Using a Strategic Model for Professional Development: The Importance of Evidence-Based Competencies as a Foundation for Professional Practice.

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Using a Strategic Model for Professional Development: The Importance of Evidence-Based Competencies as a Foundation for Professional Practice.

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Abstract

A nursing professional practice model (PPM) is designed to provide a framework for how nursing practices, communicates, leads, collaborates, and provides the highest quality of care as we navigate the complex healthcare system. An infrastructure for learning, competency, and performance needs to be integrated into this model as a foundation for accelerating business and clinical initiatives, promoting standardization, and sharing successful practices. It is now, more than ever, a necessity to have a well-trained, highly competent nursing workforce. Simply having the knowledge and the skill to do a job is insufficient; rather, it is implied that a competency has an action attached to it that verifies what is achieved by that action. This paper describes the process that a large healthcare system used to design a 5-year strategy for professional development using the framework of the High Performance Programming model (Nelson & Burns, 2005), along with components of the Nursing Professional Development Specialist Practice model (American Nurses Association, 2010). This process allowed identification of the current organizational level of practice within professional development, prioritization of each component and an operational strategy to move each towards a higher performing level. The process provided for the prioritization and development of professional and foundational competency domains and the design of a competency toolkit for professional development, which assists in aligning and embedding these competencies into current and future work. Finally, this paper describes the beginning implementation of a pilot in one region, using components of the toolkit to support the recruitment and orientation of hard-to-retain positions and its contribution to better knowledge of competencies and improved job satisfaction.
Keywords: High Performance Model, evidence-based competencies, professional development, professional practice
Section II. Introduction

In the subject large healthcare system, the world of nursing is large and multifaceted. Nurses comprise the single largest profession within the organization. The provision of nursing care is in all settings, from acute care hospital floors to physician offices and retail clinics, and from large ambulatory centers to patients’ homes. Nurses work across the continuum of care – from labor and delivery for those welcoming new life to hospice care for those coping with end-of-life decisions. Nurses provide prevention and wellness programs for children and healthy adults and care management for seniors with chronic conditions. Nurses are also found in all areas of the organization – from administration, human resources, and marketing to finance and legal, and from government relations to research and innovation. These roles help shape and execute decisions regarding all facets of strategy and management of the organization. That is why in 2010, a nursing professional practice model (PPM) was designed to provide a united voice and a framework for how nursing practices, communicates, and collaborates to provide the highest quality of care. This vision for nursing stands at the center for the provision of high-quality healthcare:

Nurses advance the art and science of nursing in a patient-centered healing environment through our professional practice and leadership – *Extraordinary Nursing Care, Every Patient, Every Time.*

To realize this vision has been a journey. To realize it day after day for the thousands of nurses caring for 10 million patients may seem impossible. As nurses, we believe that it is worth pursuing; it is the promise to our patients. Faced with enormous challenges from healthcare reform and rapidly changing technology, it is essential to create frameworks for practice to unify,
unite, and guide our nursing workforce. The PPM was developed to ensure consistency for nursing practice across the continuum. This framework guides our nurses as they provide quality care, collaborate with interdisciplinary work teams, and contribute to the profession of nursing.

**Background Knowledge**

In the center of the system’s nursing PPM is the patient and family. The nurse-patient/family relationship is the cornerstone of nursing practice and leverages the powerful role relationships play in creating a caring and healing environment. The six nursing values embedded in the practice and underscoring our work are professionalism, patient and family centric, compassion, teamwork, excellence, and integrity. Within the model are four pillars that organize the work: quality and safety, leadership, professional development, and research/evidence-based practice. This infrastructure establishes practices, processes, and systems through which our vision is achieved. It lays the foundation that makes transformational practice possible and aligns nursing with the organization’s mission. The model reflects the environments we practice in and help create, namely, caring environment, collaborative work environment, and healing environment. It also depicts what nursing brings to the organization in total health, healthy communities and population health (Appendix A).

The nursing PPM is designed to standardize and move nursing practice forward and is the framework that translates nursing theories to practice. With the use of the model, we strive to establish practices, processes, and systems through which the vision is achieved. The model becomes the foundation to transform practice and aligns nursing with the organization’s mission.

Nursing is facing tremendous pressure to adapt to shifting demands and expectations. These pressures come from both internal and political and social environments. Business drivers include the mission to provide high-quality, affordable healthcare services and to improve the
health of our patients and the communities we serve. Our leadership has made it clear that key to achieving this mission is affordability, together with our continued focus on high-quality care and service. We lower costs while delivering the best possible care through our commitment to drive performance through our people, embracing growth opportunities, and leading change at local and national levels.

There are also pressures from outside our organization. The shifting and increasing expectations of our patients are primary. The increasing need to meet the patient where they are along the healthcare continuum needs to be in partnership with the patient. We are dealing with the challenges and opportunities offered by technology. Never before have so many technological and informatics options been available to providers and patients. Properly used and applied, technology has the potential to significantly improve the health of individuals, communities, and populations. Care must be taken to make sure technology does not drive nursing practice, but that technology augments it. Finally, we are confronted with a host of policy decisions, ranging from detailed regulatory reporting requirements to the rollout of the 2010 Patient Protection and Affordable Care Act (ACA). The ACA has generated unprecedented growth in several areas of the organization, making it challenging to provide consistent, high quality services to patients.

**Local Problem**

Never has it been more important to align on shared goals of leadership, research/evidence-based practice, quality and safety, and professional development within all factions and the mission of the organization. The missing element of the process has been the shared goals around these topics across all seven regions of the system. The work in these areas
has been done in silos, with each working independently to achieve the desired outcome of quality patient care.

Alignment helps us standardize practice where there is evidence and elevate professional nursing. The ultimate aim is that, regardless of where patients enter the system, they would receive the same care, eliminating unwarranted variation. Alignment in support of the model would ensure that practice is consistent regardless of where it takes place within the healthcare system, thereby, minimizing variations that can create risk, such as gaps in care, missed or overlooked needs, or incomplete care.

**Intended Improvement and Purpose of the Change**

**Intended Improvement**

Professional development is the educational and experiential journey every nurse takes to gain the knowledge, skills, and judgment required to practice as a professional nurse. The aim of this project, through a collaborative of regional education leaders, is to transform the work of professional development by designing a 5-year strategy in alignment with all seven regions in the organization. Consequently, the process described in this project will result in a competency model, which will provide a framework and foundation for the other components of professional development and a professional development strategy.

Strategic priorities were identified as foundational to the goal of keeping nurses competent, current, and able to own and practice the philosophy of lifelong learning. This was accomplished by adopting evidence-based competencies across the seven regions and working with regional professional development directors to integrate these competencies into the practice setting. A competency toolkit was developed to support professional development to embed the competencies into daily practices and operations of the organization. The project
began to set a foundation to explore the evaluation and adoption of several components of the toolkit into the recruitment and orientation of a region for evaluation of possible contributions to retention, as well as a supportive nursing practice environment.

The project or process will be evaluated through short-term and long-term goals.

**Short-term goals.**

- Evaluation of the competency toolkit
- Implementation of a pilot in a region comprised of several hospitals to build the components of the toolkit into the recruitment process and the orientation curriculum

**Long-term goals.**

- Retention/turnover statistics for hard-to-recruit/retain positions
- Practice Environment Scale of the Nursing Work Index (PES-NWI) (Lake, 2007)

Within a complex integrative system, work is always evolving and moving as standards and practices change. The culture of an organization can either hinder or support acceleration in change and the flexibility to adapt (Nelson & Burns, 2005). Consequently, the process described in this project will evaluate the changing components within an organizational culture that inhibit movement to a high-performing level in support of a professional practice model.

The Director of Professional Development for National Patient Care Services leads this project, which is a national role within the health system. This project is also supported by the National Nursing Professional Development Committees (NNPDC) which is comprised of regional directors of nursing professional development that make decisions about the education and training which affects the organization.

**The Purpose of the Change**
The intention is to prioritize the components of the Nursing Professional Development Specialist Practice model, and begin to align and embed, the highest priority within the current work and the work for the future (Appendix B). Unanimously, the regional stakeholders felt that adopting evidence-based competencies across the seven regions and working with regional professional development directors to integrate these nursing competencies into the practice setting was the foundational first step. We could then begin to build the roles needed for current practice, retention, and those anticipated to be necessary for the nurse of the future.

It has been increasingly challenging for a large healthcare system to not have common competencies across the continuum. For example, problems arise when there are no agreed upon competencies to build roles of the future in our nursing workforce. In order to prepare and position our existing nurses to provide care in this evolving healthcare system, a workforce team was formed to provide a strategy that moves us towards the goal of conceptualizing new roles for the registered nurse (RN). The members of the group are representative of nursing and work of this group is multifaceted, but the group agreed that standardized competencies are a necessary foundation on which to build new nursing roles.

The workforce team is working in partnership with nursing to support their strategy and avoid work duplication. Their work supports nursing professional practice by building on the work of professional development and using evidence-based competencies as foundational in moving the work forward. Initiatives of this group will be integral to the outcomes of the professional development strategy.

There are three tests of change (TOC). The first TOC addresses the question: Will professional development educators use the competency toolkit effectively to educate new and
incumbent staff? The toolkit was prepared in collaboration with the directors of education in the region and within the Plan-Do-Study-Act (PDSA) framework.

The second TOC question involves the work of the workforce team. After discussion with the members of the team and sharing the toolkit, the competencies have not yet surfaced as the foundation of related work. Therefore, the second TOC question is: Will the competencies be used by the workforce team as a foundation for the future roles of nursing?

The third TOC question is about the satisfaction and retention of hard-to-recruit positions. The question is: Will using components of the toolkit create improved work satisfaction and increase the retention rate, especially with hard-to-retain positions?

**Review of the Evidence**

The project focus was to design a strategy to support professional practice from the perspective of professional development. As a result of the strategy work, the development of competency domains became the priority and foundation of the process. Professional practice models (PPM) and competency were the focus of the evidence and literature reviews.

**Evidence Supporting a Professional Practice Model to the Nursing Profession**

An evidence question was formulated using the population, intervention, comparative intervention, outcomes components, and time method (PICOT) (Melynk, Fineout-Overholt, Stillwell, & Williamson, 2010). The PICOT was as follows: P = registered nurses, I = use of a professional practice model, C = the value of the use of a model(s), O = key components of PPM, and T = 1996 to 2015. The search question was: What is the significance of a professional practice model to the profession of nursing? Key words used were nursing professional practice model, Magnet, outcomes, implementation, and professional development. A search was conducted using CINAHL, Google Scholar, and Fusion. Limiters were English, peer-reviewed
nursing journals between 2001 and 2015. This search produced 1,050 articles, which were narrowed down to 250 relevant to the topic and then further narrowed down to 83 articles. Thirteen articles relevant to the topic were critically appraised using Johns Hopkins Evidence-Based Practice Research Appraisal (JHEBPRA) (White & Poe, 2010) and entered into an evidence table (Appendix C and D).

For the last 40 years, nursing has had many conversations about the relevance of a PPM, and it is clear that most nurses continue to judge them as irrelevant (Meehan, 2012). Not practicing from a model, however, undermines the idea of nursing as a professional discipline. But with nurses feeling powerless to implement professional values in some settings, Meehan states that their ability to sustain their practice relies on relevant knowledge or relevant nursing models and those theories that they generate. Models must be found or developed that engage and strengthen nurses and provide direction for their practice. A PPM depicts nursing values and defines the structure and processes that support nurses to control their own practice and deliver care (Meehan, 2012; Slayter, Coventry, Twig, & Davis, 2015). Krautscheid (2014) provides a definition for nursing accountability that is linked to a PPM, which can help with continued research. Krautscheid describes a model as being a framework for lifelong learning, maintaining competency, and upholding both quality patient care outcomes and standards of the profession. A PPM is a theoretical framework for the profession’s practice and is usually grounded in well-established nursing concepts, such as shared governance or relationship-based care. Sometimes there is a theory, as the caring or comfort theory, connected with the model (Basol, Hilleren-Listerud, & Chmielewski, 2015; Slayter et al., 2015).

Nurses in organizations without a PPM are left to establish frameworks or guidelines for their practice on their own (Hoffart & Woods, 1996; Kerfoot, 2005). A framework for practice
necessitates not only a roadmap, but also a compass to find the way in the new age of change in delivery systems. According to Roussel & Swansberg (2009), a practice model is essential for providing scope and standards to guide the work of not only staff but also nursing management. A PPM can provide greater focus on safety, quality relationships, and healing environments. One of the most important reasons to implement a PPM is to improve the quality and safety of patient care and to improve the nursing work environment. Creating a nursing PPM can also serve to create a culture of safety and an agenda for improving safety outcomes in healthcare (Hoffart & Woods, 1996; Roussel & Swansberg, 2009). If nursing is truly a profession, an environment must be developed to support it (Roussel & Swansberg, 2009).

Other allied professionals use PPMs to guide their practices, such as occupational therapy and social work. According to Bannigan and Moores (2009), models for occupational therapists must incorporate both reflective and evidence-based thinking. When their practice is brought together in a model, it provides a powerful framework to enable therapists to respond creatively to challenges they face when providing care (Bannigan & Moores, 2009). According to Manuel, Mullen, Fang, Bellamy, and Bledsoe (2009), commonalities in performance are found across agencies for social workers who use models. Although there is a need to take into account the culture and context of the settings, organizational readiness should always be part of the introduction of the model (Manuel et al., 2009).

Bruheim, Woods, Smeland, and Nortvedt (2014) state that nurses who use a PPM to guide their care have demonstrated increased confidence in their provision of the best available care to their patients, a deeper reflection about their practice, excitement about the influence they may have in moving nursing practice forward, and a sense of being more valued and respected by their nurse and physician colleagues. Institutional benefits have included a higher level of
confidence that patients are being provided patient-centered care based on the best scientific evidence. In addition, using models has shown to result in more equal partnership and increased collaboration between nurses and other practitioners within interdisciplinary teams (Bruheim et al., 2014).

Murphy, Hinch, Llewellyn, Dillon, and Carlson (2011) discussed another PPM, which provided a process to align with a clinical advancement system. This practice model spoke to the involvement of others in the organization to support a shared governance model, while promoting effective integration with a medical center’s organization. This showed how a model could be used to change a process and a culture (Murphy et al., 2011). Another use of a PPM is within a Magnet™ system. Tinkham (2013) spoke about the “Forces of Magnetism” and the requirements to adopt a professional practice model and a shared governance structure that assists the organization in providing the necessary evidence and outcomes needed for Magnet designation. The development and use of a PPM can help create an environment of increasing job satisfaction, teamwork, and respect among caregivers (Tinkham, 2013).

Competency Domains / Competency Models

The second area of evidence centered on competency domains and/or competency models. Competency domains and/or the competency model were the first priority of the professional development strategy. Competency domains and models are the foundation for the practice and a framework for the additional strategic initiatives. A literature search was also conducted on the topic. The PICOT was as follows: P = registered nurses; I = adoption of national nursing competencies; C = the lack of standardized evidence-based competencies for nurses which provide framework for job descriptions, orientation, training, and selection criteria; O = retention rate, employee satisfaction, and right fit; and T = 2000 to 2015.
The search question was: What evidence exists for the relevance and use of competency and competency models to support professional practice? Key words were: competency and professional practice. A search was conducted using CINAHL and Fusion. Limiters were English, peer-reviewed journals between 2000 and 2015. This search produced 1,256 articles, which were narrowed down to 80 relevant to the topic. Seven articles relevant to the topic were critically appraised and entered into an evidence table (Appendix C and E).

The word “competent” is understood to mean a professional is qualified, capable, and able to understand and perform in an appropriate and effective manner (Meier, 1993). Simply having the knowledge and the skill to do a job is insufficient, rather it is implied that a competency has an action attached to it that verifies what is achieved by that action. The attainment of competency also requires judgment, decision-making, and critical thinking (Rodolfa et al., 2005). What a person brings to the job, does in the job, and the outcomes the person in the job achieves are all elements of competency. In the article, A Cube Model for Competency Development: Implications for Psychology Educators and Regulators, Rodolfa et al. (2005) defined competency as the capacity to integrate effectively the knowledge base, skills, personal and professional values and ethics, attitudes, and profession-specific factors into professional practice, defined by populations served, problems addressed, procedures used, and service settings. The authors present concepts in this article that are transferrable to the profession of nursing practice, especially as it relates to professional development and lifelong learning. As in nursing, the practice of psychology has expanded its scope of practice and reflects more than ever the changes in public need and the demand for services. It is also in part due to the expanded body of knowledge and skills necessary to practice (Rodolfa et al., 2005). This article, defining the cube model, was used extensively to begin exploring competency
models and competency domains for the nursing workforce. It was through the elements described in this model that the differing roles for current nurses and the nurses of the future were identified as foundational to professional competency domains.

Del Bueno (2001) relates job satisfaction to competencies, since they set the foundation for the role within recruitment, assessment, and selection. They are also important in employee performance management, in training and development, and play a key role in career and workforce planning efforts (Del Bueno, 2001).

Using a competency-based approach within an organization ensures that organization-funded training and professional development activities are cost-effective, goal-oriented, and productive (Lenberg, 2000). This approach documents the employee’s acquisition of the skills, knowledge, safety, and other procedures relating to each task. Competency-based approaches reduce cost of medical errors caused by poor performance or miscommunication of job expectations and improve communication between employees and management. It is also a way to increase internal employee mobility, providing the organization with greater ability to scale and flex, as needed. Competency-based approaches provide clarification for performance appraisals and create a roadmap for succession planning. These factors create a greater level of satisfaction of individuals within the organization (Lenberg, 2000).

Arnold (2002) states that competence should be used to strengthen the assessment of professional behavior by creating domains that embed traits of humanism, self-assessment, and self-reflection, as well as altruism, duty, empathy, and ethical decision-making. All are components of professionalism or exhibiting professional behavior, and these traits and values are part of a PPM that is exhibited in competent behavior and clinical performance. Arnold describes competence as a core measure of professionalism and professional behaviors. If there
is a connection between professionalism, professional behavior, and professional practice then the assessment of competence and clinical performance impacts nursing’s professional practice (Arnold, 2002).

Lenberg’s (2000) article, *Redesigning Expectations for Initial and Continuing Competence for Contemporary Nursing Practice*, calls for nursing to change its culture by creating and implementing the level of competence in professional practice required by a host of stakeholders. This is a time for increased collaboration, creativity, and flexibility in order to change the existing system to one that insures competent practice and quality care (Lenberg, 2000).

Whittaker, Carson, and Smolenski (2000) justify the decision to have identified competencies for an organization, which can provide a framework for academic partnership and assist in developing continuing experiences that reflect foundational and professional competencies. According to the American Nurses Association (ANA, 2007) Congress on Nursing Practice and Economics, the definition of competence and competency are built on several assumptions:

- The public has a right to expect nurses to demonstrate competence throughout their careers.
- The nursing profession must shape and guide any process assuring nurse competence.
- Regulatory bodies define minimal standards for regulation of practice to protect the public.
- Employers are responsible and accountable to provide an environment conducive to competent practice.
- Nurses are individually responsible and accountable for maintaining competence.
• Assurance of competence is the shared responsibility of the profession, individual nurses, regulatory bodies, employers, and other key stakeholders.

• Competence is definable, measurable, and can be evaluated.

• Context determines what competencies are necessary.

• The measurement criteria are the competence statements for each standard of nursing practice and of professional performance.

Through these assumptions, the ANA links the competence of a nurse to their professional practice, while putting responsibility for continuing competence on the individual nurse.

**Conceptual and Theoretical Framework**

Two related theoretical and conceptual frameworks informed this project: (a) The Institute for Healthcare Improvement (IHI) Framework for Spread and (b) Everett Roger’s Diffusion of Innovations Theory.

**Framework for Spread**

The IHI Framework for Spread is composed of five main components. It is a framework to consider when developing a spread concept for adoption of new ideas. The framework is not prescriptive, but gives general guidelines for consideration when undertaking a spread project (Nolan & Schall, 2007). The definition of spread is taking a process from a narrow group and broadening it to include all who may use the process. It is also a way of formalizing a process by providing reference for those in the organization needing clarity about the process or idea (North Carolina Center for Hospital Quality and Patient Safety, 2010). There are many factors to assist in the facilitation of spread. Some are the use of evidence-based efforts, tools and examples, strong leadership support, and ease of adoption. It is also easier to spread new ideas and processes if they seem pertinent and relevant to other processes, if they can be piloted or tested...
on a small scale, and if they are easily observable (Cooley & Kohl, 2006). The spread framework’s key components are leadership, better ideas, set-up, the social system, communication, knowledge management, and measurement and feedback (Appendix F).

**Leadership.** As with any large initiative, there needs to be support or sponsorship from senior leaders in the organization. The work has to support a strategic initiative and be in alignment with the goals of the initiative. This work is part of the nursing strategy and is endorsed by the National Nursing Leadership Council (NNLC), which is a group of senior nurse executives within all seven regions of the organization. The NNLC’s role is to provide guidance on initiatives, standardization of evidence-based practices, and to make decisions on issues that affect nursing across the continuum. The NNLC members are the sponsors for this work, while the regional professional development leaders, supported by a national group, are responsible for the agenda and spread.

**Better ideas.** Better ideas is defined as the project’s new ideas and their relative benefit to other ideas (Nolan & Schall, 2007). This will help present the case for acceptance more positively. In the organization, there has never been agreement on the desired competencies of a nurse. Each region, and sometimes each facility or setting, had different competencies which were skill- and role-based. When beginning work on nursing roles for the future, a gap was identified between current organizational alignment on competencies and how competencies need to change to support jobs for the future in nursing. This knowledge helped solidify this project and provide building blocks as a better idea and was agreed on by all stakeholders.

**Set-up for spread.** Set-up for spread is the foundation for the spread strategy. It takes into account the target population and guides the communication plan. It identifies a target population and the initial strategy to reach all sites in the target population with the new ideas
(Nolan & Schall, 2007). The set-up for spread began in meetings, where all the regions were involved in the process of identifying components of a 5-year professional development strategy and agreeing on the components and the priorities of the components.

**Communication.** Communication is the method to share awareness and information about the new idea. Communication is part of the foundation of the social system. It is ensuring that as many parts of the system are connected with the new idea as possible. The goal is to make participants aware of the purpose of the initiative and then be ready to provide support to make it happen (Nolan & Schall, 2007). In this case, all-new initiatives must first have approval from the NNLC, the chief nurse executives in the hospital-based regions, and the Professional Development Council. After approval from these groups, the initiative is ready to be embedded in new and existing processes. Through the communication plan, we will be targeting three groups for the roll-out: nurse managers, professional development leaders, and nurse recruiters.

**Knowledge management and measurement and feedback.** Both of these components are used to monitor progress and improve the strategy. They are essential components for spread. Knowledge management takes the best methods within the organization and uses them to spread, while measurement and feedback collects data about the process and outcomes in order to monitor and make adjustments to the process (Nolan & Schall, 2007). In this project, a toolkit was designed for the use of primary stakeholders and professional development leaders. The toolkit was designed and sent to professional development leaders in all regions for evaluation. The communication for the professional development leaders was that the document was for their use and would be evaluated and changed to reflect their insight into the tool. Additions to the toolkit were welcomed, as we built on the components of the initial
competencies. The toolkit was updated to reflect the indicated changes and is now available on the organization’s nursing website for spread.

Roger’s Diffusion of Innovation Theory

Roger’s Diffusion of Innovation Theory is the foundation of the Framework for Spread. Rogers defines it as the process through which an innovation is communicated through participants of a social system (Rogers, 2003). There are four main elements in the Diffusion of Innovation. The first is innovation, which he defines as “an idea, practice, or project that is perceived as new by an individual or other unit of adoption” (Rogers, 2003, p. 12). The second element of the diffusion process is communication channels. Rogers defines this as a process in which participants create and share information with one another in order to reach mutual understanding. The communication channel process includes an idea or practice between at least two people as a way to share information. Third, time is an element that has to be closely monitored and last is the social system. Rogers defines a social system as a group of related individuals who have a shared problem and have agreed on the pursuit of a common goal.

These four elements were in place to begin the professional development strategy work. The innovation or idea was the strategy work itself and was done at a meeting of individuals from all seven regions who came together over a 4-day period to strategize and prioritize how they would support the professional practice of nursing and the nursing strategy through professional development. Thus, the framework to begin the acceptance of outcomes from this process was in place.

The next part of the theory deals with the mechanics of diffusion and its successful spread. We know from Rogers (2003) that successful spread is an S-shaped curve. For this to occur, it is necessary to identify the groups in the process and acknowledge them and the
potential rate at which they may adopt the innovation. This begins with the innovators, those who love change and are known to be on the cutting edge. Early adopters are mostly leaders in a social system and have possibly been part of the innovative process. Early adopters take a little more time than innovators to convince but can be more easily convinced of the value of the innovation. Late majority are a bit more skeptical about the idea and its possible outcomes. Laggards are the last group and are more skeptical than the late majority and want to make sure the idea works before they choose to adopt it (Rogers, 2003).

Recognizing this theory within the framework of spread allows us to target each of the adopters collectively and individually and as they become identified. Knowing who the opinion leaders are can help to acknowledge and identify the much-hyped tipping point, which makes it easier to spread change.
Section III. Methods

Ethical Issues

The ethical issues regarding the implementation of this project are about how we think about competencies and who is accountable for the continuing competence of the nursing staff. This includes how we determine if a nurse is competent and assuring objective assessment of competence. Ethical dimensions of competency determination include job determination for the nurse, prevention of harm to the patient and the organization’s responsibility to both.

It is tempting to say that competence is entirely the responsibility of the individual, but one must consider the ethical role of the organization in the process. Is it necessary for leaders to establish national competencies for nursing and justify the rationale for the specific competence? It will be necessary to gain support within the regions to deliver the message of accountability and responsibility to provide safe care to our patients and establish within the culture of a framework for the continued competence of our nurses and managers. Is it the role of the individual nurse, professional associations, employers, or certifying agencies to assure that nurses are competent, or is it the responsibility and accountability of all?

The initiation of this policy for professional practice in every region will require that we address the underlying issues of keeping nurses competent and our patient’s safe. How we define responsibility and accountability for the individual nurse and the employer will assist us to operationalize the policy.

Responsibility is having the authority to accomplish an activity, and accountability is a commitment to making sure a particular result is achieved (Krautscheid, 2014). This would suggest that nurses are accountable for ensuring actions are carried out and are answerable for
those results. In alignment with this the statement, the employer is also responsible for giving
the nurse the authority and accountability for achievement of those outcomes. It is the
responsibility of the employer to educate staff to the definitions of accountability and
responsibility, as well as setting the stage for expectations and providing a framework for the
development of behaviors, while limiting confusion and challenges rising within the healthcare
setting (Krautscheid, 2014). Failure to provide accountability and responsibility to the staff
could result in poor nursing practice and less than competent nursing performance. It
demonstrates that nurses who engage in professional accountability and are responsible for their
practice engage in lifelong learning, quality patient care, increased competence, and continue to
uphold the standards of the nursing profession (Krautscheid, 2014).

This is an era of lifelong learning and commitment to continuing education for all
healthcare clinicians in this ever-changing practice environment. Leaders, at every level, are
ethically bound to hold our nurses accountable for competent performance through annual
competency reviews and performance evaluations that are objective and clinically sound.
Leaders and the organization are also bound to provide assistance in obtaining and sustaining the
competency of the staff before any disciplinary actions ensue.

There were no other identifiable ethical issues or conflicts of interest noted for this
project. A Project Determination form was submitted for approval by the faculty and program
chair (Appendix G).

**Setting**

The setting for this project is an integrated delivery system headquartered in Oakland,
California, which includes 10 million members, 38 hospitals, 50,000 nurses, and 16,000
physicians. It is the largest integrated delivery system in the United States. The organization
owns outpatient facilities in multiple states and contracts for hospital services in areas in which it
does not own hospitals. The company is comprised of three different organizations: a health
plan, hospitals and clinics, and the medical groups. Nurse executives from two of the three
entities (hospital and clinics and medical groups) take part in an national nursing leadership
council, which sets the strategic direction for nursing organization-wide by uniting and aligning
over 50,000 nurses under one unifying vision, set of values, and PPM. A corporate office
department, National Patient Care Services (NPCS), staffs this nursing executive leadership
council. The NPCS is a program office with a staff of 20 professionals, including four nurses.
The Chief Nursing Officer and Vice President of NPCS for the company leads this department.

The National Nursing Leadership Council (NNLC) sets the strategic direction for nursing
through designing and adopting innovative care delivery models, spreading and coordinating
successful practices across the continuum, and influencing state and national policy. These
executive nurses drive accountability for standardizing and elevating nursing practice, with the
ultimate goal of raising organization performance.

A decision to require all the nursing strategy workgroups to formulate a plan in support
of professional practice was recommended to the NNLC by NPCS and was approved
unanimously. The workgroups mirror the pillars on the PPM – professional development,
quality and safety, research, and evidence-based practice and leadership.

Participation in the nursing strategy session was by invitation only. Each group lead was
given a number of participants to invite. The instructions were to have representation from each
region that would be decision-makers within their area of expertise. NPCS, the organizing
group, facilitated the work and provided the facilities, food, and accommodations, as well as
necessary airfare. The participants in the strategy work were members of existing workgroups
that had been in existence for various periods of time before coming together for the strategy work. Between seven and ten individuals participated in each of the four workgroups, primarily RNs who had varying degrees of responsibility in the strategy work.

The success of the project and progress toward the objective were in large part due to a 4-day face-to-face planning meeting. This was the first time members of the existing groups had the opportunity to communicate on such a personal, one-to-one basis. The approach supported a framework for spread and also created early adopters, since the participants were part of this innovative process.

**Planning the Intervention**

The purpose of this intervention was to show how using the framework of the High Performance Programming (HPP) model (Nelson & Burns, 2005), along with components of the Nursing Professional Development Specialist Practice model (NPDSP) (ANA, 2010), can be used to design a strategy for nursing professional development (Appendix B and H). This process allowed us to identify the current organizational level of practice within professional development, prioritize each component, and design and prioritize an operational strategy to move professional development towards a higher performance level. During this 4-day event, the directors were asked to define the components within the NPDSP model and compare them to the HPP model levels. Each component was defined according to the NPDSP, using the levels of the framework. Consensus was reached within each level, providing the foundation for movement to the next.

**High Performance Programming Model**

Nelson and Burns’ (2005) framework, the HPP model, assists in organizational evaluation, forming a vision, and creating environments that move the process to the next
developmental level. This model is part of a larger body of work, *Transforming Work* (Adams, 2005), which explores the concept of transformational change and identifies associated principles, dynamics, and technologies. Adams (2005) moves the conversation from the traditional practice of organizational development to organizational transformation. Understanding and acknowledging the different performance levels helps organizations recognize the current state of performance and engenders an opportunity to create action steps to advance to the next level (Adams, 2005). This framework addresses the culture of an organization and how leaders can modify their frame of reference to support change. This model can be applied to individuals, the organization, or to specific work units (Wolf, Finlayson & Hayden, 2014). Another framework component discusses ways in which we adapt to changes arising from the dynamic nature of the environments within and external to healthcare. Change is inevitable; to meet the needs of our patients and the healthcare system, we can either embrace and influence the change or passively allow it to evolve. The HPP model encompasses five developmental levels: reactive, responsive, proactive, progressive, and high performing (Appendix H). The model is a nesting model in which each level builds on lower ones, except for the reactive stage, which is disintegrative in nature and unable to provide a structure to support culture change (Nelson & Burns, 2005). The organization, recognizing its current state at a transitional level between proactive and high performance, developed an additional level, the progressive or proactive plus level, to address a large perceived gap between these two levels in the HPP model framework. This added level lies between the proactive and high performing levels and was designed to highlight a process or incident that might propel the component toward the high performing level.
Reactive level. The reactive organization is one of survival and operating in the past. It is characterized by affixing blame, force-fed communication, top-down leadership, and fragmented infrastructure (Nelson & Burns, 2005). There is little ownership by staff, which feels the organization is responsible for their practice. The staff sees the strategic direction of the organization as management’s role. The environment of professional development is paper- and classroom-based, face-to-face, and prescriptive. It is teacher-driven and rewarded for volume, not value. Professional development may appear to be content-rich, but is low in interactivity, heavily reliant on slides and scripted presentations. Educators’ tolerance for and ability to change is limited, and their approaches may be characterized by rigidity. Technology is paper-based and checklist-driven. Duplicate programs and unconnected systems are the norm. The educator role is directive, pedagogical, maternal, and co-dependent. It is task-oriented, educator-focused, and linear. The role of the educator is as a performer or someone who finds gratification in delivering monologues (Nelson & Burns, 2005).

Responsive level. The responsive organization is operating in the present, with a hierarchical structure and a leadership style of coaching. It is focused on near-term goals and motivates with rewards, which leadership helps to develop and implement (Nelson & Burns, 2005). The responsive organization is characterized by cohesive teamwork and the ability to adapt to solve problems. In this environment, the manager still owns most issues based on needs that lack clarity and are not necessarily aligned. Learners are passive and feel no ownership for their continued education. Using web-based training engenders the possibility of more flexible and fluid change. Technology that supports learning is more connected, possibly including a learning management system that is resource-intensive. Educators’ success is measured by the ability of learners to perform tasks or skills. Educators become more interested
in the practice of learning. Their role focuses on managing the education exchange. The
responsive stage of performance is comfortable for individuals in the organization and may feel
like an acceptable level to remain at.

**Proactive level.** Proactive organizations are future-oriented. They are strategic, goal-
oriented and focused on the greater good and results. Emphasis on the bottom line decreases.
Organizational structure is matrixed, and leaders have trust and mutual respect for each other.
Learners take responsibility for their own success (Nelson & Burns, 2005). The environment of
professional development has less variety for learning, but it is more intentional and
incorporates more coordinated learning solutions, which include follow-up and follow-through.
Clinical support is actively present at the point-of-care. There are standard competencies for the
role of the nurse, and other competencies are connected to practice workflow. Educators’
success is measured by learners’ ability to apply the skill. Learning is consultative, and the
educator’s role is one of facilitator and coach (Nelson & Burns, 2005).

**Progressive level (proactive plus).** Quantitative and qualitative performance scores
reflect value-driven professional nursing practice. The organization is on a course toward global
holistic high standards of excellence. Universal buy-in exists and is embedded in the culture. In
this level there might be an incident which propels the organization to the high performing level.
This could be the adoption of a new model, a culture change, or a new leadership focus (Nelson
& Burns, 2005).

**High-performing level.** High-performing work achieves high standards of excellence.
The organizational focus is on excellence, seeking out new opportunities for excellence, and
releasing the flow of energy necessary for accomplishing these innovations (Nelson & Burns,
2005). Professional development is embedded in the work, and all parties are engaged.
Ownership and accountability makes it easier to do the right thing. Learning is shared among team participants, and there is an explicit and coherent message around quality, metrics, improved communication, and ongoing evaluation. The environment is dynamic, integrated, and linked to business success. Immediate, real-time data and feedback are designed with patient input. The role of educators is to manage complexity, and they are master facilitators of learning that is focused on business outcomes, performance, and organizational objectives. Learning is valued as an end unto itself and transforms practice to excellence. Educators function as coaches and are characterized by rich and integrative dialogue, creativity, and wisdom (Nelson & Burns, 2005).

**Nursing Professional Development Specialist Practice Model**

In 2010, a new approach and elements were formulated by the National Nursing Staff Development Organization (NNSDO), a professional organization of the American Nurses Association, to design a model to operationalize a professional development system composed of inputs, throughputs, and outputs. This is known as the Nursing Professional Development Specialist Practice Model (NPDS) (Appendix B). Inputs are defined as what the learner and the educator bring to the process. Learners bring their beliefs, attributes, experience, educational level, career goals, engagement, and empowerment. Educators collaborate across the organization, assess organizational needs, and facilitate continuous learning based on developmental processes (throughputs). According to the *Nursing Professional Development Scope & Standards of Practice* (ANA, 2010), seven developmental processes, guided by the model of care and the professional practice model, are intended to operationalize the role of the learner in a developmental and lifelong learning process. These throughput processes are competency programs, continuing education, academic partnership, orientation, career
development/role transition, research and scholarship, and in-service education. All are grounded in evidence-based practice and practice-based evidence. Outputs are growth and professional role competence. Arrows indicate the model’s fluidity and interrelationships between elements. The NPDSP model is a foundational pathway to help nurses in professional development guide their practice. Applying the HPP model (Nelson & Burns, 2005) to developmental processes or core components of the NPDSP model provides a process for assessing the current state and developing strategies to evolve to the next stage, with the ultimate goal of high performance.

The framework addresses the culture of an organization and how as leaders we can affect our frame of reference towards change. How organizations adapt to change in the internal and external environment of healthcare continues to affect the other component of the strategy model. Even though we know change is inevitable to meet the needs of our patients and the healthcare system, organizations can either embrace and influence the change or aimlessly allow it to evolve. This process allowed us to identify our current level, prioritize each component, and design an operational strategy to move professional development towards a high performing level while supporting professional practice. The professional development group prioritized each of the seven components and decided the top three would be competencies, academic partnerships, and orientation.

The professional development group also agreed to accept the definition of competencies as processes that are used to demonstrate the knowledge, skills, and attitudes necessary to perform a job and daily activities necessary for the benefit of the population being served, and the definition of academic partnerships as agreements between colleges/schools of nursing and
healthcare systems to support an environment of development and continuous learning (ANA, 2010).

Prior to the second 2-day intensive session in December 2014, we began looking at extant competency models, starting with those that were evidence-based, proven to support the nurse in practice, and built on the PPM. Five competency models were chosen to explore a framework to inform a dialogue with members of the session participants, who consisted of the national nursing professional development committee, the chief nurse executives, the executive nurse leaders, and organized labor partners. The five models are: Quality, Safety, and Education for Nurses (QSEN); Nurse of the Future (NOF); Institute of Medicine (IOM); Accreditation Model for Graduate Education (ACGME); and the American Nurses Association Standards of Professional Practice (Appendix I). These models were socialized, and comments were synthesized for discussion with regional professional development representatives.

At the second 2-day intensive session, we also discussed the competency domains, their definitions, and the possible frameworks to display them. We discussed the intersection of the competencies with the other three strategies’ pillars and our workforce initiatives. The outcome was the development of a competency framework. Within the framework, the decision was made to have both professional and foundational competency domains. The group designated professional competencies as those specific to the role of the nurse in this organization and foundational competencies as those which are essential to the practice of nursing, as well as the basic level necessary for seeking admission to practice at this organization as a professional nurse (Appendix J).

In developing the competencies, the committee identified a set of guidelines for the design of competency-led education in practice:
The nurse will be proficient in these competency domains. There is differentiation in competencies among practicing nurses at various levels, and competence is developed over a continuum and can be measured.

The competency domains are designed to be applicable across all care settings and to encompass all patient populations across the lifespan.

Nurse educators in the practice setting will need to use a different set of knowledge and teaching strategies to effectively integrate the competency domains into curriculum.

There are two distinct competency domains: foundational and professional. Foundational competency domains are the building blocks for what nurses do or exemplify. They are primarily taught through professional development, either through academic education or as a part of lifelong learning. Professional competency domains are the knowledge, skills, and abilities necessary for successful practice in nursing at the organization and are at the core of orientation, job descriptions, and clinical skills.

The knowledge skills and abilities of the foundational domains have implications for the professional domains. As the profession advances in both the art and science of nursing, these changes will be reflected in the foundational competency domains and then integrated into the professional competency domains, resulting in the development of new competencies.

The foundational and professional competency domains for the different levels of educational degrees – associate, baccalaureate, masters, and doctorate – should be integrated within the curriculum of our academic partners to facilitate individuals in
moving more effectively through the educational system into the practice environment.

As a result of these guidelines, the National Nursing Professional Development Committee will work to align and embed both the foundational and professional competencies into the current practice environment to provide a framework for the work of the future.

**Implementation of the Project**

The project implementation was divided into the four sequential components based on Roger’s Diffusion Theory. Rogers defines diffusion as a process by which an innovation is communicated through certain channels over time among the members of a social system (Rogers, 2003). There are four main elements in this theory: innovation, communication channels, time dimensions, and social systems.

- **Innovation:** An idea perceived as new by the individual. An evidence-based competency framework standard to all regions.
- **Communication channels:** A means by which messages get from one individual to another. The Competency Toolkit would represent this.
- **Time dimensions:** There are three dimensions of time 1) the time it takes from the knowledge to the attitude about a process, 2) the time it takes for the early adopters to adopt these new ideas, and 3) the rate an idea is adopted by the social system (Rogers, 2003). Innovators are the members of the professional development leaders who developed the competency framework, and the early adopters are those who have volunteered to pilot pieces of the toolkit. The time monitored is the time it takes for the entire social system to adopt this new process.
- **Social system:** A group of interrelated individuals who have a shared problem and are
doing problem solving in the pursuit of a common goal. This social system is nursing leaders in support of the nursing strategy within the organization, which will enable us to align standardized practices where there is evidence and elevate professional nursing.

Communication Matrix Plan

A communication plan was developed in preparation for the launch of the toolkit. Three distinctive messages were designed for the major stakeholders, nurse managers, professional development leaders, and nurse recruiters.

Core statement. The organization is launching a new toolkit that will be accessible online as a web-enabled tool. One of the goals of this tool is to improve our recruitment and retention metrics for positions that are difficult to fill and result in higher than average turnover. The tool is also for use with the incumbent staff and general nursing roles in the organization. Competency-based frameworks have been shown to increase the level of satisfaction of the workforce and support fewer errors and a higher quality of and safe experience for patients. It provides clarification or performance appraisals and creates a roadmap for succession planning. These factors support greater satisfaction of individuals within the organization and can lead to increased retention (Lenberg, 2000).

Strategic initiative. Recruiting and retaining the best people will contribute to the organization’s nursing strategic plan: extraordinary nursing care, every patient, every time.

Stakeholders

The stakeholders in this venture are the professional development leaders, recruiters, and nurse managers.

Messaging to the stakeholders.
**Nurse managers.** Interviewing can be either a fruitful or futile experience. In an interview you are assessing or evaluating applicants for the skills needed to function successfully, but you are also looking for nurses who have a strong foundation to build on. You are busy running clinical areas and handling a million tasks on an average day. Let the components of this toolkit help you screen for the right candidate and know that the results are carried through in the orientation of the new staff member. The behavioral interviewing tool can be delivered to your email system, so you can look through the assessment and get an idea of how this applicant will fit into or help change the culture on your unit. The behavioral interviewing method has been proven to reduce the rate of turnover, and this system can give you time back to focus on the most important thing – patient care (Hanna, 2008) (Appendix K).

**Professional development leaders.** It is very important that we all embrace the national competency domains we decided on in 2014. The challenge is how we begin to embed the competencies and align them with the practices of the organization. This competency toolkit is a guide that can help us do that. Introduce the behavioral interviewing questions to your managers and then tell them how other tools in the toolkit will help support that strong message in orientation and prepare the new nurse for the practice environment. As a result of selecting the best nurse for the job and then customizing training, we will reduce the possibility and expense incurred by turnover or off-boarding an employee, which includes the cost to hire a replacement, transition costs, and the cost of unit or team disruption. As part of our national workforce plan, this tool will help us prepare for jobs of the future. With the strong foundation to build on, we can be ready to move our nurses into new roles required to care for our patients (Appendix L).

**Recruiters.** The organization has a need to recruit nurses, especially in hard to fill areas, and that need is growing in value exponentially as we seek to hire the best and the brightest
employees. As hiring begins to increase as baby boomers retire, the skills and experience of a recruiter are critical. Recruiters will be judged on who they bring into and how they contribute to the company. Let this competency tool reduce subjectivity, save you time and effort, and deliver a screened and qualified candidate to the nurse manager. We should no longer evaluate your performance on how many recruiters it took to hire X numbers of employees, but on what percentage of employees who are performing and still at the company after two years (Appendix M).

The author also sent a questionnaire to the professional development leaders and received feedback and ratings about which components they would like to see in the toolkit (Appendix N). An online presentation of a draft of the competency toolkit was delivered to a small subset of professional development leaders by the author. The presentation reviewed the design, presentation, and evaluation of the resources and tools. Three practicing directors of professional development received a copy of the initial toolkit for their review. One director presented the toolkit to the facility education directors for their input.

**Competency Toolkit**

The toolkit is composed of eight documents. Four documents were relevant to the project as it relates to competency and professional practice and use of educational foundations for recruitment and orientation: (a) the competency domain model, (b) behavioral interviewing tools, (c) competency self-assessment, and (d) nursing competencies and case studies (Appendix O).

**Planning the Study of the Intervention**

A Gantt chart was constructed early in the intervention process (Appendix P). The chart was divided into five areas reflective of the work: (a) the 5-year strategy for professional development; (b) the competency discussion and approval process, (c) the design of the
competency model, (d) the timeline for the competency toolkit, and (e) the adoption of components of the toolkit into the recruitment and orientation curriculum of a hard-to-recruit position in 2016 by one region. That last process will not be available for evaluation until 2017, when the components are built into the curriculum. Retention results will be available 16 to 24 months later.

Part of the plan for the competency toolkit adoption was the development of a business case that the proposed region can use to capture the reasoning and potential for proposing this project to their senior leaders. The development of this business case was developed as an important mechanism to promote change and to maximize validity of the project (Appendix Q).

**Methods of Evaluation**

**User Feedback**

Online surveys were created for two target audiences to evaluate the documents in the toolkit: professional development leaders and staff and workforce members who would be using some of the documents to design roles of the future. Survey participation was voluntary. Twelve people participated in the survey. Each survey was constructed for completion after the review of the document. This information was compiled for each and then compiled in aggregate (Appendix R). The results of the survey were then incorporated into the final document.

**SWOT Analysis**

A strength, opportunity, weakness, and threat analysis (SWOT) was done to develop a strong business strategy by making sure we had considered all of our strengths and weaknesses, as well as the opportunities and threats faced in the organization as we prepare to align and
embed these competencies using the toolkit. Strengths and weaknesses are internal to the organization. This includes those resources and experiences readily available, such as financial, human resources, and processes in the organization that will either support or detract from this initiative. Opportunities and threats are external to the organization and are factors we might want to take advantage of, address, or mitigate, such as market trends, funding and the political environment of the organization. (Appendix S).

**Northwest Pilot**

One method of evaluating the usefulness of the toolkit is the implementation of a pilot to demonstrate a return on investment through the retention of a hard-to-recruit and retain position. Through the use of the competency toolkit, we will align with the foundational competencies that each individual nurse would need to possess at a level consistent with the roles for which they are applying. At the same time, we will provide a change in hiring practices, capturing information about the knowledge level of both the foundational and professional competencies and then building a development plan for each nurse. This information will be used to objectively evaluate whether the applicant possesses these competencies and at what level. This change in the screening process and orientation curriculum would facilitate a successful fit and could positively affect the turnover rate in nursing by evaluating the individual’s foundational competency domains of leadership, ethics, communication, and technology-enabled care and professionalism.

In order to build the culture of professionalism within our nurses, nursing leaders feel it is important to have a stable management workforce who believe in the nursing strategy, mission, and values and possess a high level of the foundational competencies. One of those positions is the RN assistant administrator in the ambulatory environment. This position provides a crucial
role in the day-to-day activity in the outpatient setting and has a great impact on both nursing staff and patient care. Currently, there is a need to attract, recruit, and maintain this position, which is challenging due to such variables as responsibilities, salaries, labor challenges, and increased workload. Retention for this position is 16 to 18 months, and the average days to recruit of 90 to 120. Given the sheer numbers of nurses that are projected to be needed in the future ambulatory setting, discussion of the costs of turnover and benefits of retention of RN assistant administrators is of utmost importance to maintain the consistent culture we are developing.

Throughout 2016 and 2017, there will be an evaluation of the toolkit with the support of the regional directors of education and other stakeholders. Because of the high turnover of these positions, the Northwest region will be the pilot for the toolkit. While this is not a panacea for the complex recruitment and retention challenges of this position, it has been used as a tested methodology for improving hiring results. Nurses whose belief and behavior systems appear congruent with our organizational culture feel more competent and are more satisfied. They will likely have a better chance of working well in the existing environment. Nurses who fail to fit into the existing workplace environment generally leave to find a work environment or culture which is more congruent with their own values and beliefs (Hanna, 2008).

Armed with the information in this project, professional development leaders will be able to present their case for change, articulate the vision, and describe the benefits for use of these competency components in their organization. Justification will be based on retention and nurse satisfaction. Performance will be measured on standard indicators over a 2-year period. The baseline measure will be at the beginning of orientation and analyzed in comparison of performance to baseline over the course of the probationary 90 days. The evidence demonstrates
that the pilot for the RN assistant administrators can be self-funded through cost avoidance, savings due to recruitment and turnover costs.

The curriculum design team will:

- Complete current state analysis and learning needs assessments (for nurse administrators).
- Cross-walk the assessments against the core competencies for all nurse, as defined by National Patient Care Services.
- Determine which of the tools should/could be used for onboarding/orientation to their new role and incorporated into the onboarding/orientation programs.
- Determine which of the tools should/could be used for development of current nurse administrators and identify steps needed for implementation.
- Develop a project plan, timelines, and measures for this work.

**Budgetary return on investment plan for the Northwest pilot.** The cost of embedding this tool into the recruitment and orientation of this group of nurses is nominal compared to the returns for using the screening process and components of the toolkit. The start-up cost of this pilot is $8,750 in 2015, $6,400 in 2016, and an annual maintenance cost of $2,700 beginning in 2017. Based on historical turnover rates, in July of 2017, 18 months after the start of the program, we should have lost two (20%) of the 10 RN administrators. Nurse turnover costs have been estimated at 1.3 times the salary of a departing nurse, or $162,500 for this RN manager in this pilot (Jones, 2005). There are many factors that contribute to the retention and turnover of an employee, so the author is considering only 20% of the total amount as the potential benefit for this analysis. The retention of approximately one nurse who would have otherwise left the organization is approximately breakeven for the pilot period, using the above conservative
Given the relatively low ongoing annual maintenance costs, the region can confidently expect a positive return on an ongoing basis after the pilot phase. A sample business case for the approval and implementation of a pilot program for the designated region is included in the business case appendix (Appendix Q).

Comprehensive Budgetary Return on Investment and Cost Benefit Analysis

The aforementioned budget for the Northwest region contains only the incremental costs for their region. The costs incurred to develop the organization-wide strategy must be amortized over the broader organization. The assumption in this comprehensive budgetary return on investment is that after the successful pilot in the Northwest, there will be willingness for the other six regions to develop curriculum, which embeds and aligns the components of the competency toolkit into the recruitment and retention efforts for hard-to-retain positions.

One of the goals of this project was the design of a 5-year strategy for professional development. Realizing this goal resulted in the design and development of organizational competencies that were approved by the executive nursing leaders within the organization. Evidence shows that competency-based approaches reduce the cost of medical errors caused by poor performance or miscommunication of job expectations and improve communication between employee and management. It is also a way to increase internal employee mobility, providing the organization with greater ability to scale and flex, as needed. It provides clarification or performance appraisals and creates a roadmap for succession planning. These factors support greater satisfaction of individuals within the organization and can lead to increased retention (Lenberg, 2000).

In support of this goal, a competency toolkit was selected for the vehicle that could
convey the message to the professional development consultants within the organization, so they could use the components of the toolkit to recruit, educate, and ultimately, retain new employees, as well as inform the incumbent employees. The strategy was to work with regional professional development leaders to integrate nursing competencies into the practice setting by providing a competency toolkit for the use of regional educators.

The benefits of this toolkit of information is that it provides customizable templates and forms, including definitions, applicability in the inpatient and outpatient settings, evidence-based competencies, and scenarios to assist with transferring knowledge focused on the particular work setting. The templates are adaptable, allowing for efficient implementation of standardized concepts and usage within specific areas or specialties.

The estimated project costs are divided into three separate sections: the 4-day, face-to-face strategy sessions; the development of the competency toolkit; and the startup cost of a pilot project using the toolkit components to affect retention. The strategy session was a 2-day event in August and December of 2014. The total cost was $124,240, including participants’ travel and lodging. The competency toolkit development and design costs were $16,350 in 2015, and the projected pilot costs for utilizing components of the toolkit is $8,750 in fourth quarter 2015. Both the competency toolkit and the pilot have projected costs in 2016 and 2017, which include a 2% inflation factor assigned to the projected costs for those years (Appendix T).

Once the four components of the competency toolkit are embedded in the regions, we can look at the cost benefit analysis across the entire organization for some hard to recruit train positions. Currently, there are 380 frontline management positions that have a 20% turnover rate in both the inpatient and ambulatory settings. At 20% turnover, the expectation is that 76 of the 380 nurses will leave each year. In 2018, the frontline manager’s salary is assumed to average
$138,000. If the average cost to replace the position is 1.3 times the salary, the average cost to replace a nurse would be $179,400. Assuming only 20% of the benefit of retaining a nurse accrues to this project, the benefit of retaining an individual nurse is $35,800. Using the same assumptions, to calculate the benefit of retaining three employees in each of the seven regions (21), there is a positive return on investment of $751,800. If 21 nurses stay in the system that would have otherwise left, the turnover rate is reduced to 15%. The breakeven is 15 nurses or the total cumulative cost for this project divided by the $35,800 of retention benefit per nurse (Appendix U).

**Analysis**

Both quantitative and qualitative data were collected from the participants to evaluate the toolkit components. The responses were collected through Survey Monkey online survey software that collected and tabulated responses to questions on a 4-point scale. The data were tabulated in the Survey Monkey software and exported to a spreadsheet for analysis as individual components and in aggregate. Qualitative data were requested from all parties in the form of comments following each question and at the conclusion of the survey questionnaire. Survey results are available in Appendix V.
Section IV. Results

Program Evaluation and Outcomes

There were four documents in the competency toolkit that were the focus of the evaluation: the Nursing Professional Competencies and the Case Studies, the Competency Domain Model, the Competency Self-Assessment, and the Behavioral Interviewing for Foundational Competencies (Appendix O). Twelve professional development leaders and educators reviewed the documents, as well as four members of the national patient care department.

The Nursing Professional Competencies and the Case Studies component rated 3.2 on a 4-point scale. This tool is for the use of the educators to thoroughly describe the professional competencies of collaborative care, informatics, quality and safety, research and evidenced based practice, and resource utilization. The tool defines each domain, provides questions for learning, and then gives a scenario or case study for discussion. The case studies are meant to be used in orientation, continuing education, and huddle messages and can be a leader-led or self-taught learning tool (Appendix O).

The Competency Domain Model rated a 3.8 on a 4-point scale. The competency domain model is a design framework that helps to depict the five foundational competency domains and the five professional competency domains. The model is set up in such a way that the learner is able to click on the competency and then is taken to a table that gives examples of the knowledge, skills, and ability needed to successfully meet this competency. It further defines the competency in a way that the learner is able to understand how they can achieve success (Appendix O).
The Competency Self-assessment rated a 2.8 on a 4-point scale. This self-assessment is meant to create a gap analysis between the practice habits and the awareness of the professional competencies and their use in the nurse’s daily practice. By identifying the gap, we can provide a framework of knowledge, skills, and ability to close those gaps (Appendix O).

Most of the comments were about the Behavioral Interviewing for Foundational Competencies tool. This tool is an instrument designed to provide information for hiring of nurses who are aligned with, and equipped to deliver on, the mission and whose behavior and professional practice reflect the foundational competency domains of leadership, ethics, communication, technology-enabled care, and professionalism (Appendix O). Employers use this tool to evaluate a candidate’s experiences and behaviors in order to determine their potential for success. This approach is based on the belief that past performance is the best predictor of future behavior. The behavioral interviewing tool rated a 3.0 on a 4-point scale. Comments were: “I’m not sure the tool gives the reader sufficient information about what behavioral based interviewing is and why it is the preferred interview style.” “This is well done and a practical application of how the competencies can be used and why they matter.” “I would like to see the leadership role encompass more of the nurse’s independent scope of practice and decision making authority.” Questions were changed on the tool to reflect some of these comments. For example: Tell me about a time you disagreed with the medical plan of care, what was the situation, and what did you do? Tell me about a time you advocated for a patient, what was the situation, and what did you do?

Another comment was about both the leader and ethical dimensions. Questions to address concerns expressed were inserted: Tell me about a time you saw someone practicing outside of their scope of practice, what did you see, and what did you do?; Nursing's Code of
Ethics speaks to the responsibility for self-care, how do you incorporate this provision into your practice? In the communication domain, evaluators said they would like a question directed at escalating concerns up the chain of command or examples of giving/receiving peer feedback. A question was designed that said, Tell me about a time you altered the course of the plan of care based on feedback you received from the patient/family. How did you gather their input, and how was it incorporated?

Under professionalism, additional questions were poised: Nursing is always changing, how do you stay on top of your practice, what do you do to stay current? What is professional nursing? What does nursing bring to the table that is unique, when compared to the other care team members? Tell me about a time you made a mistake? What was the situation, and what did you do?

Based on the comments and the scoring of the four documents, changes were made and the documents were updated accordingly. The expectation is that the documents will undergo additional changes as we prepare them to be used in the Northwest pilot.
Section V. Discussion

Summary

This was a complex project in a complex organization. The project began with using reliable experts to develop a 5-year strategy and culminated with the willingness of the Northwest Region leaders to use components of the competency toolkit to develop a retention and orientation strategy for retention of a group of nurse managers. The process of developing and gaining consensus on competencies at all levels of the organization took several months. We had levels of controversy about definitions, the look and the design of the model, and how we were going to use the model to align and embed within our individual practices.

The implementation of the Competency Toolkit brought the regions together to begin the discussion of how this model might change the way we hire, orient, and work with academic partners. The deliverable of a business case to help validate the reason behind why this project should move forward and the tool to convince senior leadership of its potential return on investment is important to the pilot’s acceptance. The Northwest Region’s decision to move this project forward is testimony to their support in driving the growth of professional practice and the nursing strategy, and their continued leadership will be critical in spreading the toolkit across the organization.

Some of the more important lessons were the face-to-face meetings that moved the project exponentially towards group decisions that would have taken months or even years to accomplish using the normal venues. The lessons on ownership were made evident at the time of decision-making. The decision makers at the face-to-face meetings were transformed into champions of this work. This was not a national decision being driven by “corporate”; this was a
decision that the regions owned. Not following through on the decisions made at the strategy meeting were seen as “letting their colleagues down” and not fulfilling the promises they made to each other. This model of decision-making will be considered going forward as a framework for other decisions in the organization.

**Relation to other Evidence**

Evidence was sought to gain a full understanding regarding how a competency-based framework was being implemented across the country and the benefits to increasing quality and safety, competence, and retention. The articles for this discussion were obtained from using the key words: evidenced-based framework, professional practice model, and competencies.

There were several articles in the literature which used an evidenced-based framework for implementing a PPM. One of the articles involved providing an evidence-based framework in establishing nursing professional practice (Murphy, Hinch, Llewellyn, Dillon, & Carlson, 2011). At a large tertiary organization, the authors used the components of a PPM to link with competencies or performance expectations. As a result, they were able to design a clinical advancement system, redefining role expectations, creating a shared governance model, and creating a transformational change in alignment with their Magnet status (Murphy et al., 2011).

There were several examples of using a competency-based framework and creating avoidance of a specific outcome (Del Bueno, 2001; Rodolfa et al., 2005; Whittaker et al., 2000). One of those was the use of an evidence-based competency framework to design an orientation for two critical care units. Nurses’ perception of the experience revealed 30% of new to practice nurses left within the first year, and more than 50% left within the first two years. The evidence framework for orientation provided the support to move the nurses past the initial orientation
timeframe and provided them with support during the important post-orientation period, while significantly decreasing the turnover rate.

The evidence in other published material was very similar to the author’s experience of using an evidence-based framework as foundational to developing this project. There were no references to creating an independent strategy, but the closest comparison was using Magnet as the overall foundation for an evidence-based approach. Since many of the organization’s regions are preparing for the Magnet journey, the relationship to the evidence in this project may help to contribute to the documents for Magnet.

**Barriers to Implementation/Limitations**

At the beginning of the project, when competencies were identified as the highest priority, the decisions about the look of the model were politically charged. Even the word “model” was debated, and the decision to call it a framework to reduce confusion with the professional practice model was discussed. Multiple diagrams, colors, and fonts were discussed at length before consensus was reached. In the implementation of the competency components, one large barrier was the willingness of devoting resources to review the documents, give feedback, and to engage in a pilot. There were two regions willing to participate, but the inpatient facility felt there were no resources to devote to the project, and they had very few hard-to-recruit positions. The individual facilities in the organization are small, but in aggregate, the 50,000 nurses providing care in those facilities have a large impact on the organization. Individual facilities, however, have wide variation on how acutely they experience retention and recruitment deficiencies.

Another barrier to implementation is that we cannot prove that the behavioral interviewing and the use of competencies contributes to the retention of hard-to-recruit staff in
the pilot. One of the biases that is often confronted in the daily work of the organization is that if it is not proven in the two largest regions, it is unreliable data. Since they are the largest and most complex of the seven, the belief is that it will only work if it works in these regions. Conversely, some of the smaller regions consider themselves to be fundamentally different than the two largest regions, so proven processes and approaches can be deemed “irrelevant” for their operations.

Other barriers to the potential success of the pilot and implementation of the competencies in to the recruitment and orientation process are (a) willingness of human resources to embrace the foundational competencies as basic to their process, (b) noted barriers to implementation of the competencies by the professional development leaders and the nurse executive in the regions, (c) the degree to which the regional and facility nurse executive is convinced of the intervention, (d) the strength of the evidence of the pilot, (e) the confidence in the projected return on investment, and (e) the amount of power and influence the professional development leaders exert within the organization. The components of the toolkit are limited in terms of the timeliness of the information. Information will require updating within one to two years by a group of professional development experts. The components need to have the input of all regions in order to remain viable.

**Interpretation**

The 5-year strategy, the competency development, and the toolkit enjoyed a great deal of success within the organization. The professional development group has whole-heartedly embraced the fact of having a standardized set of competencies across all regions. Tying the work into the PPM has helped it become embedded into the organization, but more examples of this type of work need to be identified in order for it to become a formalized process.
In the framework of spread, we have received leadership support. We also have presented the idea of standardized competencies as a better idea than what is currently being done. The pilot for the competency toolkit has targeted a population of high turnover individuals, and the initial strategy is to follow through with a larger segment of the nursing population. Our next stage will be communicating the results of the pilot, while continuing to find ways to embed the competencies into existing practices and making as many of the social systems aware of the competencies as possible. We will also continue to measure the results of the pilot and the spread to different parts of the organization and through different modalities.

Conclusions

In conclusion, the strategy for professional development and the competency development and toolkit have demonstrated just one example of the usefulness of the PPM and its impact on the control over the framework of care and the environment in which care is managed and delivered. The design and the development of the foundational and professional competencies laid the groundwork for the evidence-based framework for enhancing nursing professional practice and positioning the organization for the future of nursing. These competencies can be used as a framework for professional thinking and enable the skill-based profession of nursing to be more “professional thinking” as we approach tasks, behaviors and further our lifelong learning goals. This may mean changes to the organization, care delivery, and the academic institutions we seek out as partners. This paradigm shift will affect both management and staff, not only in nursing, but other interdisciplinary partners.
Section VI. Other Information

Funding

Full funding of this project was provided by the organization. This funding was for general expenditures, the 4-day off-site meeting, assembling the toolkit, and a portion of the salary of the project director. No external organizations or foundations participated in this funding. The final cost is outlined in the Project Costs (Appendix T).
Section VII. References


doi:10.1097/NNA.000000000
Section VIII. Appendices

APPENDIX - A
Nursing Professional Practice Model

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peggi.x.winter@org

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APPENDIX - B
Nursing Professional Development Specialist Practice Model
## APPENDIX – C
**Evidence Rating Scale**

<table>
<thead>
<tr>
<th>Level I</th>
<th>Experimental study/randomized controlled trial (RCT) or meta-analysis of RCT</th>
</tr>
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<tbody>
<tr>
<td>Level II</td>
<td>Quasi-experimental study</td>
</tr>
<tr>
<td>Level III</td>
<td>Non-experimental study, qualitative study, or meta-synthesis</td>
</tr>
<tr>
<td>Level IV</td>
<td>Opinion of nationally recognized experts based on research evidence or expert consensus panel (systematic review, clinical practice guidelines)</td>
</tr>
<tr>
<td>Level V</td>
<td>Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience)</td>
</tr>
</tbody>
</table>

### A  High

<table>
<thead>
<tr>
<th>Research</th>
<th>Consistent results with sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summative reviews</td>
<td>Well-defined, reproducible search strategies; consistent results with sufficient numbers of well-defined studies; criteria-based evaluation of overall scientific strength and quality of included studies; definitive conclusions.</td>
</tr>
<tr>
<td>Organizational</td>
<td>Well-defined methods using a rigorous approach; consistent results with sufficient sample size; use of reliable and valid measures</td>
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<tr>
<td>Expert opinion</td>
<td>Expertise has been clearly evident</td>
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</tbody>
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### B  Good

<table>
<thead>
<tr>
<th>Research</th>
<th>Reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summative reviews</td>
<td>Reasonably thorough and appropriate search; reasonably consistent results with sufficient numbers of well-defined studies; evaluation of strengths and limitations of included studies; fairly definitive conclusions.</td>
</tr>
<tr>
<td>Organizational</td>
<td>Well-defined methods; reasonably consistent results with sufficient numbers; use of reliable and valid measures; reasonably consistent recommendations</td>
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<tr>
<td>Expert opinion</td>
<td>Expert opinion</td>
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</table>

### C  Low quality or major flaws

<table>
<thead>
<tr>
<th>Research</th>
<th>Little evidence with inconsistent results, insufficient sample size and conclusions cannot be drawn undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results; conclusions cannot be drawn.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summative reviews</td>
<td>Undefined, or poorly defined methods; insufficient sample size; inconsistent results; undefined, poorly defined or measures that lack adequate reliability or validity</td>
</tr>
<tr>
<td>Organizational</td>
<td>Expert Opinion</td>
</tr>
</tbody>
</table>

Newhouse R, Dearholt S, Poe S, Pugh LC, White K. Johns Hopkins Evidence – Based Practice Appraisal. The Johns Hopkins Hospital
### APPENDIX - D

**Table of Evidence**

**Question:** What is the significance of the professional practice model to the profession of nursing?

<table>
<thead>
<tr>
<th>#</th>
<th>Author/ Article</th>
<th>Study Design (Validity/Methods)</th>
<th>Study Result</th>
<th>Study Conclusion</th>
<th>Relevance</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bannigan, K., et.al. (2009) A Model of professional thinking: integrating reflective practice and evidence-based practice. <em>Canadian Journal of Occupational Therapy</em></td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality)</td>
<td>Reflective practice and evidence – based practice are important components of professional thinking in occupational therapy. When they are brought together in a model they provide a powerful skill to enable therapists to respond creatively to challenges they face when providing care.</td>
<td>Incorporating reflective and evidence-based practice as part of professional thinking reduces a practitioner’s capacity to respond to the complexity of health and social services and without putting them together it encourages oversimplification to the issues they face.</td>
<td>Models for professional practice must incorporate both reflective and evidence based thinking for occupational therapy as well as for nursing.</td>
<td>Level V</td>
</tr>
<tr>
<td>2</td>
<td>Basol, R., et. al. (2015) Developing, Implementing, and Evaluating a Professional Practice Model. <em>The Journal of Nursing Administration</em></td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality)</td>
<td>Article describes how a professional practice model was developed through clinical nurse involvement, review of literature, expert opinion and an innovative schematic. Demonstrated opportunities for professional nursing development and future planning</td>
<td>Provides a literature review supporting the use and value of a PPM to nursing practice.</td>
<td>The PPM describes how nurses practice, collaborate, communicate, and develop professionally It also shows how PPM’s drive current and future nursing practice.</td>
<td>Level V</td>
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<tr>
<td></td>
<td>Authors</td>
<td>Year</td>
<td>Title</td>
<td>Qualitative</td>
<td>Results/Findings</td>
<td>Methodology</td>
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<td>3.</td>
<td>Bruheim, M., et al.</td>
<td>2014</td>
<td>An educational program to transition oncology nurses at the Norwegian radium hospital to an evidence-based practice model: development, implementation, and preliminary outcomes. <em>Journal of Cancer Education</em></td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality)</td>
<td>Using a PPM participants have shown increased confidence in providing the best patient care, deeper reflection about their practice, and a sense of being valued by their nurse and physician colleagues. PPM has resulted in increased collaboration between interdisciplinar y clinical problem solving teams. This could serve as a role model for other cancer hospitals to move to a PPM not only for nursing but for diverse teams.</td>
<td>Level III</td>
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| 4. | Hoffart, N., et al. | 1996 | Elements of a Nursing Professional Practice Model *Journal Of Professional Nursing* | Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience) | Definition of a Professional Practice Model and the five subsystems of Professional Values, Management Approach, Professional Relationships, Compensation and rewards and Patient Care Delivery Systems The authors state that all need to be in place in order to see improved outcomes. They also feel that long term evaluation on outcomes must be done in order to prove or disprove the theory | The KP Professional Practice Model was designed to unite and align the nurses of KP. Since all of these components, especially the compensation one is not in place, it might be worthwhile to explore that area as an option | Level V | B Good }

**Level III**
- B Good
- Well-defined methods; reasonably consistent results with sufficient numbers; use of reliable and valid measures; reasonably consistent recommendations

**Level V**
- B Good
- Expert Opinion
<table>
<thead>
<tr>
<th></th>
<th>Author(s)</th>
<th>Title</th>
<th>Methodology</th>
<th>Findings</th>
<th>Level</th>
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<tbody>
<tr>
<td>5.</td>
<td>Krautscheid, L. (2014).</td>
<td>Defining Professional Nursing Accountability: A Literature Review</td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience</td>
<td>Professional nursing accountability is a core aspect that underpins professional nursing practice. In this article recommendations are made for nursing education practice and recommendations for nursing education research are proposed.</td>
<td>Level V B Good Expert Opinion</td>
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<td>6.</td>
<td>Kerfoot, K., et al (2006).</td>
<td>Conceptual Models and The Nursing organization: Implementing the AACN Synergy Model for Patient Care©</td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience</td>
<td>Use of the model has differentiated this system in the marketplace. Vacancy and turnover has decreased dramatically as well as patient and family satisfaction. This model raises the bar for nurses as well as creating a well-articulated path to improve their practice.</td>
<td>Use of the model has differentiated this system in the marketplace. Vacancy and turnover has decreased dramatically as well as patient and family satisfaction. This model raises the bar for nurses as well as creating a well-articulated path to improve their practice.</td>
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<td></td>
<td>Manuel, J., et.al.</td>
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<td></td>
<td>Preparing Social Work Practitioners to use Evidenced-Based Practice.</td>
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<td></td>
<td>Research on Social Work Practice.</td>
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<td></td>
<td>Quasi experimental which showed that the intervention of training to develop team members competencies in using an EBP model can be successful in the use of the model in practice.</td>
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<td></td>
<td>This project demonstrated that there is commonalities across agencies who use models there is a need to take into account the culture and context of the setting</td>
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<td></td>
<td>Training is in large part successful when used in a blended style of didactic and focused practice but the culture of the setting must be taken into consideration. Organizational readiness should always be part of the introduction of a model</td>
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<td></td>
<td>As we introduce the professional development components to support the PPM at KP we need to not only introduce forms of training but also assess culture and organizational readiness. Possibly extending the introduction of various models to academic partners.</td>
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<td>Level II</td>
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<td>Grade B: Good Reasonably consistent results</td>
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<tr>
<td></td>
<td>The Caring Nursing philosophy and professional practice model Journal of Clinical Nursing</td>
</tr>
<tr>
<td></td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience</td>
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<td></td>
<td>This article presented information about models and their relevance to today’s nurses. The author feels the approach to adoption of a practice model must encompass the nature and dignity of the person, the experience of an infinite transcendent reality in life processes and health as human flourishing.</td>
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<tr>
<td></td>
<td>A PPM can help decrease the incidents of incompetent and insensitive practice and sustain already exemplary practice. It can also close the gap between nursing practice and nursing science.</td>
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<td>This article relates the relevance of clinical practice to a PPM It balances attentive tenderness in the nurse-patient relationships with clinical skill and judgment by helping nurses establish prof practice boundaries and take responsibility for their practice.</td>
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<td>Level V</td>
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<td></td>
<td>Grade B: Good Expert Opinion</td>
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<td>Author(s)</td>
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<td>9.</td>
<td>Murphy, M., et al (2011)</td>
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<td>10.</td>
<td>Roussell, L., et al (2009)</td>
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<td></td>
<td>Slayter, S., et.al. (2015). Professional practice models for nursing: a review of the literature and synthesis of key components. <em>Journal of Nursing Management</em></td>
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<td>11.</td>
<td>Stichler, J. (2015) Using Magnet as a Framework for Nurse Participation in Facility Design. <em>Journal of Nursing Administration</em></td>
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<td>13.</td>
<td>Tinkham, M. (2013) Pursuing Magnet Designation: Choosing a Professional Practice Model. <em>AORN Journal</em></td>
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## APPENDIX - E
### Table of Evidence

**Question:** What evidence exists for the relevance and use of competency and/or competency models in support of professional practice?

<table>
<thead>
<tr>
<th>Author/ Article</th>
<th>Study Design (Validity/ Methods)</th>
<th>Study Result</th>
<th>Study Conclusion</th>
<th>Relevance</th>
<th>Evidence rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Nurses Association Congress on Nursing Practice and Economics (2007) Draft White Paper on Competence and Competency</td>
<td>Opinion of nationally recognized experts based on research evidence or expert consensus panel (systematic review, clinical practice guidelines)</td>
<td>As the professional association representing the profession of over 2.9 million nurses, ANA provides the leadership position on the complex issue of assuring competence of the nursing workforce.</td>
<td>The definitions of competence and competency and the accompanying descriptions of related concepts should be included in the ANA scope and standards documents. This information should also be used to guide nursing education, staff development, credentialing, and legislative and regulatory initiatives.</td>
<td>This white paper provides the profession with the expert opinion of the American Nurses Association. They are making a statement about the relevance of competency to professional practices of all nurses in the present day workforce and within current and future professional activities.</td>
<td>Level IV B Good Expert Opinion</td>
</tr>
<tr>
<td>Arnold, L. (2002) Assessing Professional behavior: Yesterday, Today and Tomorrow Academic Medicine</td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience</td>
<td>The author interprets the art of assessing professional behavior in medicine. In the article it defines the concept of professionalism, reviews properties of assessing professionalism, convey the major findings that these approaches produce and discuss recommendations to improve the assessment of</td>
<td>There are many tools out there to measure professionalism but the measurement properties should be strengthened, refine quantitative assessments of competence, and evaluate the elements of professionalism.</td>
<td>This article uses competence as a core measure of professionalism and professional behaviors. If we believe there is a connection to professionalism, professional behavior and professional practice then the assessment of competence and clinical performance impacts our professional practice.</td>
<td>Level V B Good Expert Opinion</td>
</tr>
<tr>
<td>Del Bueno, D. 2001 Buyer Beware: The Cost of Competence Nursing Economics</td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience</td>
<td>Staffing shortages and increasingly complex patient populations are challenging nurse leaders to recruit and retain staff while maintaining and improving competencies.</td>
<td>Competency based frameworks are used to compare job satisfaction to competencies since they set the foundation for the role within recruitment, assessment, and selection. They are also important in employee performance management, in training and development and play a key role in career and workforce planning efforts</td>
<td>Provides relevance of competency-based frameworks to areas within the environment of nursing that affect professional practice and job satisfaction and thus retention of staff.</td>
<td>Level V B Good Expert Opinion</td>
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<tr>
<td>Lenburg, C. (2000) Redesigning Expectations for Initial and Continuing Competence for Contemporar y Nursing Practice. Online Journal of Issues in Nursing</td>
<td>Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience</td>
<td>Complexities of healthcare compels the profession to confront the issues of promoting documentation of initial competence of new grads and the continuing competence of experienced nurses.</td>
<td>Provides an overview, context and rationale for competency based education and practice and selected methods relevant to performance assessment and related contemporary issues</td>
<td>This is a call for nursing to change its culture by creating and implementing the level of competence in professional practice required by a host of stakeholders. This is a time for increased collaboration; creativity and flexibility in order to change the existing system to one that insures competent practice and quality care.</td>
<td>Level V B Good Expert Opinion</td>
</tr>
</tbody>
</table>
| Ludwick, R. (2000) | Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience | It is incumbent upon nursing and nursing practice to examine how we are preparing for new skills and updating ongoing skills. The purpose of this article is to raise questions, which encourage ethical thoughtfulness about issues, related to competency and suggest actions that increase thought, reflection, and discussion of competence. | Issues related to competence are not easily resolved but are crucial to the trust that has been place in nursing by society. | 1. Assess your competencies. 2. Involve yourself in groups that set policy regarding competencies 3. Be informed 4. Think proactively | Level V  
B Good  
Expert Opinion |
|---|---|---|---|---|---|
A Cube Model for Competency development: Implications for Psychology Educators and Regulators  
*Professional Psychology* | Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience | This article provides a conceptual framework for training in professional psychology focusing on the construct of competency. The authors provided a 3-dimensional competency model that provides a framework for those responsible for education of psychologists. | This framework is used to train and inform the practice and training involved in the practice of psychology. It portrays a competency cube with functional, foundational and the stages of professional development for the profession of psychology It portrays a pictorial design for the evolution of competencies from the earliest stages of entry to the practice through life long learning. | The concepts in this article were very transferrable to the profession of nursing practice especially as it relates to professional development and life long learning. As in nursing, the practice of psychology has expanded its scope of practice and reflects more than ever the changes in public need and the demand for services. It is also in part due to the expanded body of knowledge and skills necessary to practice. | Level V  
B Good  
Expert Opinion |
| Whittaker, S., et al (2000). | Qualitative: Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience | This article reviews approaches to ensure the continued competence of health care providers, beyond the competency of initial licensure. Specific methods are discussed and nursing questions around policies are presented. | Continued competence continues to be explored by local and national groups. Even though this article was written in 2000 nursing is still struggling with the decisions around initial and continued competence | This article justifies the decision to have identified competencies for an organization, which can provide a framework for academic partnership and assist us in developing continuing experiences that reflect out foundational and professional competencies. | Level V B Good Expert Opinion |
APPENDIX - F
A Framework for Spread
DNP Statement of Non-Research Determination Form

Title of Project: Using a Strategic Model for Professional Development: The Importance of Evidence-Base Competencies as a Foundation for Professional Practice.

Brief Description of Project: In early 2008, the organizations Nursing Executive Leadership Council agreed to unite and align our then 50,000 nurses under a single vision set of values, and nursing model across all regions and the continuum of care. It would standardize practice where there is evidence, and elevate professional nursing in the organization. The ultimate aim was that regardless of where patients entered the system, they would know a nurse was caring them for. It would be the first time such a vision was set forth in our sixty-five year history. Four pillars support this vision, which is within our professional practice model, leadership, quality and safety, research and professional development. The one I will explore is Professional Development. This project identifies the core components of Professional Development that will be part of a five-year strategy for nursing professional practice within the organization. There are seven development and educational components contributing to the professional development of practicing nurses and other learners. They are orientation, competency, continuing education, career development/role transition, research and scholarship, inservice and academic partnership. I will take each component, and using a framework, diagnosis the current levels of performance while understanding the potential for performance at the highest level. From this visioning process I will be able to design an operational plan to address each component and move us to the high performing level.

As a result, I will take one of the core components, competency, and design an evidence based competency domain framework. I will design a competency toolkit and get a region to agree to build the components into a curriculum for hard to retain positions in the organization. This will be done to provide a pilot for the other six regions.

A) Aim Statement: The aim of the project, through a collaborative of regional education leaders, is to transform the work of professional development by designing a five years strategy in alignment with all seven regions. By using a high performance model with the seven components of the Nursing Professional Development Specialist Practice Model, I will assess the current level of each component, and the development of an operational strategy to move toward the ultimate goal of attaining and sustaining high-level performance. As part of this strategy development, the process described in this project will result in a competency model, which will provide a framework and foundation for the other components of professional development and its strategy.

B) Description of Intervention: The intervention will be the development of a competency toolkit for educators/professional development specialists, which will change how they develop curriculum, orientation, and job descriptions. It will also be used to provide a foundation for future role design across all seven regions. As a result of this toolkit, I will provide a business case for the adoption of the core components in the recruitment and the orientation of a hard to retain position as a pilot in one of the seven regions.

C) How will this intervention change practice? It will provide standard competencies across all seven regions and provide a foundation for other areas such as behavioral interviewing, orientation, and job description and for use with the workforce planning to develop roles for nursing in the future. As a result of the adoption of components of this toolkit for high turnover positions, we will pilot this process in one of
the seven regions to explore whether hiring for best fit has a positive impact.

D) **Outcome measurements:** Evaluation of the toolkit by the Professional Development community and continued evaluation once the toolkit is available on the KP Nursing website. I will also be using retention for high turnover positions as an ROI component.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:  (http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

**Comments:**

**EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST * **

**Instructions: Answer YES or NO to each of the following statements:**

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. ALL participants will receive standard of care.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project is <strong>NOT</strong> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <strong>NOT</strong> follow a protocol that overrides clinical decision-making.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <strong>NOT</strong> develop paradigms or untested methods or new untested standards.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <strong>NOT</strong> seek to test an intervention that is beyond current science and experience.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project has <strong>NO</strong> funding from federal agencies or research-focused</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
organizations and is not receiving funding for implementation research.

| The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients. | X |
| If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: “This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.” | X |

**ANSWER KEY:** If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does **NOT** meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

---

**STUDENT NAME (Please print):**
Mary M Winter (Peggi)

Signature of Student: __________________________ DATE 8/26/2015

**SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):**

Signature of Supervising Faculty Member (Chair): __________________________ DATE
**APPENDIX - H**
Nursing Professional Development:

**DEVELOPMENTAL GRID**

For further inquiries and information, please contact the author:

**Peggi Winter, DNP(c), MA, RN, NE-BC**

peggi.x.winter@kp.org

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<table>
<thead>
<tr>
<th>ORIENTATION</th>
<th>REACTIVE 0-24%ile</th>
<th>RESPONSIVE 25-49%ile</th>
<th>PROACTIVE 50-74%ile</th>
<th>PROGRESSIVE 75-89%ile</th>
<th>HIGH PERFORMING 90-100%ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGY/PROCESS</td>
<td>TASK DRIVEN</td>
<td>VALUE DRIVEN (Buy-In Achieved)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Orientations are all different for every region/facility
- Information shared is “how we’ve always done it”
- Topics are disseminated and considered as being enforced by leadership.
- Forms, checklists, compliance, transactional, paper based
- Ownership/management driven

- Orientations are building processes
- One national orientation, then regional, facility and then unit specific
- Formalized onboarding
- Manager and RN review checklist
- Ownership: management/HR
- Evaluation: task oriented and timely
- Content can be top down initiatives to roll into a short

- Strategic onboarding
- Extended onboarding program,
- Clear ownership,
- Ownership management, staff and orientee HC team
- More clarity regarding outcomes
- Along orientation continuum there is increase accountability and ownership of

- Evaluation RN and HC team participate
- And in some cases a multidisciplinary team
- All of the staff “own” the success of the new employee
- 2 way communication and contribution of the orientation encompasses.
- Question what tools do we need

- Multidisciplinary onboarding,
- Team building activities, engagement, socialization
- Individually driven
- Lifelong learner
- Ideally the Individual relies on a responsive team who supply resources
- Evaluation: Manager, RN, HCT with employee development plan.
- Eval of orientation is
<table>
<thead>
<tr>
<th>No formal time for mtg/eval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluations: task oriented</td>
</tr>
<tr>
<td>Inconsistent process</td>
</tr>
<tr>
<td>Lack of standardization acr a MC and across the program</td>
</tr>
<tr>
<td>Inconsistent Process for:</td>
</tr>
<tr>
<td>o Time frame</td>
</tr>
<tr>
<td>o Structure</td>
</tr>
<tr>
<td>o Process of evaluation</td>
</tr>
<tr>
<td>o Organization of content</td>
</tr>
<tr>
<td>o Can be crisis oriented and pulling the Employee early due to ‘needs’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Educators not at the table for discussions that impact the program</td>
</tr>
<tr>
<td>- Standardized orientation for the entire medical center or at least sections of it</td>
</tr>
<tr>
<td>- Manager driven</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>orientation on employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Evaluation completed by Preceptor, new employee, and managers</td>
</tr>
<tr>
<td>- Program is EB</td>
</tr>
<tr>
<td>- Program is integrated</td>
</tr>
<tr>
<td>- Clearer outcomes</td>
</tr>
<tr>
<td>- Preceptor more engaged</td>
</tr>
<tr>
<td>- The employee receives more structured feedback</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>to be successful including HS LMS, KPHC, Smart Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>360’</td>
</tr>
</tbody>
</table>

| - The HCT values new hires, perspectives, ideas, innovation |
| - Input from the new employee is valued – rather than “We don’t do it that way” |
| “You and your Professional Practice” |

<table>
<thead>
<tr>
<th>COMPETENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Competencies only considered clinical skills, not knowledge or ability</td>
</tr>
<tr>
<td>- There are no similar competencies for all KP nurses</td>
</tr>
<tr>
<td>- Keep adding on new ones without validating current ones</td>
</tr>
<tr>
<td>- No definition of a competency</td>
</tr>
<tr>
<td>- Competencies are designed in a framework of new initiatives and vendor products</td>
</tr>
</tbody>
</table>

| - Competencies are developed to achieve goals and plan for the present |
| - Data around competencies are collected but not used except ad hoc or for regulatory rules |

| - Multiple ways to validate competencies and staff chores |
| - Needs assessment |

| - Donna Wright Model |
| - Team collaborates on competencies |

| - Professional competency Portfolio |
| - Interdisciplinary team validates portfolio |
| - Professional portfolio where employee submits evidence of competency (council of peers reviews portfolio – interdisciplinary |
| **ACADEMIC PARTNERSHIP** | - Academia is thought of as a means to an end.  
- Criticism of the nurses graduating.  
- No integration of practice world with academic learning’s  
- Practice expects academia to know what competencies are needed.  
- No clear road map for attaining next level of education.  
- Contracts reflect clinical agreements  
- Academic partnership is formed around a framework of answering the present needs of practice.  
- Competencies are around skills for the new grad to get employed  
- Preceptors and students working together  
- Take students and unit preceptors  
- Ease transition with students who are familiar with system  
- NCLEX questions: The HealthCare system influences NCLEX questions to ensure that ambulatory questions are in place; this leads to academia including ambulatory content into the curriculum  
- Local edu department designs clinical experience with clinical expertise with clinical incentives (?)  
- Help influence curriculum of academic-practice partnership  
- Model is designed for Academic-Practice partnership  
- Residency program in place  
- Formal mentoring program in place  
- Leverage APN to assist with students  
- T2P  
- HR works with team to find jobs for RN students with in the MC  
- Ambu Care: bringing in new grads into ambulatory environment and helping to shape the nurse of the future through practicum and curriculum  
- Agreed upon competencies for both practice and academia. Built into curriculum and onto onboarding and competency program in practice environment  
- Leverage strategy and relationships from other disciplines  
- Partner with the BRN to change rules if necessary to accommodate nurse of the future  
- Partnership between practice and academia—we teach with them at school and they participate with us in the practice environment  
- Share best practices across the program  
- Purposeful designed clinical experience to shape the nurse of the future.  |
| **CONTINUING EDUCATION** | - Education is thought of as an individual activity.  
- No outcome measures are necessary  
- Only thought of as # of CE’s Prescriptive.  
- Continuing Nursing Education done in response to a need.  
- Outcomes may be level 1 and 2—“butts in seats” but not related to change in practice or change in patient outcomes  
- Journal Club  
- Staff willing to work as a SME  
- Part of a bigger plan  
- Create learning objectives and tie to patient outcomes  
- Incorporate what they learned, how they have changed their practice in their professional portfolio  
- RN’s apply and demonstrate CNE to impact of patient care outcomes  
- Build business case for change in infrastructure that tracks educational time and link NPD, research and tech |
| CAREER DEVELOPMENT/ROLE TRANSITION | - Up to the individual  
- No mentors or guidance for the nurses  
- Silos  
- Systems in place but not connected  
- Minimal organizational support for development.  
- Majority of staff do not value advancement or value in professional growth. |
| - Processes are consistent and tailor able with some integration  
- several system connect through manual process  
- Organizational support for advancing knowledge and skills  
- Staff participates because of expectations set by others or job description. |
| - Integrated role transition  
- Focus on connecting systems and processes  
- Team is responsible for talent initiatives  
- Strong organizational support for advancing knowledge and skills with staff willing to commit to utilizing it.  
- Staffs develop self-awareness of development needs and begin to own and organize professional development activities. |
| - Staff commit to self-development. Encourage and participate in the development of peers  
- Certified nurse’s support and mentor colleagues towards their certification |
| - Strategic  
- Fully integrated processes and systems used to make business decisions  
- Talent management is business- driven  
- Nurses drive change based on their acquired knowledge and are able to align their development goals with the strategic plans  
- Career coaching begins at orientation  
- Integrated into new role via understanding of patient centric team culture  
- Exposure to new area through shadowing |

| RESEARCH AND SCHOLARSHIP | - Research is not part of nursing practice  
- No time built in for journal clubs.  
- Certification is not encouraged.  
- Tuition is the same for everyone  
- No formal plan to incorporate research and scholarly practice |
| - Alignment of tuition with career development strategies  
- Current hiring of ADN nurses and then work with academia to get them their degrees. |
| - Tuition assistance is leveraged in support of employee development goals  
- Showcase ‘best practices’  
- BSN is entry level  
- Learners rate model research and scholarly practice and mentor the rest of the team  
- Certification of all nurses within two years of hire |
| - Nurses collaborate with researchers to determine research opportunities and benefit unit  
- Leader rate model research and scholarly practice  
- Monitor and team do the same |
| - Baccalaureate degree is entry to practice at KP  
- Certification for all nurses within two years of hire  
- Development and delivery of custom degree programs  
- Assistance/support with gaining points on career ladder  
- MSN in practice  
- DNP in practice  
- Infrastructure to allow |
<table>
<thead>
<tr>
<th>IN SERVICE EDUCATION</th>
<th>years of hire</th>
<th>employees to continue education</th>
</tr>
</thead>
<tbody>
<tr>
<td>- In-service is owned by the education or training department.</td>
<td>- Monetary incentives</td>
<td>- Continued as a part of the continuum of professional development.</td>
</tr>
<tr>
<td>- It is force fed</td>
<td></td>
<td>- Nurses are involved in the implementation and planning of the programs.</td>
</tr>
<tr>
<td>- It is enforced by leadership</td>
<td></td>
<td>- Emphasis on adult learning in designing program content.</td>
</tr>
<tr>
<td>- Attendance is either mandatory or a punishable offense.</td>
<td>- Little planning is involved and is more around the activities of the present.</td>
<td>- Use of adult oriented models of active learning as the design for in-service programs.</td>
</tr>
<tr>
<td>- It is sometimes seen as the way to solve management issues.</td>
<td>- Structure is top down</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX - I
Five Competency Models

<table>
<thead>
<tr>
<th>competency model</th>
<th>NOF</th>
<th>IOM</th>
<th>ACGME</th>
<th>QSEN</th>
<th>ANA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement</td>
<td>Apply Quality Improvement</td>
<td>Quality Improvement</td>
<td>Quality of Practice</td>
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<td></td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>Provide Patient-Centered Care</td>
<td>Patient-Centered Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Teamwork and collaboration</td>
<td>Work in interdisciplinary teams</td>
<td>Teamwork and collaboration</td>
<td>Collaboration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informatics and Technology</td>
<td>Use informatics</td>
<td>Informatics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emploee evidence-base practice</td>
<td>Emploee evidence-base practice</td>
<td>Evidence-based practice</td>
<td>Evidenced-Based Practice and Research</td>
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<td>Systems-based practice</td>
<td>Systems-based practice</td>
<td>Resource Utilization</td>
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<tr>
<td>Professionalism</td>
<td>Professionalism</td>
<td>Professional Practice Evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Interpersonal &amp; communication skills</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical knowledge</td>
<td></td>
<td>Education</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Leadership</td>
<td>Practice-Based Learning &amp; Improvement</td>
<td>Leadership</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Environmental Health</td>
<td></td>
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</tr>
</tbody>
</table>
APPENDIX - J
Competency Framework
APPENDIX - K
Message Map: Nurse Managers

Extraordinary Nursing Care: Every Patient, Every Time

Nurse Managers

- Qualified candidates prescreened for foundational competencies
- Web enabled tool will provide a report for decision making
- Incentive to decrease turnover
- Follow through in orientation of same competency discussion

- Decreased Turnover
- Wrong culture fit
APPENDIX - L
Message Map: Professional Development Leaders
APPENDIX - M
Message Map: Professional Development Leaders

Extraordinary Nursing Care:
Every Patient, Every Time

Recruiters

Increase retention
Retention rates for your hires are tracked and successful

Time saver
Frees you to focus on other aspects of your job

Delivers screened for foundational competencies applicants thru a well thought out process

Reflects positively on your role and effectiveness as a recruiter
APPENDIX - N

Questionnaire for Professional Development Leaders

National Nursing Professional Development Committee’

As you may be aware, we have approved and are now in the adoption phase for the KP Professional and Foundational Competency Domains.

As a result of this competency adoption, NPCS would like you to spend a few minutes completing a survey on the use of the competencies and possible contents of a toolkit for the practice environments. These questions will provide a framework so that we might assist you and your colleagues to integrate and align the competencies into your existing work.

This survey will help us identify your current use of KP foundational and professional competencies, which we can share, and, potential content for a toolkit that will assist in integrating the competencies into the components of your professional development practice.

1. Do you currently have a standardized process for developing competencies?
   - Yes/No | If yes, please explain

2. Have you begun integrating the competency domains into practice?
   - Yes/No/Don’t Know | If yes, please explain how

3. Rate the extent to which each of these competencies have been integrated into processes or systems in your regions.

<table>
<thead>
<tr>
<th>Competency Domains</th>
<th>Never or Rarely</th>
<th>Sometimes</th>
<th>Usually or Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research/EBP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informatics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology Enabled Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Leadership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#4 In the process of integrating and aligning the KP nursing competencies, which of the following might be useful

<table>
<thead>
<tr>
<th></th>
<th>Check all that Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency White Paper</td>
<td></td>
</tr>
<tr>
<td>Curriculum Blueprint</td>
<td></td>
</tr>
<tr>
<td>Evaluation Tool</td>
<td></td>
</tr>
<tr>
<td>Competency Template</td>
<td></td>
</tr>
<tr>
<td>Behavioral Interviewing tool</td>
<td></td>
</tr>
<tr>
<td>Examples of Knowledge Skills and Abilities for each competency</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>
# 5 What external framework(s) does your region use to guide professional staff development?

<table>
<thead>
<tr>
<th>Check all that Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP Professional Practice Model</td>
</tr>
<tr>
<td>Joint Commission / National Patient Safety Goals</td>
</tr>
<tr>
<td>Institute of Medicine Report</td>
</tr>
<tr>
<td>Nursing Theorist / Other Model</td>
</tr>
<tr>
<td>Benner's Carnegie Report</td>
</tr>
<tr>
<td>QSEN</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

# 6 What internal framework(s) would you use competencies to guide its development?

<table>
<thead>
<tr>
<th>Check all that Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Orientation</td>
</tr>
<tr>
<td>Competency programs</td>
</tr>
<tr>
<td>Job descriptions</td>
</tr>
<tr>
<td>Nursing Councils</td>
</tr>
<tr>
<td>Performance Evaluations</td>
</tr>
<tr>
<td>Preceptor Training</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

# 7 What other resources would be helpful to guide Competency integration?

<table>
<thead>
<tr>
<th>Check all that Apply</th>
<th>List top 3 Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Toolkit</td>
<td></td>
</tr>
<tr>
<td>Leadership Consensus Building</td>
<td></td>
</tr>
<tr>
<td>Workshops/Educational Sessions</td>
<td></td>
</tr>
<tr>
<td>Webinars</td>
<td></td>
</tr>
<tr>
<td>In person Deep Dives</td>
<td></td>
</tr>
<tr>
<td>Increase in NNPDC Meetings</td>
<td></td>
</tr>
<tr>
<td>Shared examples from Regions</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX - O
Competency Toolkit

For further inquiries and information, please contact the author:
Peggi Winter, DNP(c), MA, RN, NE-BC
peggi.winter@gmail.com

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INSTRUCTIONS
Click on each of the icons under Professional Competencies and blue buttons under Foundational Competencies to find out more information about each one.

NOTE
Please view the competency on each of the following pages. After reviewing the competencies, please complete the Competency Assessments.

Thank you.
FOUNDATIONAL COMPETENCIES

PROFESSIONALISM

The KP nurse will demonstrate accountability for the delivery of standard-based care that is consistent with moral, altruistic, legal, ethical, regulatory, and humanistic principles. (Adapted from NOF, 2010)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participates in the evaluation of professional standards of practice, including evaluation of the legal and regulatory factors that apply and the responsibility and accountability for outcomes.</td>
<td>Abides by professional standards of practice</td>
<td>Applies professional standards of practice</td>
</tr>
<tr>
<td></td>
<td>Upholds legal and regulatory principles</td>
<td>Implements plan of care within legal, ethical, and regulatory framework of nursing practice.</td>
</tr>
<tr>
<td></td>
<td>Recognizes personal capabilities, knowledge base, and areas for development.</td>
<td>Provides and receives constructive feedback to/from peers.</td>
</tr>
<tr>
<td></td>
<td>Demonstrated collegiality, openness to critique, and peer review.</td>
<td></td>
</tr>
<tr>
<td>Describes factors essential to the promotion of professional development</td>
<td>Committed to life-long learning</td>
<td>Demonstrates life-long learning</td>
</tr>
<tr>
<td>Describes the role of a professional organization shaping the practice of nursing.</td>
<td>Establishes mentoring relationships</td>
<td>Demonstrates ability for reflection to achieve personal and professional growth.</td>
</tr>
<tr>
<td>Describes the importance of reflection to advancing practice and improving outcomes of care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)

FOUNDATIONAL COMPETENCIES

LEADERSHIP

The nurse will influence the behavior of individuals or groups of individuals within their environment in a way that will facilitate the establishment and acquisition/achievement of shared goals. (Adapted from NOF, 2010)

<table>
<thead>
<tr>
<th>Knowledge</th>
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<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies leadership skills essential to the practice of nursing</td>
<td>Recognizes role of nurse leader</td>
<td>Integrates leadership skills of systems thinking, communication, and facilitating change in managing member’s needs.</td>
</tr>
<tr>
<td>Describes critical thinking and problem solving processes</td>
<td>Applies clinical reasoning and critical thinking processes in the management of client care situations</td>
<td>Uses systems thinking approaches in problem solving</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrates purposeful, informed, outcome oriented thinking</td>
</tr>
<tr>
<td>Identifies the roles and skills of the healthcare team</td>
<td>Recognizes personal attitudes and beliefs influences one’s leadership style</td>
<td>Promotes a productive culture by valuing individuals and their contributions</td>
</tr>
<tr>
<td></td>
<td>Incorporates the expertise of each member of the team</td>
<td>Models effective communication and promotes positive behavior</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Examines different viewpoints</td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)
## TECHNOLOGY-ENABLED CARE

The nurse will use emerging technology to change the practice of nursing by using technology to facilitate mobility, communication, and relationships (ANA, 2013)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe concepts included in basic computer competencies</td>
<td>Recognizes the importance of basic computer competence to contemporary nursing practice.</td>
<td>Demonstrates proficiency with the computer in work settings.</td>
</tr>
<tr>
<td>Describe the importance of information and technology skills as essential to the professional nurse</td>
<td>Recognizes the importance of computing and that all health professionals need to seek life long and continuous learning of technology skills</td>
<td>Integrates electronic resources and integrated into knowledge base. Evaluates information and its sources critically and incorporates information into professional knowledge. Seeks how information is managed in the care setting before providing care.</td>
</tr>
<tr>
<td>Defines the impact of computerized information management on the role of the nurse</td>
<td>Acknowledges role in influencing attitudes of other nurses toward computer use for practice.</td>
<td>Accesses essential information effectively and efficiently. Applies appropriate technology in the process of assessing and monitoring consumers.</td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)

## COMMUNICATION

The nurse will interact effectively with patients, families, and colleagues, fostering mutual respect and shared decision making, to enhance patient satisfaction and health outcomes. (Adapted from NOF, 2010)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands the principles of effective communication through various means</td>
<td>Accepts responsibility for communicating effectively</td>
<td>Uses clear concise, effective written, electronic and verbal communication. Documents interventions and nursing outcomes according to professional standards and work unit policy</td>
</tr>
<tr>
<td>Knows grammar, spelling, and health care terminology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses effective strategies for communicating and resolving conflicts with team members</td>
<td>Values the role of each member of the team</td>
<td>Communicates effectively with colleagues. Contributes to resolution of conflict</td>
</tr>
<tr>
<td></td>
<td>Recognizes each individual involved in a conflict has accountability for it and should work to resolve it</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)
**PROFESSIONAL COMPETENCIES**

**INFORMATICS**

The nurse will use information and technology to communicate, manage knowledge, mitigate error, and support decision making (QSEN, 2007)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe concepts included in basic computer competencies (e.g., software, hardware, database, password authentication)</td>
<td>Recognizes the importance of basic computer competence to contemporary nursing practice.</td>
<td>Demonstrates proficiency with the computer in work settings (use of keyboard, use of and maintenance of wireless carts)</td>
</tr>
<tr>
<td>Describe the importance of information and technology skills as essential to the professional nurse (use of EHR, EMR, PHR)</td>
<td>Recognizes the importance of computing and that all health professionals need to seek life long and continuous learning of technology skills</td>
<td>Integrates electronic resources and integrated into knowledge base (use of clinical library and electronic resources within HC) Evaluates information and its sources critically and incorporates information into professional knowledge (Difference in and why you would use Google, Wikipedia, and Lippincott) Seeks how information is managed in the care setting before providing care. (Reviewing the chart, Handoff information, care planning)</td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)

**RESOURCE UTILIZATION**

The PP nurse will demonstrate an awareness of factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing and other services (ANA, 2013)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the difference between microsystems and macro systems in healthcare</td>
<td>Acknowledges the role of the staff nurse in the operation of an effective microsystem Recognizes how the elements of the microsystem impacts one’s practice</td>
<td>Plans, organizes and delivers member care in the context of the work setting level</td>
</tr>
<tr>
<td>Describe the impacts of macro system changes on planning, organizing, and delivering care in the work setting Describes interrelationships among nursing, the nursing work unit, and organizational goals</td>
<td>Recognizes the complexity of the work setting environment as well as individual and group practice on a care setting Recognizes the impact of one’s decision on the care setting</td>
<td>Consider influence of the macro system when making member care decisions Seeks to solve problems encountered at the point of care Informs problems encountered in daily practice and informs those who can facilitate resolution Identifies inefficiencies and failures Participates in solving work unit inefficiencies and operational failures which impact member care especially those involving supplies, medications, equipment and information</td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)
### RESEARCH/EBP

The nurse will identify, evaluate, and use the best current evidence coupled with clinical expertise and consideration of patients’ preferences, experience and values to make practice decisions (Adapted from NOF, 2010)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates knowledge of basic scientific methods and processes</td>
<td>Acknowledges strengths and weaknesses of scientific bases for practice</td>
<td>Critiques research for application to practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participates in data collection and other research activities</td>
</tr>
<tr>
<td>Describes the concept of evidence-based practice (EBP), including research evidence, clinical expertise and consumer values</td>
<td>Acknowledges the concept of EBP as integral to determining best clinical practice</td>
<td>Develops individualized care on best current evidence, consumer values, and clinical expertise</td>
</tr>
<tr>
<td>Describes reliable sources for locating evidence reports and clinical practice guidelines</td>
<td>Acknowledges the importance of accessing relevant clinical evidence</td>
<td>Accesses evidence-based reports related to clinical practice topics and guidelines</td>
</tr>
</tbody>
</table>

### QUALITY & SAFETY

The nurse uses data to monitor the outcomes of care processes, and uses improvement methods to design and test change to continuously improve the quality and safety of healthcare systems (QSEN, 2010)

The nurse will also minimize the risk of harm to patients and providers through both system effectiveness and individual performance (QSEN, 2010)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the nursing context for improving care</td>
<td>Recognizes that quality is an essential part of nursing</td>
<td>Actively seeks information about quality initiatives in their own care settings and organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Actively seeks information about quality improvement in the care setting from relevant institutional, regulatory and local/national sources</td>
</tr>
<tr>
<td>Understands that nursing contributes to systems of care and processes that affect outcomes</td>
<td>Recognizes that team relationships are important to quality improvement</td>
<td>Participates in the use of quality improvement processes to make processes of care interdependent and explicit</td>
</tr>
</tbody>
</table>
### COLLABORATIVE CARE

The nurse will function effectively within nursing and interdisciplinary teams, foster open communication, mutual respect, shared decision making, team learning, and development (Adapted from NOF, 2010)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies strengths, limitations, and values in functioning as a member of a team</td>
<td>Recognizes own responsibility for contributing to the effectiveness of a team Appreciates collaboration</td>
<td>Demonstrates limitations as a team member. Plans for self-development as a member of a team. Acts with integrity, consistency, and respect for differing views.</td>
</tr>
<tr>
<td>Describes scope of practice and role of the team members.</td>
<td>Values perspective of all team members</td>
<td>Functions competently</td>
</tr>
<tr>
<td>Identifies the contribution of others in helping patient and families achieve health goals</td>
<td>Values perspectives and expertise of all health team members.</td>
<td>Functions competently within own scope of practice as a member of the team.</td>
</tr>
<tr>
<td>Describe strategies for identifying and managing overlaps in team member roles and accountabilities.</td>
<td>Respects the unique professional and cultural attributes that bring to a team.</td>
<td>Initiates requests for assistance when situation warrants it.</td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)

### FOUNDATIONAL COMPETENCIES

### ETHICS

The nurse practices with integrity that includes elements of honesty, responsibility, credibility, and the ability to use ethical considerations to guide decisions and actions. (Adapted from ANA, 2013)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes/Behavior</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the concept of accountability for own nursing practice</td>
<td>Accepts responsibility for own behavior</td>
<td>Exercises clinical reasoning and critical thinking within standards of practice.</td>
</tr>
<tr>
<td>Justifies clinical decisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describes ethical principles, values, concepts, and decision making that apply to nursing and consumer care.</td>
<td>Applies application of ethical principles in daily practice Acts in accordance with the code of ethics and accepted standards of practice Clarifies own personal and professional values and recognizes their impact on decision making and professional behavior</td>
<td>Incorporates ANA code of ethics into daily practice Utilizes an ethical decision making framework in clinical situations Responds to ethical concerns, issues, dilemmas that affect nursing practice to clinical practice</td>
</tr>
</tbody>
</table>

(Adapted with Permission from the Massachusetts NOF Core Competencies)
For further inquiries and information, please contact the author:

Peggi Winter, DNP(c), MA, RN, NE-BC

peggi.x.winter@org

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BEHAVIORAL INTERVIEWING TOOL

This tool is an instrument designed to provide information for the hiring of nurses that are aligned with and are equipped to deliver on the mission, and whose behavior and professional practice reflect the foundational competency domains of leadership, ethics, communication, technology-enabled care and professionalism. Employers use this tool to evaluate a candidate’s experiences and behaviors in order to determine their potential for success. This approach is based on the belief that past performance is the best predictor of future behavior. In fact, behavioral interviewing is said to be 55 percent predictive of future on-the-job behavior, while traditional interviewing is only 10 percent predictive. The interviewer identifies desired skills and behaviors, and then structures open-ended questions and statements to elicit detailed responses. A rating system is developed and selected criteria are evaluated during the interview.

This tool reflects the values of professionalism, teamwork, excellence, integrity, and patient- and family-centered care, which are part of our nursing model. It allows evaluation of the behavioral and competency requirements of a job thereby ensuring we select and develop the right people into the right positions. It does not label the profiles “good or bad”: it simply describes the individual’s behavioral characteristics and compares it to the defined needs of the organization. The behavioral-based technique isolates the qualities needed for a job and focuses questions and scenarios on those critical behaviors. As the process evolves, the questions in the behavioral assessment can adapt and change to more clearly define the competencies we are looking for in a potential employee. This process is only meant to help you to address the foundational competency domains. This tool does not take into consideration technical skills or performance skills.

Along with the definitions of the five foundational competencies there are questions and a rating scale, which managers can use to indicate the level of performance as it relates to the competency domain.

Getting Started
The nurse uses data to monitor the outcomes of care processes, and uses Improvement methods to design and test change to continuously improve the quality and safety of healthcare systems (QSEN, 2010). The nurse will also minimize the risk of harm to patients and providers through both system effectiveness and individual performance (QSEN, 2010)

Review the job information
- Job description
- Minimum job qualifications
- Projected needs for the role
Performance Expectations

Using the knowledge of the material above, create a list of the important things done on the job. Begin any performance expectations with an action verb followed by the object of the verb, followed by an "in order to" clause. Example, "Responds to the needs of the patient, meeting the professional code of conduct for the profession, in order to provide the highest level of quality and safety protection for the patient.

There are three levels of ratings. With each competency domain you should also consider, the frequency, (how frequently does this happen?), duration, (what is the duration when it happens?) and impact, (what is the impact of not doing this activity or doing it poorly?).

Ratings

1. Must display this consistently but does not significantly impact the success in this role
2. Must display this consistently and reflects an essential activity that is necessary to do the job well. It may be required on a regular basis for long periods or to gain important results
3. Must display this competency that is extremely essential for the success of the job. It may be required frequently for long durations and necessary for long periods of time.

Circle the level of rating for each competency based on the position:

<table>
<thead>
<tr>
<th>Ethic</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Technology-Enabled Care</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Professionalism</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
**ETHICS**

The nurse practices with integrity that includes elements of honesty, responsibility, credibility and the ability to use ethical considerations to guide decisions and actions (ANA, 2013).

<table>
<thead>
<tr>
<th>Very strong Evidence Skill is not Present</th>
<th>Strong Evidence Skill is not Present</th>
<th>Some Evidence Skill is Present</th>
<th>Strong Evidence Skill is Present</th>
<th>Very Strong Evidence Skill is Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**QUESTIONS**

1. Think of a situation when it required you to be politically correct but helpfully honest? What did you say?
2. Tell me a time when it was challenging for you to show consistency with your actions and words?
3. Describe a time you did the right thing even though no one was looking?

**INTERPRETATIONS**

1. Was the candidate sensitive to the opinion in a clear way?
2. Was there consistency in their story? Did the story provide detail enough to show how they may have wrestled with the decisions that had to be made?
3. Did they describe something that was believable and in line with the values of the organization?

**LEADERSHIP**

The nurse will influence the behaviors of individuals or groups of individuals within the environment in a way that will facilitate the establishment and acquisition/achievement of shared goals (NOF, 2010).

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<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Continued >
QUESTIONS

1. Tell me a time you disagreed with the medical plan of care, what was the situation and what did you do?

2. Think of a time when you did an especially good job at managing a team to achieve a desired outcome. What did you do and how did it work out?

3. Describe a situation where you had to lead by example. Walk me through what you did.

4. Tell me about a time when you saw someone practicing outside their scope of practice, what did you see and what did you do?

INTERPRETATIONS

1. Did the candidate describe a skill, which would be useful for the job they are applying for? Was it a successful experience as a result of the leadership skill?

2. Did the project have timelines, and measurable outcome?

3. Did the candidate give a key example that led you to believe in the processes success?

4. Did the candidate give you a significant example that could be applied to the position they are applying for?

TECHNOLOGY-ENABLED CARE

The nurse will use emerging technology to change the practice of nursing by using technology to facilitate mobility, communication, and relationships.

<table>
<thead>
<tr>
<th>Very strong Evidence Skill is not Present</th>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

QUESTIONS

1. Describe a time when you demonstrated true mastery of the technical skill relevant to your job.

2. Give an example of leading edge research or similar work that technology has supported.

3. Describe how you see the importance of information and technology skills essential to the professional nurse (use of E.H.R., EMR, PHR)

INTERPRETATIONS

1. Did the candidate use knowledge or skills that reflect expertise as opposed to traditional everyday use? Was there use of knowledge/skill that most regular users have?

2. Did the candidate play a critical role in a project that was applied to the care of the patient?

3. Did the candidate show how they manage information in the care setting before providing care? (Reviewing the chart, Handoff information, care planning)

Continued >
COMMUNICATION

The nurse will interact effectively with patients, families, and colleagues, fostering mutual respect and shared decision making, to enhance patient satisfaction and health outcomes. (NOF, 2010).

<table>
<thead>
<tr>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

QUESTIONS

1. Describe a situation in the clinical setting when you had to use a communication style which was very different from your own

2. Tell me about a time you altered the course of the plan of care based on feedback you received from the member/family. How did you gather their input, and how was it incorporated?

3. Discusses a situation when effective strategies were used for communicating and resolving conflict with team members

INTERPRETATIONS

1. Did the candidate identify a communication style that would be of value in the role you are hiring for?

2. Did the candidate describe good and bad styles, which would make you, believe they can differentiate between both?

3. Did the candidate discuss why the strategies were effective and how they resolved conflict?

Continued >
PROFESSIONALISM

The nurse will demonstrate accountability for the delivery of standard-based care that is consistent with moral, altruistic, legal, ethical, regulatory, and humanistic principles (NOF, 2010).

<table>
<thead>
<tr>
<th>Very strong Evidence Skill is not Present</th>
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<th>Some Evidence Skill is Present</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

QUESTIONS

1. Describe a situation when you have provided constructive feedback to peers.

2. Think of a time when you have had to be a patient advocate.

3. Explain to me the professional practice model or theory you practice under.

4. What is professional nursing? What does nursing bring to the table that is unique when compared to the other care team members?

INTERPRETATIONS

1. Describes a situation where constructive feedback has been well received or not and how they positively dealt with the situation.

2. Creates a scenario that demonstrates taking the side of the patient for the improvement of care.

3. Candidate will explain a model at another place of employment or a theory that guides their practice.

4. Defines in detail their definition of professionalism, which includes the conduct, aims, or qualities that characterize or mark a profession or a professional nurse.
For further inquiries and information, please contact the author:

Peggi Winter, DNP(c), MA, RN, NE-BC

peggi.x.winter@org
**COMPETENCY SELF ASSESSMENT**

**DIRECTIONS**
This self-assessment is meant to create a gap analysis between the practice habits and awareness of the professional competencies and their use in the nurse's daily practice. By identifying the gap, we can begin to provide a framework of knowledge, skills, and ability to close that gap.

**Resource Utilization**
The nurse will demonstrate an awareness of factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing and other services (ANA, 2013)

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Collaborative Care

The nurse will function effectively within nursing and interdisciplinary teams, foster open communication, mutual respect, shared decision making, team learning, and development (Adapted from NOF, 2010)

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Quality and Safety

The nurse uses data to monitor the outcomes of care processes, and uses Improvement methods to design and test change to continuously improve the quality and safety of healthcare systems (QSEN, 2010). The nurse will also minimize the risk of harm to patients and providers through both system effectiveness and individual performance (QSEN, 2010)

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(Continued)
**Research/EBP**

The nurse will identify, evaluate, and use the best current evidence coupled with clinical expertise and consideration of patients’ preferences, experience, and values to make practice decisions (Adapted from NOF, 2010)

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**Informatics**

The nurse will use information and technology to communicate, manage knowledge, mitigate error, and support decision making (QSEN, 2007)

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Peggi Winter, DNP(c), MA, RN, NE-BC
peggi.x.winter@kp.org

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COLLABORATIVE CARE

The nurse will function effectively within nursing and interdisciplinary teams, fostering open communication, mutual respect, shared decision making, team learning and development. (Adapted from NOF, 2010).

What is Collaborative Care?
Collaboration and effective teamwork go hand in hand. Successful collaboration requires working relationships that are respectful as well as joint communication and decision-making between nurses and other disciplines. Extensive evidence shows the negative impact of poor collaboration on measurable indicators such as patient and family satisfaction, patient safety, professional staff satisfaction, nurse retention and cost. The Institute of Medicine points to “a historical lack of inter-professional cooperation” as one of the barriers to safety in hospitals (Stanton et al, 2013)

The diverse team of practitioners within healthcare organizations must collaborate and function together as a team if safe, quality patient care is to be achieved. Without the ongoing collaborative work of the healthcare team, including all disciplines, patient and family needs cannot be met in today’s complex healthcare system. Nurses are key players in the coordination of care and must be highly skilled in the areas of collaboration and teamwork. The nurse of the future will be called upon to bring the members of the healthcare team together and lead the process of collaborating and working together effectively.

Questions for Learning
1. Why is collaborative care important in healthcare? In nursing practice?
2. Describe a team that is working well together. What principles are at work?
3. What are the elements necessary for a team to work effectively together?
4. How do you evaluate the effectiveness of a team?
5. What are the barriers to successful teamwork?
6. Describe the team you currently work in. Is it functioning effectively as a team?

Scenario(s):
Caring for COPD patients can be challenging for the staff. In one unit, the Respiratory Care Practitioners feel that they are the best choice to coordinate the care of the patient while the nurses feel that the traditional case management role of the RN is the most appropriate. This is causing friction in the team. How might the team address this issue and bring it to a successful end?

References
INFORMATICS

The Nurse of the Future will use information and technology to communicate, manage knowledge, mitigate error, and support decision-making (QSEN, 2007).

What is Informatics?
The ANA defines nursing informatics as a specialty that integrates nursing science, computer science and information science to manage and communicate data, information, knowledge and wisdom and nursing. In 1994, the American Nurses Association recognized nursing informatics as a professional specialty, and certification is now available at the generalist level.

Nurses harness information and technology to support their practice and provide superior care for their patients. The goal of nursing informatics is to improve the health of populations, communities, families, and individuals by optimizing information management and communication. The core competency of informatics allows the nurse to serve as a bridge between the clinical world and the areas of technology.

Nurses help patients to navigate the healthcare system, understand their clinical situation, and make choices about their care. With each passing year, patients are looking to technological resources to gain insight into clinical problems and address. The nurse of the future helps them take advantage of the technological tools available to them make wise choices to acquire accurate information.

Questions for Learning
1. How does technology improve nursing care?
2. What are the barriers that impact the quality of the interaction of an individual (patient and/or nurse) with technology?
3. How do you feel about patients using the Internet to seek information about their health? Can they be trusted to go to accurate sites to make good choices?

Scenario 1
The Surgical Ambulatory Care Units at a large metropolitan hospital completed major redesign and renovation of the outpatient surgical clinic area. The design and architectural drawings were initiated in 2002 with the space finished and finally occupied in May 2005. An informatics nurse was not assigned to the project. The registered nurse manager for the nursing services in these surgical clinics found the lack of planning for informatics support and supplies for the clinic areas to be an impediment that prevented a smooth move into the new spaces and transition to new business processes. The absence in the existing clinical information system patient education documentation form of post-surgical procedure teaching information created significant problems. The surgical clinic nurse requested assistance from the nursing informatics department to modify the form to include documentation of the patient education, a request due in part to fulfill the documentation requirements from the Joint Commission on Accreditation of Hospital Organization (JCAHO).

Discuss the following:
1. What other information might an informatics nurse address?
2. Explain how you use information technology to support your practice
**Scenario 2**
The outreach nurse observes that there is a 30 y/o patient, who is a single mom that has abnormal lab results in their inbasket notifications. In looking in the patient’s progress notes, there has not been a return call back to the patient to notify, and it is high priority for them to have a provider visit.

1. What are additional ways that technology could be leveraged to reach this patient to notify of the abnormal results?
2. How can the nurse be efficient to set up a provider visit for the abnormal labs, while also meeting the needs of the patient?
3. What would be pertinent information that the nurse should convey to the provider regarding this patient? What would be the best way for the nurse to accomplish this?

**References**

**QUALITY AND SAFETY**

**Safety**
The Nurse of the Future will minimize risk of harm to clients and providers through both system effectiveness and individual performance (QSEN, 2007).

**What is Safety?**
It is indisputable that safety is essential to ensuring positive client outcomes; however safety has been narrowly defined in terms of individuals and did not always encompass the concept of safety from a systems perspective. To ensure safety, nurses must understand, establish and maintain a culture of safety which involves planning, assessing and evaluating client care, the assessment and evaluation of individual and systems, providing and interpreting information accurately, and utilizing technology appropriately.

Nurses in practice as well as pre-licensure students must be competent in developing and maintaining the knowledge, skills and attitudes necessary to provide quality and safety throughout the health care system.

**Questions for Learning**
1. How do best practices contribute to safe member care?
2. How does evidence determine best practice?
3. What is the role of the nurse in establishing a culture of safety?
4. How can cultural influences affect safety?
**Scenario 1**
An elderly client is admitted to a rehab facility with a c. difficile infection. The client is weak and requires assistance for activities of daily living. The client has uncontrolled diarrhea requiring frequent skin care to maintain cleanliness and comfort and prevent skin breakdown. Following one episode of cleaning the patient and changing the bed linen, the nurse immediately went to a second patient to provide care without performing hand washing.

**Discuss the following:**
1. Using the Chain of Infection, where did the nurse deviate from the standard of care?
2. In this situation, should hand-washing or hand hygiene be performed? Support your answer using evidence.
3. List several nursing interventions that are appropriate for the nurse to include on the client’s care plan if the goal is to maintain skin integrity

**Scenario 2**
Mrs. Jackson was active in her community, volunteered at the local library, and enjoyed sharing blooms from her showcase flower garden. She was proactive in maintaining her health through regular activity, such as walking and water aerobics, and by healthy eating. She had not been a hospitalized patient since an abdominal hysterectomy 20 years previously.

Mrs. Jackson did have a well-documented, Grade 6, systolic heart murmur stemming from a childhood illness. She had been asymptomatic her entire life until recently when she experienced two episodes of ‘passing out’ with only minimal exertion. She was admitted to Hospital Hope for diagnosis and treatment and soon scheduled for an aortic valve replacement. The surgery was uneventful and Mrs. Jackson was admitted to the Surgical Intensive Care Unit (SICU) for recovery and post-operative care.

During her eight-day SICU stay, Mrs. Jackson, who had a 10 year history of type 2 diabetes, developed hospital-acquired pneumonia, experienced three episodes of hypoglycemia (including one blood glucose level of 39 mg/dL), and developed a CLABSI requiring removal and re-insertion of her central line. Her recovery was slow and her two daughters, one a nurse educator and the other a lawyer, were at her bedside as often as SICU visiting hours allowed. They were eager to help in their mother’s recovery by assisting her with bathing, feeding, and ambulation. However, the doctors and nurses appeared to be reluctant to involve them in their mother’s daily plan of care. After eight days in the SICU and 5 days in the step-down unit, Mrs. Jackson was discharged to an extended care facility for continued recovery and rehabilitation and eventually returned to her home.

Mrs. Jackson survived hospitalization without permanent injury despite experiencing three preventable conditions during her hospital stay, namely pneumonia, a central line infection, and episodes of hypoglycemia, all of which could have been prevented if established, evidence-based care had been practiced. Her story did not make headlines; her case did not get anyone’s attention. Yet she was harmed in not one, but three instances. The costs associated with her care, in terms of dollars, psychological stress to Mrs. Jackson and her family, and the discomfort and inconvenience of her preventable morbidity, were unnecessarily high.

**Discuss the following:**
1. A culture of safety has the following components: leadership, evidence-based practice, teamwork, communication, and a learning, just, and patient-centered culture. How could each of these components contribute to the patient experience of Mrs. Jackson?
2. Nurses are leaders whether in the boardroom or at the bedside—they lead from wherever they stand. How in your leadership level could you have worked to ensure a better culture of safety for
QUALITY AND SAFETY (Continued)

Quality
The Nurse of the Future will use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems (QSEN, 2010).

What is Quality?
The primary goal of quality is the continuous improvement of the delivery, quality, efficiency, and outcomes of patient care. This is accomplished through a systematic collection and review of data from ongoing monitoring and the use of data for decision-making, evaluation and improvement activities and patient outcomes. The process for quality improvement aims to drive quality care through education, evidence based practice and innovation, leadership and advocacy. Excellence is fostered at every level of practice by defining, measuring and educating about quality improvement and nursing sensitive outcomes across the continuum of care.

Nursing is a unique, identifiable, and autonomous profession with the right, duty, responsibility, and expertise to determine the scope and standards of nursing practice. Therefore, providing high quality care to patients is a priority for professional nursing. Quality care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Institute of Medicine: Strategy for Quality Assurance).

Quality improvement is designed to enhance patient care through the implementation of action plans to improve the quality, safety and appropriateness of care rendered by the nursing staff. Action plans are developed considering the impact of the issue, best practice and are evidence based.

Questions for Learning
1. How do we enculturate the commitment to quality throughout, in all roles and at all levels?
2. How do I use benchmarked data as the driver for quality improvement?
3. Identify nurse sensitive indicators.
4. Do nurse sensitive indicator data outperform the mean, median or other benchmark statistic of the database used?
5. How best to disseminate comprehensive quality data and analysis of data to direct care nurses?

Scenario 1
You are staff for an ambulatory care center that provides outpatient diagnostic and minor emergency services. The center is staffed with nurses, allied health personnel, secretarial staff, and physicians. A diverse range of services is provided, requiring interdependence among all members of the care team. The center is open from 9 a.m. to 11 p.m. daily. As the nurse in this center, you are aware that patients have complained about the amount of time they must wait for results of diagnostic tests. Based on your knowledge about the services provided, you realize that this complaint does not have a simple answer. To provide continuous improvement in your care delivery, you decide to create a team of nurses and your manager to evaluate this problem. The first step is to create a fishbone diagram with your team using your imagination and existing knowledge of causes for typical delays in diagnostic services. This diagram is As you identify possible causes of delays, you will create the "fishbone" diagram by asking why? Repeatedly, at each level of the problem. Continue to ask why? Until the class agrees that they are at the root of the problem(s).

Discuss the following:
1. As you diagrammed how many different sources of the problem did you identify?
2. Where would you go from here in evaluating and improving this problem?
3. Explain assumptions and implications behind creating a fishbone diagram to evaluate a problem
SIMULATION SCENARIO

Strategy objectives
1. Participants will understand concepts of Lean Process Management including “waste”, non-value added work, elimination of non-value added tasks in a work process, role of “the system” in quality, and importance of team based care.
2. Participants will understand steps in a PDSA cycle.
3. Participants will understand that with small changes in system, both quality and efficiency can be improved applying insights gained from this interactive exercise, back to their clinical settings to begin or enhance improvement efforts.

Number of Participants Needed
4 – 8 per team

A bus filled with 16 Potato Head family members is in a terrible crash! At the scene of the accident, Emergency Medical Services arrives to find only scattered body parts. Luckily, one of the family members was carrying a photo album with a photo of each family member. There are men, women, children, and pets on the bus. A health care team is waiting in the emergency room to correctly assemble as many family members as possible in 7 minutes. On the health care team, two of the members are designated “Implantation Specialists” (a.k.a. trauma surgeons). Only they can “implant” the parts into the potato bodies. The number of correctly assembled Potato Heads and the number of errors are tracked through each PDSA cycle.

Materials:
- http://qsen.org/wp-content/uploads/formidable/MrPotatoHeadLeanExerciseSlides.pptx
- http://qsen.org/wp-content/uploads/formidable/MrPotatoHeadSimulationInstructions.docx

Discussion debrief
1. The system is a critical determinant of performance; usually more significant than the skills or efforts of the people.
2. Good communication is essential for a high-functioning team.
3. Good ideas for improvement can come from anyone on the team.
4. Data is essential to drive improvement efforts.
5. Repeating PDSA cycles is a valuable process in Quality Improvement.
6. Efficiency is enhanced when waste is reduced.
7. All steps should add value. Strive to eliminate all steps that do not add value.
8. Simple changes in the system, can improve both quality and efficiency!

Scenario 2
A patient comes in for a carpal tunnel repair surgery. After the completion of the procedure, the patient asks “nurse, why do I have a dressing on my right arm, my surgery was supposed to be on my left arm?” The nurse immediately goes back to the computer and realizes that the surgery was for left carpal tunnel repair.

1. What should be the next steps to take regarding what just occurred with this patient?
2. Map out all steps the nurse is to take preoperatively in preparation for a patient’s procedure to prevent this type of outcome.
3. What potential adverse outcomes could occur as a result of this wrong site procedure?
4. How can this omission impact the patient’s quality of life?
**References**


**RESEARCH/EVIDENCE-BASED PRACTICE**

The Nurse of the Future will identify, evaluate, and use the best current evidence coupled with clinical expertise and consideration of patients preferences, experience and values to make practice decisions (NOF, 2010).

**What is Evidence Based Practice in Nursing?**

Today's nursing force must be educated and equipped to challenge the "status quo" and they must learn to investigate the many traditions embedded within the culture of nursing as well as evaluate their usefulness and validity in practice (Dimitroff, 2011). It is interwoven and connected to outcomes and includes the identification of clinical problems that relate to patients and or nursing. Through the modes of knowledge, ability (behaviors), and skills (KAS), nurses in practice develop and gain expertise in its use.

**Questions for Learning**

1. How does evidence based practice influence and improve nursing care?
2. What are barriers and probable limitations for implementing research and evidence based practice and how would one overcome them? What type of infrastructure is necessary to support Research/EBP within organizations?
3. How does research and evidence based practice facilitate decision making in nursing about patients?
4. What steps are used to evaluate the evidence within clinical practice guidelines and how are these taught in academic settings?
5. How can a culture be created to promote the use of Research/EBP and how does it enhance the critical thinking at the bedside?

**Scenario 1**

Health professionals noticed that ventilator dependent adults often developed pneumonia. They started questioning what might be going on. They reviewed the literature and found that there was little "evidence" to support this phenomenon, but there was some. Over the past few years, more and more institutions examined ventilator-associated pneumonia (VAP). Based on these reviews, guidelines or best practices were developed to decrease the incidence of VAP in adults. Now, research and EBP studies examine VAP as a measure of quality of care; consider costs associated with VAP versus preventative costs; and use VAP as a benchmarking tool for quality care and patient safety.
Scenario 2
A group of nurses were asked to attend an informational meeting by a vendor on a new product that could assist in the reduction of central line infections. The vendor discusses the value of the product and presents company articles of success stories. Explain the process that the nursing group must do before initiating a practice change. Based on the information presented provide an example of a question or problem statement for clinical inquiry (i.e. PICOT).

Scenario 3
A nurse/nurse student brings forward the question on whether it is better to cleanse a pressure ulcer with saline or half strength peroxide and water. A guide would assist the nurse in following the steps of the evidence based practice process. Write out a pathway of the steps with an explanation of each step.

References

RESOURCE UTILIZATION
The nurse of the Future will demonstrate an awareness of factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing and other services (ANA, 2013)

What is Resource Utilization?
The goal of systems-based practice is to improve the safety and quality of patient care. A systems-based practice has been described as a “village.” Each health care provider must work within a community to deliver quality patient care (Ziegelstein & Fiebach, 2004). Nurses play a critical role in the microsystems and macrosystems of health care delivery and the nurse of the future will recognize the importance of individual and group actions on quality and safe patient care. Nurses will need to understand and initiate cost containment, resource allocation, patient advocacy, and interdisciplinary collaboration to ensure the delivery of quality patient care. Successful implementation of resource utilization would include interdisciplinary patient rounds; mechanisms for respectful interdisciplinary approaches to patient care issues and team building activities (McCauley & Irwin, 2006). .

Microsystems are constantly evolving in the healthcare environment responding to the needs of the patients, clinicians, technology, cost containment, system inefficiencies, and regulations. A micro-system in health care delivery can be defined as a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, shared information environment and produces performance outcomes. They evolve over time and are (often) embedded in larger organizations. Each microsystem is unique within the larger (macro) organization. Nurses must possess the necessary knowledge; attitudes and skills to provide care in a variety of patient care settings and become part of the “village.”

The key to appropriate resource use is to accurately evaluate factors related to safety, effectiveness availability, and expense as one considers the various options available to create a particular health outcome for a patient. It is therefore important to have an extensive working knowledge of supplies, technologies, techniques, medicines, available staff to perform a procedure and the costs associated with each one. With this knowledge available you can then match the best techniques with the best use of medical supplies and personnel with the lowest overall cost. This then allows money to be saved for the patient and the hospital that in turn frees up those resources to be used elsewhere in the organization to achieve the best results possible for the organization, medical staff and the patients.
Questions for Learning

1. What is the difference between microsystem and macrosystem in healthcare
2. How can nurses be apprised of the cost of staff, supplies, and medicines?
3. How can delegation to other staff in your “village” provide proper resource utilization?

Scenario(s)/Case Studies

Read two articles below learn how two teams worked together to reduce infection


Scenario 1

The nurses on the Oncology unit notice that while administering infusions to their patients, they often times have to repeatedly adjust the volume infusion pump (Alaris) to administer the infusions, which can prolong the amount of time that the patient is receiving their infusion. The nurses are also made aware that they have decreased scores for their compliance of guardrails usage during infusions.

1. How does “overriding” the guardrails impact the safety and efficiency of providing patient care?
2. Why are the guardrails for the Alaris pump considered a safety measure?
3. If you administer infusions and notice repeatedly that the medications you are administering are not in the clinical library, what would your next steps be?

References


PROJECT NAME: Using a Strategic Model for Professional Development: The Importance of Evidence-Based Competencies as a Foundation for Professional Practice.

Peggi Winter RN, MA, DNfC, NE-BC, CENP

### APPENDIX - P

**Gantt Chart**

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<td>2 Planning and prep of second off site meeting</td>
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<td><strong>B</strong> Competency Discussions and Approvals</td>
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<td>1 Five competency frameworks discussed with Nurse Executive Leadership Group for input and approval</td>
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<td>1.2 Framework Designed</td>
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<td>1.3 Sent out to members of the Prof Dev Group for vote</td>
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<td>1.4 Model formatted with input from Prof Dev Group</td>
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<td><strong>C</strong> Competency Model</td>
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<td><strong>D</strong> Competency Toolkit</td>
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<td>1 Survey Monkey questionnaires sent for input into design of toolkit</td>
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<td>1.2 Designed and developed by Prof Dev department</td>
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<td>1.3 Survey Monkey(s) evaluation attached to each component of the toolkit</td>
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<tr>
<td>1.4 Data from evaluations collated and changes made</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E</strong> Building the components of the toolkit into the curriculum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Exploring with the ambulatory area of the NW Region possibility of building parts of the toolkit into a curriculum for hard to retain positions Scheduled to begin in 2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- **Completed**
- **Projected**
APPENDIX - Q
Business Case for NW Pilot

Sample Business Case for a Competency-Based Framework for Selection and Orientation

Developed as a Template for
Professional Development Leaders

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SAMPLE EXECUTIVE SUMMARY
The word competent is understood to mean a professional is qualified, capable, and able to understand and perform in an appropriate and effective manner. Simply having the knowledge and the skill to do a job is insufficient, rather it is implied that a competency has an action-attached to it that verifies what is achieved by that action. The attainment of competent also requires judgment, decision-making, and critical thinking (Rodolfa et al., 2005). What a person brings to the job, does in the job and the outcomes the person in the job achieves are all elements of competency (Reilly, Barclay, & Culbertson, 1977). Meier (1993) defined competency as the capacity to integrate effectively the knowledge base, skills, personal, professional values and ethics, attitudes, and profession-specific factors into professional practice, defined by populations served, problems addressed, procedures used and service settings. Domains of competencies are areas of professional activities in which competencies are developed and clusters of knowledge, skills, and activities are used in professional practice (McIvried & Bent, 2003). This paper is an attempt to explain the journey to develop standardized competencies for the incumbent and future nurses and as guideposts for justification of the implementation of components of the existing toolkit for the selection and retention of nurses.

SAMPLE INTRODUCTION
According to the Nursing Strategy White Paper: At the heart of the Nursing Professional Practice Model is the patient and family. The nurse-patient/family relationship is the cornerstone of nursing practice and leverages the powerful role human relationships play in creating caring and healing environments. It honors the unity of the whole human being – mind, body, spirit – and is the lens through which Kaiser Permanente nurses look to ensure that they meet the needs of the patient and families. Six nursing values are embedded in our discipline/practice and help to demonstrate what it means to be a Kaiser Permanente nurse. The values that underpin our work are: Professionalism, Patient and Family Centric, Compassion, Teamwork, Excellence, and Integrity. Four key areas organize the work of nursing: Quality and Safety, Leadership, Professional Development, and Research/Evidence-Based Practice. This infrastructure establishes practices, processes, and systems through which our vision is achieved. It lays the foundation that makes transformational practice possible and aligns nursing the organizations mission (Leavell, 2013)

We acknowledge the educational and experiential journey every nurse takes to gain the knowledge, skills, and judgment required to practice as a professional nurse is actualized through professional development. Competencies help guide our work by establishing behaviors that are consistent with the practice standards and guidelines. They establish the philosophy of lifelong learning, which leads them to seek opportunities to learn about current trends and practice changes. Nursing at Kaiser Permanente is dedicated to providing and promoting a learning organization necessary in our complex and rapidly changing health care system.

In August of 2014, the organization convened a group of experts to explore a four level development framework using the four components to begin to design a 5-year strategy. The pillar of Professional Development used the Association Nursing Professional Development (ANPD) Scope and Standards model and placed it in a framework called High Performing Programming (HPP), which helps evaluate vision and create environments that move the process to the next developmental level. By understanding and acknowledging these different levels it helps recognize where an organization is in the process and informs the creation of action steps to advance to the next level. The framework addresses the culture of an organization and how as leaders we can affect our frame of reference towards change. How organizations adapt to change as the internal and external environment of healthcare continues to affect the other component of the strategy model. Even though we know change is inevitable to meet the needs of our patients and the health care system, organizations can either embrace and influence the change or aimlessly allow it to evolve. The High Performance Programing (HPP) model illustrates four developmental levels: reactive, responsive, proactive, and high performing (Nelson & Burns, 2005). The model is a nesting model, meaning that each level builds on the previous, except for the reactive stage, which is disintegrative in nature and unable to provide enough structure to support culture change. Kaiser Permanente chose to integrate an additional level to the model, called progressive. This level is between proactive and high performing and was designed to call out a process or incident, or “tipping point” that might propel the component toward the high performing level. This exercise, allowed us to identify our current level, prioritize each component, and design an operational strategy to move professional development towards a high performing level while supporting professional practice.

The process was completed at a two day session where all seven regions sent representatives for each of the four pillars. This project is specifically about Professional Development and two of the seven ANPD core components identified as priorities of the group: competencies and academic partnership. Competencies are defined as processes that are used to demonstrate the
knowledge, skills, and attitudes to perform a job and daily activities necessary for the benefit of the population being served (“NPD Scope and Standards,” 2010). Academic partnerships are agreements between colleges/schools of nursing and healthcare systems to support an environment of development and continuous learning (“NPD Scope and Standards,” 2010).

Building on our Professional Practice model, its values, and its components we began looking at extant competency models and defining those that will support the nurse in practice. Five evidence based competency models were chosen to begin exploration of a framework to begin dialogue with members of the executive nurses. They were the Quality and Safety Education for Nurses (QSEN), Nurse of the Future (NOF), Institute of Medicine (IOM), Accreditation Model for Graduate Education (ACGME), and the American Nurses Association Standards of Professional Practice (ANA) (Appendix A).

An important outcome of the 2-day meeting was the conception of a competency framework that was presented and adopted by the nursing regional leader. Within the framework were both professional and foundational competency domains. The decision of the group was to designate professional competencies as those specific to the nurse and the role. Foundational competencies are those which are essential to the practice of nursing and their basic level are necessary for seeking admission to practice as a professional nurse (Appendix B).

**SAMPLE OF THE COMPETENCY DOMAIN FRAMEWORK**

The Competency Domain framework is a graphic representation of the professional and foundational domains and their relationship to patient focused care. In the framework, patient centered care has been in the center to represent how the member reflects the art and science of the profession of nursing and is in the center of all we do. The five foundational competencies, ethics, leadership, communication, technology enabled care and professionalism, are at the base of the framework and supports, influences and is a part of each professional competency. We expect every nurse to come with some elements of each one of these foundational competencies. The Professional competencies, resource utilization, collaborative care, quality and safety, informatics and research and evidence based practice are those which are specific to the nursing role. The order of either of these competencies does not indicate any hierarchy, as all the competencies are of equal importance (Appendix C).

**SAMPLE OF ASSUMPTIONS**

In developing the competencies, the committee identified a set of assumptions for the design of competency-led education in practice. The assumptions include the following:

- Advancing the education of all nurses is increasingly recognized as essential to the future of nursing practice.

- The Nurse will be proficient in these competency domains. There is differentiation in competencies among practicing nurses at various levels and competence is developed over a continuum and can be measured.

- The competency domains are designed to be applicable across all care settings and to encompass all patient populations across the lifespan.

- There are two distinct competency domains: Foundational and Professional. Foundational competency domains are the building blocks for what nurses do or

- Nurse educators in the practice setting will need to use a different set of knowledge and teaching strategies to effectively integrate the competency domains into curriculum.

- The knowledge skills and abilities of the foundational domains have implications for the professional domains. As the profession advances in both the art and science of nursing, these changes will be reflected in the foundational competency domains and then integrated into the professional competency domains resulting in the development of new competencies.

- The foundational and professional competency domains for the different levels of educational degrees, associate, baccalaureate, masters and doctorate
exemplify. They are primarily taught through professional development, either through academic education or as a part of life-long learning. Professional competency domains are the knowledge skills and abilities necessary for successful practice in nursing at Kaiser Permanente. They are the core of orientation, job descriptions, and clinical skills.

should be integrated within the curriculum of our academic partners to facilitate individuals in moving more effectively through the educational system into the practice environment.

**SAMPLE OF RECOMMENDED NEXT STEPS FOR IMPLEMENTING COMPONENTS OF THE TOOLKIT IN SELECTION, ORIENTATION AND ROI**

As a result of this competency adoption the National Nursing Professional Development Committee will be working to align and embed both the foundational and professional competencies into the current practice environment.

One of the methods for evaluating the usefulness of the toolkit is the construction of a pilot to demonstrate a return on investment through the retention of a hard to recruit and retain position. Through the use of the competency toolkit we will be looking at ways to align with the foundational competencies that each individual nurse would need to possess at a level consistent with the roles for which they were applying. While at the same time we would provide a change in hiring practices, capturing information about the knowledge level of both the foundational and professional competencies and then building a development plan for each nurse. This information would be used to objectively evaluate whether the applicant possessed these competencies, and at what level. This change in the screening process and orientation curriculum would facilitate a successful fit, and positively affect the turnover rate in nursing by evaluating the individual’s foundational competency domains of leadership, ethics, communication, and technology enabled care and professionalism.

In order to build the culture of professionalism within our nurses, nursing leaders feel it is important to have a stable management workforce who believe in the nursing strategy, its mission, and its values and possess a high level of the foundational competency domains. One of those positions is the RN assistant administrator in the ambulatory environment. This position provides a crucial role in the day-to-day activity on a unit and in the outpatient setting thus having a great impact on both nursing staff and patient care. Currently, there is a need to attract, recruit, and maintain this position, which is challenging due to such variables as responsibilities, salaries, labor challenges, and increased workload. Retention for this position is less than 16-18 months and the average days to recruit is 90-120. Given the sheer numbers of nurses that are projected to be needed in the future, discussions of the costs of turnover and benefits of retention of assistant nurse managers are of utmost important to maintain the consistent culture we hope to build.

Throughout 2017 and 2018 of initiating this process with this group of nurses, there will be an evaluation of the toolkit with the support of the regional directors of education and other stakeholders. Because of the high turnover of these positions, they will be the pilots for the toolkit. While this is not a panacea for the complex recruitment and retention challenges of this position, it has been used as a tested methodology for improving hiring results. Hiring nurses whose belief and behavior systems appear congruent with our organizational culture and feel more competent are more satisfied and have a better chance of working well in the existing environment. Nurses who fail to fit into in the existing workplace environment generally leave to find a work environment or culture which is more congruent with their own values and beliefs (Hanna, 2008).

Armed with the information in this project, we will be able to present the case for change, articulate the vision, and draw the relationships and conclusions for use of these competency components in the organization. Justification would be based on the retention and nurse satisfaction. Performance would be measured on standard indicators over the pilot of a two year period, measured at the beginning of orientation and analyzed in comparison to performance of baseline over the course of the probationary 90 days.. The evidence demonstrates that the pilots for the RN assistant administrators could be self-funded through cost avoidance; savings due to recruitment and turnover costs.

**SAMPLE OPTIONS**
Option #1
Take no action to change the hiring process by using these tools. Continue to improve retention and recruitment through conventional actions such as salary and role definition changes. Regions and individual facilities would address issues independently.

Option #2
Full rollout of web based behavioral interviewing with all applicants for nursing positions across the continuum.

Option #3 (Recommended option)
Roll this pilot out for a high turnover position to evaluate the benefits of behavioral interviewing for the broader nursing organization.

Options analysis
In option #1, we do not initiate the components of the toolkit as a first step in solving to the recruitment and retention problem. In this approach, we would not be leveraging the opportunity to learn collectively, or take advantage of the benefit of scale in designing a solution.

Option #2 would be the most extensive, comprehensive and challenging, due to the size of the organization. The marketing, education, and training that would have to take place would be extensive for implementation at this scale. It would be difficult to evaluate the potential success of using this tool and whether it has made a difference in the turnover/retention in all roles of nursing.

Option #3 would be the least costly and most scalable approach due to the fact there are only a small number of these positions in the NW region. The retention and turnover numbers would be easier to monitor and the training of the nurse manager and recruiter would be easier to rollout. Also the data would be more reliable because we would be able to put more controls in place to manage the program and prepare for better decision-making going forward.

SAMPLE MARKET ANALYSIS
Over the past three years the role of assistant nurse manager has been difficult to fill for a variety of reasons. Ninety to one hundred twenty days are necessary to fill the position and retention averages two years or less. This position remains the most difficult to fill and has been the subject of much concern due to its high degree of frontline involvement and relationship to patient satisfaction. This tool has the potential to increase selecting the right person for the position (Appendix D).

SAMPLE OF BUDGETARY RETURN ON INVESTMENT FOR THE NW PROJECT
The cost of embedding this tool into the recruitment and orientation of this group of nurses is nominal compared to the returns using the screening process and components of the toolkit. The start up cost of this pilot in 2015 is $8,750 with a decrease of $6,400 in 2016 and an annual maintenance cost of $2,700 beginning in 2017. In July of 2017, eighteen months after the start of the program, historically, we should have lost 4 of the 10 RN administrators, or 40%. In July of 2017 if we have retained one position we will realize a return on investment for the organization of $14,650.) Nurse turnover costs have been estimated at 1.3 times the salary of a departing nurse (Jones, 2005). There are many factors that contribute to the retention and turnover of an employee, so we are using a conservative 20% of the salary of this position for the return on investment. Given the low cost of implementation and its minimal risk, this project appears to result in a positive return. A sample business case for the approval and implementation of a pilot program for the designated region is included (Appendix D).
SAMPLE OF CONCLUSION
Achieving a consistent, superior care experience requires a competent, educated nursing professional. This is about creating a culture of extraordinary nursing practice— one that is driven by an inspirational vision, animated by powerful core values, and guided by a shared professional practice model.

Nurses advance the art and science of nursing in a patient-centered healing environment through our professional practice and leadership.

Extraordinary nursing care.
Every patient.
Every time.

REFERENCES


http://dx.doi.org/10.1037/0735-7028.36.4.347
Sample Business Case for a Competency-Based Framework for Selection and Orientation Appendices:

**Appendix A**

**Competency Models**

<table>
<thead>
<tr>
<th>NOF</th>
<th>IOM</th>
<th>ACGME</th>
<th>QSEN</th>
<th>ANA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement</td>
<td>Apply Quality Improvement</td>
<td>Practice-Based Learning and Improvement</td>
<td>Quality Improvement</td>
<td>Ethics</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>Provide Patient-Centered Care</td>
<td>Systems-Based Practice</td>
<td>Patient-Centered Care</td>
<td>Education</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Work in interdisciplinary teams</td>
<td>Patient care, interpersonal and communication skills</td>
<td>Safety</td>
<td>Evidenced-Based practice and Research</td>
</tr>
<tr>
<td>Systems-based practice</td>
<td>Employ evidence-base practice</td>
<td>Professionalism</td>
<td>Teamwork and collaboration</td>
<td>Collaboration</td>
</tr>
<tr>
<td>Safety</td>
<td>Use Informatics</td>
<td>Medical knowledge</td>
<td>Evidence-based practice</td>
<td>Quality of Practice</td>
</tr>
<tr>
<td>Teamwork and collaboration</td>
<td></td>
<td></td>
<td>Informatics</td>
<td>Communication</td>
</tr>
<tr>
<td>Leadership</td>
<td></td>
<td></td>
<td></td>
<td>Leadership</td>
</tr>
<tr>
<td>Informatics and Technology</td>
<td></td>
<td></td>
<td></td>
<td>Professional Practice Evaluation</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td>Resource Utilization</td>
</tr>
<tr>
<td>Research and Evidence Based Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B
### Competency Definitions

<table>
<thead>
<tr>
<th>PROFESSIONAL COMPETENCIES</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Utilization</td>
<td>The KP nurse will demonstrate an awareness of factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing and other services (ANA, 2013)</td>
</tr>
<tr>
<td>Collaborative Care</td>
<td>The KP nurse will function effectively within nursing and interdisciplinary teams, foster open communication, mutual respect, shared decision making, team learning, and development (Adapted from NOF, 2010)</td>
</tr>
<tr>
<td>Quality &amp; Safety</td>
<td>The KP nurse uses data to monitor the outcomes of care processes, and uses improvement methods to design and test change to continuously improve the quality and safety of healthcare systems (QSEN, 2010). The nurse will also minimize the risk of harm to patients and providers through both system effectiveness and individual performance (QSEN, 2010)</td>
</tr>
<tr>
<td>Research/EBP</td>
<td>The KP nurse will identify, evaluate, and use the best current evidence coupled with clinical expertise and consideration of patients’ preferences, experience and values to make practice decisions (Adapted from NOF 2010)</td>
</tr>
<tr>
<td>Informatics</td>
<td>The KP nurse will use information and technology to communicate, manage knowledge, mitigate error, and support decision making (QSEN, 2007)</td>
</tr>
<tr>
<td>FOUNDATIONAL COMPETENCIES</td>
<td>DEFINITION</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ethics</td>
<td>The KP nurse practices with integrity that includes elements of honesty, responsibility, credibility, and the ability to use ethical considerations to guide decisions and actions. (Adapted from ANA, 2013)</td>
</tr>
<tr>
<td>Leadership</td>
<td>The KP nurse will influence the behavior of individuals or groups of individuals within their environment in a way that will facilitate the establishment and acquisition/achievement of shared goals. (Adapted from NOF, 20)</td>
</tr>
<tr>
<td>Technology-Enabled Care</td>
<td>The KP nurse will use emerging technology to change the practice of nursing by using technology to facilitate mobility, communication, and relationships (ANA, 2013)</td>
</tr>
<tr>
<td>Communication</td>
<td>The KP nurse will interact effectively with patients, families, and colleagues, fostering mutual respect and shared decision making, to enhance patient satisfaction and health outcomes. (Adapted from NOF, 2010)</td>
</tr>
<tr>
<td>Professionalism</td>
<td>The KP nurse will demonstrate accountability for the delivery of standard-based care that is consistent with moral, altruistic, legal, ethical, regulatory, and humanistic principles. (Adapted from NOF, 2010)</td>
</tr>
</tbody>
</table>
Sample Business Case for a Competency-Based Framework for Selection and Orientation Appendices:

Appendix B

**Kaiser Permanente Nursing Competency Domains**

**Professional Competencies**

- Resource Utilization
- Collaborative Care
- Quality & Safety
- Research & EP
- Informatics

**Patient- / Family-Centered Care**

The RN nurse will demonstrate an awareness of actions related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing and other services (ANA, 2013).

The RN uses data to monitor the outcomes of care processes, and use improvement methods to design and test change to continuously improve the quality and safety of healthcare systems (QSEN, 2013). The nurse will also estimate the risk of harm to patients and providers through both system effectiveness and individual performance (QSEN, 2013).

The RN nurse will identify, evaluate, and use the best current evidence coupled with clinical expertise and consideration of patient preferences, experiences and values to make practice decisions (Adapted from NQF, 2019).

The RN nurse will use information and technology to communicate, manage knowledge, mitigate errors, and support decision making (QSEN, 2007).

**Foundational Competencies**

- Ethics
- Leadership
- Technology-Enabled Care
- Communication
- Professionalism

2015 Kaiser Permanente Patient Care Services
## SWOT Analysis

### Strengths
- Objective way to assess an applicant.
- Past performance is a good indicator of future performance.
- Consistent way of screening a candidate.
- Same competencies throughout system.

### Weakness
- Questions may not be reflective of the competency.
- Cost of updating and evaluating questions.

### Opportunities
- May be able to spread to other nursing roles.
- May become a standard for the organization.
- Increase staff and patient satisfaction.
- Stability for management of a unit.
- Might attract more professional staff.

### Threats
- Applicant might not understand the questions.
- Lacks of nurse manager buy in.
- CNO finds the system time consuming.
### Appendix E

#### Project Costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Key Assumption</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum Design for NW Pilot</td>
<td>Dir. of Prof Dev. meets with professional development consultants from Aug to December every two weeks for 1 hour Every other week meeting with NW team 3x$75x24hrs. Meeting with planning team for curriculum adjustment and updates. 3x$75x12hrs</td>
<td>6,750</td>
<td>5,400</td>
<td>$2,700</td>
</tr>
<tr>
<td>Material</td>
<td>Written material and guidebook for hard copy and online access.</td>
<td>$2,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Proposed Total Cost for Pilot</td>
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<td>$8,750</td>
<td>$6,400</td>
<td>$2,700</td>
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### Budgetary Return on Investment Plan

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Projected Costs</td>
<td>$8,750</td>
<td>$6,400</td>
<td>$2,700</td>
</tr>
<tr>
<td>Cumulative Total Costs</td>
<td>($8,750)</td>
<td>($15,150)</td>
<td>($17,850)</td>
</tr>
<tr>
<td>Annual Benefit</td>
<td>0</td>
<td>0</td>
<td>$32,500</td>
</tr>
<tr>
<td>ROI</td>
<td>($8,750)</td>
<td>($15,150)</td>
<td>$14,650</td>
</tr>
</tbody>
</table>

**Assumption:**
One RN administrator position salary: $125,000x1.3x salary = $162,500 /20% = $32,500
### APPENDIX - R

Competency Tool Evaluation

<table>
<thead>
<tr>
<th>COMPETENCY DOCUMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FULL NAME (Optional)</td>
</tr>
<tr>
<td>REGION (Circle one)</td>
</tr>
</tbody>
</table>

Thank you for your time in reviewing this component of the Competency Toolkit.

Place an (X) in the box with your response for each question and add brief comments for that row. Also please complete the Summary of Comments section at the end of the evaluation. This information will be used to evaluate the program and inclusion of your recommendations.

<table>
<thead>
<tr>
<th>PROGRAM CONTENT</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Excellent</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate how the content is suited to meet the educational requirements and standards for educator use</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rate how this contributes to your knowledge regarding the competency domains</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate the amount of sufficient details within the covered topic</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rate the documents contribution to a clearer understanding of how to use the competency domains</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate clarity of the document</td>
<td></td>
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</tr>
<tr>
<td>Rate usefulness of documents</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Overall rating of the document</td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**SUMMARY COMMENTS**

What, if anything, would you change/add/delete?

What new practice (s) will you implement as a result of this program?
**APPENDIX – S**

**SWOT Analysis**

### Strengths
- Creates a template adaptable to individual needs.
- Standardized for use in all regions.
- Provides a foundation for job description presently and for the future.
- Strong leadership support
- Competencies have demonstrated improvements and positive impact on quality and safety.
- No cost for the use of the toolkit
- Competency frameworks have shown to improve recruitment and retention of staff

### Weakness
- Non-specific to all areas of the organization
- Cost to redo already existing orientation
- Education resources are already stretched
- Systems will need to be changed to utilize the components of the toolkit.
- Competencies are evaluated differently and by different methods in various regions
- Some of the regions are more resistant to change
- Requires change to current job descriptions and roles

### Opportunities
- Standardized competencies for the organization will help with Magnet journey
- Provide foundation for discussion with academic partners
- May improve safety and quality for patients/members.
- Project will provide possible external publishing on the concept.
- Discussion points with contracted hospitals

### Threats
- Cost of time spent redoing current processes
- Pilots in NW and SCAL are not successful as planned
- Time frame for improvement too short
- Lack of continuous visible support from executive leadership council and CNO’s
## APPENDIX – T
### Project Costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Key Assumption</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Leader 32 hrs @$120/hr</td>
<td>Salaries of major staff organizer</td>
<td>$3,840</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Project Staff (6) X 80 hrs @$60/hr</td>
<td></td>
<td>$28,800</td>
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</tr>
<tr>
<td>Clerical Support (3) 80 hrs @$40/hr</td>
<td></td>
<td>$9,600</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Facilitator $4,000/day x 4 days</td>
<td></td>
<td>16,000</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hotel $7,500x4</td>
<td>Events (4 day conference offsite)</td>
<td>$30,000</td>
<td>$12,000</td>
<td>$16,000</td>
<td></td>
</tr>
<tr>
<td>Travel 30x$400</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering $100x40x4 days</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Printed Material 2,000X2</td>
<td>Communications</td>
<td>$8,000</td>
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<tr>
<td>Cost for 4 day strategy offsite</td>
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<td>$124,240</td>
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<tr>
<td>Survey Monkey™</td>
<td>Yearly subscription $800</td>
<td>$800</td>
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<tr>
<td>Web Masters Salary</td>
<td>Initial: Creating documents for the competency toolkit</td>
<td>$7,200</td>
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<tr>
<td></td>
<td>Initial: 120 hours X$60/hr.=$7,200</td>
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<tr>
<td></td>
<td>Annual updates for revisions and new components: 40X$60/hr.=$2,400</td>
<td>$2,400</td>
<td>$2,400</td>
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<tr>
<td>Web Designer</td>
<td>Initial: Creation of evaluation through survey Monkey for all components of the toolkit. Analysis of the data 20 hours X$35 = $700</td>
<td></td>
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<tr>
<td></td>
<td>8 hours X $35 annually =</td>
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<td></td>
<td></td>
<td>$700</td>
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<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Web based Meeting for design team</td>
<td>6,750</td>
</tr>
<tr>
<td>Initial: 9 Regional Directors of Professional Development initial meeting</td>
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<tr>
<td>for 10 hours @ $75/hr design, development, and review.</td>
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<tr>
<td>Annual meetings for 9 directors 6x for 1hr @$75/hr. for review and</td>
<td>$4,050</td>
</tr>
<tr>
<td>additions</td>
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<tr>
<td>Marketing and Communications for National Rollout</td>
<td>$900</td>
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<tr>
<td>Communication expert consultation and development of a communication plan</td>
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<tr>
<td>to all regions = 8 hrs.</td>
<td>$400</td>
</tr>
<tr>
<td>Web master provides access, design and content to Nursing Pathways</td>
<td>$400</td>
</tr>
<tr>
<td>website 8 hours</td>
<td></td>
</tr>
<tr>
<td>Cost for initial Toolkit and Updates</td>
<td>$16,350</td>
</tr>
<tr>
<td></td>
<td>$7,931</td>
</tr>
<tr>
<td></td>
<td>$7,930</td>
</tr>
<tr>
<td>Curriculum Design for NW Pilot</td>
<td></td>
</tr>
<tr>
<td>Dir. of Pro Dev. meets with 3 NW professional development consultants</td>
<td>$6,750</td>
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<tr>
<td>from Aug to Dec every two weeks for 1 hour</td>
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<tr>
<td>3x$75/hrx30hr</td>
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<tr>
<td>Every other week meeting- 1 hour</td>
<td>$5,400</td>
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<td>3x$75x24</td>
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<tr>
<td>Meeting for curriculum update</td>
<td>$2,700</td>
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<td>3x$75x12hrs.</td>
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<td>Material</td>
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<td>Written material and guidebook for hard copy and online access.</td>
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<td>Start up and annual</td>
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<td></td>
<td>$1,000</td>
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<tr>
<td>Proposed Cost for Pilot</td>
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<tr>
<td></td>
<td>$6,400</td>
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<tr>
<td></td>
<td>2,700</td>
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<td>Project Director</td>
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<td>Time of project director</td>
<td>$23,000</td>
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<td></td>
<td>$64,000</td>
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<td>$23,000</td>
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<td></td>
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<tr>
<td>Grand Total for off site, initial toolkit and pilot</td>
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<td>$90,882</td>
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<td>$38,824*</td>
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<td>$35,648*</td>
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- Additional 2% annual increase
## Comprehensive Budgetary Return on Investment Plan

### Cost Assumptions:

1. Base year expenses 2015, expense assumptions inflated 2%/year in subsequent years.
2. Project expanded to six regions in 2018, at a cost of $9,275/region.
3. Rollout schedule in each region assumes maintenance level of expenditure beginning in year 3, $2,943/region (2020)

### Benefit Assumptions:

1. Benefit of rollout in now 7 regions realized in 2020 (3rd year of implementation)
2. Additional retention above baseline of 3 RN managers per region.
3. RN Manager salary in 2018 now averages 138,000/year. Average cost to replace position is 1.3 x average salaries for position or $179,400. Assuming 20% of this benefit attributable to the project= $35,800.

### Break even

$538,655 /$35,800 = 15 nurses

### APPENDIX - U

<table>
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<tr>
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<tbody>
<tr>
<td>Annual Projected Cost</td>
<td>$147,240</td>
<td>$90,882</td>
<td>$38,824</td>
<td>$35,648</td>
<td>$92,011</td>
<td>$78,561</td>
<td>$55,489</td>
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<td>Cumulative Total Cost</td>
<td>($147,240)</td>
<td>($238,122)</td>
<td>($276,946)</td>
<td>($312,594)</td>
<td>($404,605)</td>
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<td>Annual Benefit</td>
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<td>ROI</td>
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<td>($238,122)</td>
<td>($276,946)</td>
<td>($312,594)</td>
<td>($348,955)</td>
<td>($386,044)</td>
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**Breakeven**

$538,655 /$35,800 = 15 nurses
APPENDIX - V
Competency Evaluations

Average Ratings, Competency Toolkits (Combined)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Overall rating of the document</th>
<th>Rate clarity of the document</th>
<th>Rate how this contributes to your knowledge</th>
<th>Rate the amount of sufficient details within the...</th>
<th>Rate the documents contribution to a clearer...</th>
<th>Rate the usefulness of this tool for an educator</th>
<th>Rate usefulness of documents</th>
</tr>
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Rate the usefulness of this tool for an educator:

Rate usefulness of documents:

Competency Toolkit Evaluation Survey:
Behavioral Interviewing for Foundational Competencies

Please select your response for each question and add brief comments for that row.
Competency Toolkit Evaluation Survey: Kaiser Permanente Nursing Professional Competencies and Case Studies

Please select your response for each question and add brief comments for that row.

Overall rating of the document
Rate usefulness of documents.
Rate clarity of the document.
Rate the documents contribution to a clearer understanding of how to use the competency...
Rate the amount of sufficient details within the covered topic.
Rate how this contributes to your knowledge regarding the competency domains.
Rate the usefulness of this tool for an educator.

0.00 1.00 2.00 3.00 4.00