reviewed very soon
- that RNs may perceive the tool to be shifting the responsibility of assessment solely to them, whilst providing no extra help
- that it will reduce the complex job of nursing to a simple *“skills set”*
- that some may be reluctant to change as they find the broadness of the existing ANMC competencies appealing.



Overall, however, weaknesses were difficult for participants to articulate, and three of the 10 interviewees could not think of any to mention.

In terms of the implementation of the CAT, participants suggested many potential challenges to this in practice. Getting the universities to agree to use the CAT was mentioned, as was the difficulty of instigating a *“cultural shift”* both at the university and hospital level. Staff resources were another concern. Staff and RNs would need to be properly trained to use the tool, and thus some participants felt that the tool must include a *“training component”* and a good *“communication strategy”*, which will necessarily involve *“executive sponsorship at a local level”* and *“ensuring people know and understand the tool and feel confident and comfortable using it”*.

The benefits of implementing the CAT were almost identical for all participants. They consisted of two components – ease and consistency of use, and a definition of what can be expected of newly graduated nurses. It was thought that the tool would *“make life easier”* in the long run by providing a *“consistent methodology”*. This is thought to have the potential to allow consistent expectations to be articulated in terms of what nurses should be able to do and a *“common understanding of what is ‘core’”*.

Conclusion

Overall, an analysis of documentation and an evaluation of the project conducted through a series of interviews indicate that:

- the project remained consistent with the original goals
- the project achieved (and possibly exceeded) the desired outcome
- that the small deviations in methodology from the original plan were undertaken in a systematic and thoughtful way
- participants from varying groups and parts of the country were keenly interested and were invited to participate in the project
- participants and staff (with various levels of involvement and differing roles in the project) all appeared to have a consistent view of the key project elements (ie aims, outcomes, rationale, etc).



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