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Collaborative voices: Ongoing reflections on nursing competencies

ABSTRACT

In a rapidly changing Australian health care environment, providers of undergraduate nursing programs are continually upgrading their assessment methods to ensure that graduates are competent and safe to practice. Competence assessment is based on the existing Australian Nursing & Midwifery Council (ANMC) Competency Standards for Registered Nurses. It is acknowledged that there are issues surrounding the validity and reliability of current assessment methods, primarily due to organisational constraints both at the University and the service provider level. There are a number of highly reliable tools available that enable assessment of nursing students in the psychomotor domain. Assessment in other domains is less precise. This paper explores some of the issues relating to competence assessment processes in order to promote discussion and discourse between educators, facilities and policy makers. It is envisaged that increased debate will result in an enhanced level of academic and clinical preparation for the upcoming nursing workforce in this country.

KEY WORDS

nursing;
competence;
curriculum;
clinical
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PAM McGRATH

NHMRC Senior Research Fellow
International Program of Psycho-Social Health Research
Central Queensland University – Brisbane office
Kenmore QLD, Australia

JENNIFER ANASTASI

Program Manager/Lecturer –
Competence Assessment Service
School of Nursing & Health Studies
Central Queensland University
Rockhampton QLD, Australia

STEPHANIE FOX-YOUNG

Director, Research and Policy Program
Queensland Nursing Council
Brisbane QLD, Australia

DON GORMAN

Acting Professor
Department of Nursing
University of Southern Queensland
Toowoomba QLD, Australia

LORNA MOXHAM

Head, School of Nursing & Health Studies
Central Queensland University
Rockhampton QLD, Australia

JOANNE TOLLEFSON

Senior Lecturer, School of Nursing
James Cook University
Townsville QLD, Australia

BACKGROUND

This paper focuses on questions arising in response to an invitation for the authors, a group of nurse academics, nurse practitioners, policy makers and researchers, to participate in an international collaboration reviewing nursing competencies in a number of developed countries. The invitation initiated a conceptual discussion about the nature of competencies and the possibility of standardization. Following is a record of the group's journey with this exploration, written as a polemic with the intent of stimulating debate on this ongoing and difficult issue for the nursing profession. The authors seek to inform the debate by situating the discussion in the relevant literature, raise important issues for consideration and take a stand. The authors' hope and expectation is that the discussion will prompt others to communicate their position on this topic, whether it be one of difference or similarity, and in so doing reinvigorate the debate.

Concern about competency-based education is a central and continuing theme throughout the international nursing literature (Benor & Leviyof 1997; Roberts-Davis & Read 2001; Sangpoisit 2000; Smith 2003; Tsuzuki 2004; Wendt 2001) stimulating research across the spectra of nursing settings such as preventive health (Sangpoisit 2000), critical care (Clark, Dunn & Walker 1996) and mental health (Rudge & Gerschwitz 1995). Core nursing competencies are reported as important for adapting to new environments and for performing effective professional care (Frisch et al. 2003; Zhang et al. 2001). Recent research indicates that nurses' satisfaction with their own nursing competencies is a key predictor of overall satisfaction with job performance (Tzeng 2004). The naming of competencies is reported as clarifying the practice knowledge of clinicians and provides a language for articulation and expansion of nursing practice (Zerwekh 1990).

COMPETENCIES IN NURSING EDUCATION

Both the nursing profession and the communities they serve expect nurses to be competent in order to deliver quality care. It is generally recognised that universities manage the development of students' theoretical knowledge, with practice skills developed through work in health care. The two sectors work together to produce the best product possible, but it is clinical education that is seen as vital for developing nursing competencies in students (Malko 1988). There is now seen to be a market demand for competency that drives conceptualisation of educational programs in nursing schools (Tzeng 2003). There is increasing evidence that, in order to respond to the needs of the rapidly changing health care environment, nurse educators are required to continually redefine competencies (Filer 2001). Agreed competencies are used as a measure of the appropriateness of various programmes used in nursing education (Poster & Marcontel 1999; Roberts-Davis & Read 2001). Indeed, in recent years research findings on nursing competencies have contributed to the emerging paradigm of evidence-based decision-making about nursing curriculum reform, both in the classroom and in the clinical practice areas (Utley-Smith 2004).

COMPETENCIES IN AUSTRALIAN NURSING EDUCATION

In Australia, professional competency standards are seen as informing the university nursing curriculum, especially at baccalaureate level (Chapman 1999). These standards provide a national framework and identify the legal and professional relationships that nurses have with other professions.

Competence assessment, based on the Australian Nursing and Midwifery Council¹ (ANMC) Competency Standards, has become a central component of the assessment of nursing students undertaking nursing programs at universities

throughout Australia. According to the ANMC, 'the National Competency Standards for the Registered Nurse establish a national benchmark for registered nurses and reinforces responsibility and accountability in delivering quality nursing care through safe and effective work practice' (<http://www.anmc.org.au/>).

As a result of the strong focus on safe patient outcomes, there is an expectation by registering bodies, based on such assertions as those elucidated above, that universities will incorporate assessment using the ANMC Competency Standards into their curricula. How this is to be undertaken must be demonstrated when curricula are submitted to registering bodies for accreditation, with those that do not incorporate competency assessment unlikely to be accredited. This is consistent with the intent of the licensure, which exists to provide for the public's safety (Pohlman 2001).

WHY USE ANMC COMPETENCY STANDARDS?

Competency standards in Australia establish an entry level for demonstration of fitness for the award of the title of Registered Nurse that is consistent across the states and is recognized by the profession as such. With the award of registration, the regulating authority in each of the states is declaring that the individual has satisfactorily achieved a level of practice that is both adequate and safe. This competency-based approach to nursing registration is not unique to Australia and is also the model currently in use in the United Kingdom, Eire, the United States and many of the European Union jurisdictions. An overview of the issues relating to students' competence to practice and assessment of competence in undergraduate programs in the United Kingdom was commissioned by the Nursing and Midwifery Council (NMC). The study, undertaken by Kathleen Duffy (2004), focused mainly on the role of mentors in assessing the clinical competence of students. In Australia, this process of assessment

against recognised minimum competency standards has underpinned undergraduate nursing programs for the last fifteen years and yet, issues raised by Duffy in the UK appear to remain unresolved in the Australian setting despite many years of implementation in this country.

In nursing, as in other professions, there is a certain amount of pride in the knowledge that there is a benchmark for entry as an RN, with the standard clearly visible both from within and outside the profession, nationally and internationally. The transferability of skills that assist nurses to gain employment is guaranteed by the regulatory grounding in the competency standards and is dependent upon the confidence that employers have in the regulating authorities. Of necessity, the competency standards form the backbone of curricula development and assessment and have also come to be used by the health care industry as selection criteria.

Hospitals and other employing facilities trust that the newly graduated registered nurse is adequately prepared and competent at a beginning level and offer employment on this basis. Nursing and medical colleagues base their interactions with the new graduate on this trust, with new graduates being given a brief time to demonstrate their ability to meet the competency standards to their colleagues. If they are able to do this, they are accepted as a member of the team. If they have difficulty, they may be rejected and spend several months moving from unit to unit trying to demonstrate their ability in a different context.

INCREASING VOICES OF DEBATE

At a simplistic, positivist level it is appealing to accept the notion of basic competency standards for nursing education as an unqualified 'good'. However, on deeper reflection, the concept of standardising competencies across nursing specialities and cultural boundaries presents quite significant epistemological, philosophical and pragmatic dilemmas.

Since competency standards were developed,

the concept of competencies has been reified as a valid construct in a professional discourse that affirms the importance and necessity of standardisation. For the last decade there has been an increasing critique of the notion of competencies. Firstly, while acknowledging the indisputable fact of the competency approach to nursing education, there are increasing voices of debate within the literature that challenge the dominance of the nursing competency rationale in curriculum development (Chapman 1999). The reification of the notion of standardisation is seen to not accommodate the nuances of the myriad of cultural, economic and socio-political contexts of nursing praxis. Secondly, standardisation is also considered problematic because of the lack of systematic approaches for incorporating specific competencies into curriculum evaluation models (Freese 1989). Thirdly, there is a concern, generated in the context of a contemporary nursing environment that values (w)holistic care (Kermode & Brown 1995), to ensure that the needs of patients, rather than market forces, drive nursing competencies to achieve optimal patient outcomes (Villaire 1996).

Finally, recent debate in the literature incorporates a concern about the process of identifying the underlying competencies that contribute to effective nursing performance. To date, competencies are derived from researchers' conceptual analysis based on practitioners' direct report (Zhang et al. 2001) or derived through consensual methods such as the use of the Delphi survey process (Roberts-Davis & Read 2001). The controversy over defining the content and number of competencies required by nurses is diverse, with this paper contributing to this discourse (Fitzpatrick, While & Roberts 1997; Gibson, Fletcher & Cassey 2003; Utley-Smith 2004; Zerwekh 1990; Zhang et al. 2001).

ASSESSING CLINICAL COMPETENCE: ISSUES WITH RELIABILITY AND VALIDITY

A variety of instruments that define and meas-

ure nursing competence for educational and practitioner uses have been developed (Norman et al. 2002). These include King's Nurse Performance Scale (Fitzpatrick et al. 1997), the Slater Nursing Competencies Rating Scale (Wandelt & Stewart 1975) and the Nursing Competencies Questionnaire (Norman et al. 2002). Recent moves affirm and embrace the notion of student and practitioner self-assessment (Birkholz et al. 2004) but as the following discussion indicates, the use of such instrumentation is built on problematic notions of validity and reliability.

A factor that tends to limit the effectiveness of competence assessment is that standardised tools that are seen as reliable are given a high level of credibility. This is understandable, as unreliable tools are virtually useless and reliability is relatively easy to demonstrate. Thus, the emphasis tends to be on assessment tools that are easy to complete and ensure that all assessors will give any individual student the same score.

However, one of the continuing concerns with assessing clinical competence is the tension between valid and reliable assessment strategies. The more valid (closer to the 'real' clinical experience) an assessment becomes, the less reliable (consistent) it is. For example, assessment in the actual clinical setting is most likely to give an indication of how competent a person is in meeting the varied demands of the role. However, inter-rater reliability in such situations is always questionable, and test/retest reliability is almost impossible to achieve given the different variables that will inevitably arise in any practice setting.

A number of strategies have been utilised in an attempt to overcome this tension. These include:

- Objective Structured Clinical Assessment, in which actors follow a set script in a simulated environment to test the competence of a student to respond to particular, standardised stimuli;
- Assessor training in the use of standardised

clinical assessment instruments (as identified above) to increase inter-rater reliability;

- Using video technology to enable moderation of clinical assessments either in the simulated or, less frequently because of ethical issues, in the real setting; and
- Development of interactive, computer-based assessments that limit and standardise the variables that impact on the assessment.

However, the more that an assessment is 'standardised' the less valid it becomes in its capacity to reflect the actual complexity of clinical settings. Similarly, the more real the situation is, the less likely it is that the same rating will be given by different assessors, or that the assessment environment can be reproduced for subsequent review. Reliability does not ensure validity. The fact that all assessors give the same score does not mean that the tool is measuring what it purports to measure. As mentioned earlier, there are some concerns about the validity of competence measurement tools in nursing and validity is usually much more difficult to demonstrate than reliability.

QUANTIFYING QUALITY: 'MEASURING' THE NON-TECHNICAL

At first glance, the incorporation of competency-based assessment into nursing curricula would seem to be an appropriate means of ensuring that the graduates of these programs would have demonstrated their readiness to become competent nurse clinicians. As already discussed, this assumption is questionable as even if the assessment tools are valid and reliable, something that has not been demonstrated, there remains concerns about the use of competency-based assessment.

Nursing, because of its close links to medicine, has been subject to a scientific positivist paradigm predicated on notions of measurable, empirical realism that asserts that only what is observed actually exists (McGrath 1999). This

means that nursing competency needs to be demonstrated by scientific evidence, ie: quantitative measurement, utilising measurement tools that have been proven to be valid and reliable. There is, however, a growing concern both in society at large and within nursing that immersion in the scientific paradigm has meant that phenomena that do not lend themselves readily to reliable, quantifiable, measurement tend to be devalued or even ignored (McGrath 1999; 2001).

Professional competence involves more than just theoretical content knowledge. This discussion is recurrent throughout the literature in relation to all disciplines that have adopted a competency-based system as a way of guiding entry level performance (Carr 1993; Barnett 1994; 1997; Gerber & Velde 1997; Grant 1999). Barnett (1997) has long argued that in higher education, while assessment of competence has a place in student learning, it is by no means the end goal and universities have a broader role than merely preparing students for effective functioning in the workforce. Universities have a responsibility to provide a group of people to challenge and question social values and to affect future directions. Barnett (1994:61) states that basing university level education on competency standards, with an emphasis on technique, may limit outcomes and trade off the achievement of higher level abilities that are much more difficult to quantify, such as the use of insight in decision-making, critical thinking, professional self awareness and communicative reasoning.

To be a competent nurse, one must demonstrate critical thinking as well as logical and safe decision-making. The practice of nursing consists of some aspects that lend themselves readily to quantifiable measures (technical skills) and other aspects that are not so easily demonstrated to an assessor using a standardised instrument. Most people would agree that caring is a central component of nursing and that while some measurable behaviours could be said to

demonstrate caring, the presence of these behaviours is not sufficient to prove the nurse is a caring nurse, nor does the absence of these behaviours prove a lack of caring by the nurse. One of the issues associated with attributing caring to a nurse on the basis of the presence of certain measurable behaviours is the fact that it is extremely difficult to take into account the context in which behaviours take place. For example, a nurse may speak firmly to a patient about their need to undertake some activity. A quantitative tool, even if one existed, that could validly and reliably measure firmness (something that in itself is highly questionable) could not take into account a number of other factors, such as the importance or urgency of the particular activity, the personality characteristics of the patient, the strength and form of the relationship that the nurse has with the patient and the expectations the patient has of the nurse's behaviour. In the absence of such contextual information, it is impossible to judge the appropriateness of the nurse's behaviour. Therefore, firmness may be construed as either demonstrating a high level of competence or incompetence. It could be argued that the assessor should be expected to take these factors into account. If this were done, however, it would not be the tool that was measuring the nurse's competence, but would rather be a professional judgment on the part of the assessor who would be taking into account factors that may not have been able to have been foreseen and therefore not able to have been incorporated into the assessment tool.

The major criticism of competency assessment in nursing programs is that technical skills, which are the easiest aspect to measure, have become the primary focus of competency assessment. Realities of time limitations and limited staff resources mean that assessment tends to concentrate on those aspects that are readily measured or quantified. Employing the competency standards in the manner in which they were intended is both time and (human)

resource consuming. The time constraints that result cause the assessor to become task oriented and not to assess the underpinning knowledge, judgment, attitudes and other attributes of professional practice. Moreover, the assessor may feel even more time pressure because they know that, following assessment, they must not only provide feedback to and counsel the student if they have not done well but must also help to manage the extra work needed to raise the student's level of competence. Because the nature of the assessment process is ongoing, the assessor needs to monitor the student across a range of situations, meaning that any one assessment is not 'absolute'.

Of particular importance is the issue of what is not being assessed and, as discussed earlier, there is more to effective nursing practice than technical skill acquisition. Certainly, if we are to truly strive for competence in our graduates, we must assess all aspects of competence, not just those that are easily tested and demonstrated. We must argue for recognition of the fact that the hidden, less measurable aspects of competence are of equal importance.

PRECEPTOR/MENTOR VERSUS ASSESSOR FUNCTION IN COMPETENCE ASSESSMENT: A CONTRADICTION IN ROLES

The preceptor role includes supporting the student as they develop, providing constructive feedback and pacing their learning (Ohrling & Hallberg 2001). This is generally a very positive experience for both parties, however, there is a tension caused by the duality for the person undertaking both the preceptor and the assessor role. On the one hand, the mentor/preceptor is expected to be a nurturer, providing guidance, support and gradual exposure to more and more complex tasks and situations to facilitate the experiential learning of the student. The mentor role is highly valued amongst professional colleagues and is deemed to be recognition of one's own ability as a 'good'

nurse. To fail the student is then, in part, to admit that one's own ability as a mentor is lacking. Furthermore, one's own ability to perform as an effective nurse comes under scrutiny. The student will mirror many of the practices of their mentor. How then can the mentor distinguish the student's shortcomings when they may, in fact, be the mentor's own practice deficits?

Duffy's study in the UK (2004) described the many faces of the mentor's dilemma in 'failing' students in the clinical practice environment. She explained the discomfort experienced by mentors as being surrounded in a fear of the reaction from students. In addition, there is increasing pressure being placed on assessors to pass students as a result of the shortage of nursing staff available in the workforce. On the other hand, nurse regulators remind us that clinical mentors must focus on providing good quality clinical assessment to protect patients. Duffy also argues for increased support for nurse mentors to enable them to exercise their responsibilities in the crucial role of professional gate-keeper, in order to protect the public from incompetent or unsafe nursing practice. Personality factors, as outlined by Alfaro-Lefevre (2004), including 'avoider' and 'accommodator', may also work to inhibit the assessor's level of comfort and therefore their efficacy at assessing students.

In contrast then, who makes a good assessor? Ideally, this should be an experienced practitioner with additional assessing skills, who is impartial and preferably does not have the same personal investment in the student as the preceptor. The assessor becomes the guardian of the discipline at the practice level. This responsibility requires the assessor to be clear about the minimum standards required and to make fair judgments against the assessment criteria that are linked to the ANMC Competency Standards. As the ANMC Competency Standards infer transferability across clinical settings, the generic nature of the student's performance

must be central to the assessment. The assessor is the judge of the student's ability.

The contradiction in roles is clear, in that the preceptor/mentor helps the student to identify gaps in knowledge and practice and works with the student to minimise risks and weaknesses in performance. The assessor, on the other hand, must look for gaps, as it is the gaps, or the lack thereof, that provide the evidence required to pass or fail the student (Jones 1999). The assessor role includes the planning, conduct and review of the required assessment process and it is the designated assessor only who should perform the summative assessment. This requires the assessor to carefully orchestrate the practice context so that sufficient valid and reliable evidence can be gathered to enable a judgment to be made. Menges (1975) argues that multiple sources of evidence are necessary to improve the accuracy of performance evaluation. It is essential then that a variety of assessment strategies be used to determine clinical competence, rather than relying solely on standardised clinical assessment instruments based on competency standards.

The impressions described above are supported strongly in literature that reviews similar problems with programmes like medicine and teaching that need to demonstrate ongoing professional competence. Lew and associates (2002) argue that there are a number of processes that need to be in place to ensure fair and equitable practice assessment. In the case of nursing, this would incorporate the range of cues associated with the ANMC Competency Standards (2000). Qualifications and selection processes for assessors are critical to assessment success. Lew and associates (2002) suggest that assessor training should be aimed at ensuring cultural appropriateness and have an emphasis on the assessor's interactive style. According to McAvoy et al. (2001), it should also include training in group dynamics, effective report writing and the ability to follow sound processes that are capable of withstanding legal challenge and scrutiny. Consistency between

assessors is crucial to the overall reliability of the process. This can be achieved by regular workshops, debriefing and networking. Ongoing updating of assessor knowledge and skill to reinforce the professional gate-keeping role and to maintain assessor integrity is suggested. Given this detailed examination of the assessor role, assessment is clearly not something that should fall to a busy clinician with a full client load on or near the final day of the student's clinical experience. An experienced, appropriately trained person who can focus, with impartiality, on the assessment task should be the one to carry it out.

Appropriate education and support for the preceptor is crucial for these assessment processes to contribute positively to student learning and to be educationally effective in relation to the final outcomes (Moxham & Reid-Searl 2005).

SPECIFIC CHALLENGES FOR COMPETENCY ASSESSMENT TOOLS FOR PSYCHOMOTOR SKILLS

Notwithstanding the complexities of assessing the non-technical aspects of a nurse's ability to perform to professional standards, there are also challenges with the more easily assessed competency standards for psychomotor skills.

Lum (2004:495) describes the 'non-discursive nature of human capability that renders impossible the description of competence in detail and that effectiveness is inferred from the student's performance'. However, assessment of even these codified skills (Wheelahan 2004) is fraught with difficulties for the student and the assessor. There are organisational considerations, which may specify a particular method of accomplishing any clinical skill. A student may come from a university with a skill taught on 'principle' which, if performed differently to the 'procedure manual' of the specific clinical environment, could cause the student to be failed. Criticism of the student's method threatens their tenuous grasp of the skill and students

who respond to criticism with evidence may, in turn, threaten the assessor. The assessor may consequently consider that their judgment of the student is not sound, not because the assessor cannot do the skill but because they may not be able to articulate the evidence or underlying principles that support their own practice methods. Further, the preceptor giving feedback on poor performance engenders their own fear of 'hurting' the student, because most nurses are nurturers. A protective strategy would be to respond with compassion rather than a professional critique, particularly if a student is seen to be working very hard. Expression of negative feedback and critiquing are learned skills and are amenable to education, so that preceptors can be seen more to be giving helpful suggestions and support rather than stating the difficulty in the negative terms of criticism. Assessors also run the risk of becoming emotionally involved in the assessment, with the effects of assessment processes ranging from stressful, through frustrating, to infuriating. The self-esteem implications are challenging for both parties if an assessor or preceptor handles the giving of feedback to the student ineptly. Preceptors are a product of their own learning experiences and are frequently influenced by the more traditional, hierarchical teacher/student relationship, which in turn influences the way that feedback is delivered to the student.

ASSESSMENT CHALLENGES: COMPETENCY AS FRAMEWORK NOT TOOL

The competency standards were created to provide a framework within which assessment could occur. This framework requires the assessor to judge the global 'principle based' understanding, ability to link theory to practice and sound clinical judgment of the student rather than their ability in accomplishing any specific task. Judgement, however, is not being adequately acknowledged or respected. This is particularly interesting when we consider that a

commonly accepted practice to develop and validate a measurement tool is to compare it to the judgment of practitioners who are considered to be experts in the field. Does this not suggest that in fact the judgment of the expert is a higher level of authority than the tool being validated against it? Some would respond in the negative, alleging that the validity of expert judgement is questionable because experts can differ in their judgments. We would argue that this simply demonstrates the complexity of what is being assessed and does not prove that any of those judgements were invalid. Just as reliability does not prove validity, lack of reliability does not disprove it as, when dealing with complex issues, there can be multiple truths.

On the positive side, the assessment tools are structured and are reasonably concrete, making assessment of the student readily accomplished, especially by the nurse preceptor who may have little training in assessment. Some of the tools actually operationalise many of the competency statements (Tollefson 2004) and are usually designed to fit with the learning objectives of the curricula and have clear criteria for each category of competence. Achieving the criteria at a minimum standard infers competence (Hager & Becket 1995: 3). The language used and interpretative statements within the tool contribute to consistency between assessors, university faculties and across institutions (Tollefson 2004). The students benefit from clear and appropriate feedback since there are concrete examples of the underpinning knowledge required. As well, the assessor who has been properly prepared has an unambiguous understanding of the knowledge level required, thus increasing their confidence in their own ability to assess effectively. The knowledge required and presented in the tool is evidence-based, so best practice is fostered. The tools are structured based on principle so that they are flexible and useful across a range of facilities and contexts.

There are also challenges in assessing many of the areas important to professional nursing

(ethical matters, advocacy, use of research) because there has been little development of criteria to actualise the competency standards. Along with this, there are problems with interpretation in that the competency standards are written in very general language in order for them to be widely contextually applicable. However, assessors see the lack of specific criteria, in the form of cues, as a barrier to effective assessment of ability and skill in areas of judgment and attitude.

Occasionally, the assessment tool may be used as a 'recipe' by both student and preceptor to assess a skill, even when it is not appropriate for the time or place. The tool then reverts to the anachronistic task checklist. For assessors without experience, the assessment categories seem ambiguous. The apparent lack of clarity about the achievement categories arises because the assessor is meant to rely on their own expert judgment rather than on specific cues in the tool. This remains a significant concern for educators.

POLITICAL ISSUES IMPACTING ON COMPETENCY ASSESSMENT

Academics have expressed considerable concern about their ability to attest to the overall competence of graduates although they accept that they have a responsibility to the public and to the registration body to ensure that graduates are safe to practice. This is more than just not having any concrete evidence to the contrary; academics express concern that they, or their university, could be held legally accountable for the incompetent acts of their graduates. Morally responsibility is also assumed.

At times the suitability of a student for registration as a nurse is questionable. Similar issues arose in the previous hospital-based nursing education, where concerns about the suitability of a nursing student were often dealt with by 'counselling' that student about the likelihood of successfully completing the course. The educator in a hospital-based nursing course general-

ly identified such students as being 'unsuitable' to be nurses. The kind of unsuitable behaviour that the students exhibited was often related more to character (honesty and ethical behaviour) than to any component of 'competence' as defined in the ANMC Competency Standards. Neither the ANMC Competency Standards nor the Code of Ethics for Nurses in Australia (2002) actually address honesty per se, although it may be implied that dishonesty could bring the profession into disrepute.

In university courses, however, there may be no capacity to 'counsel the student' to leave the course, particularly if they are passing their assessments. The issue of character or personal attributes is one that is really missing from the competency standards and is usually one that creates a great deal of difficulty for assessors.

In the hospital-based courses, students were subjected continuously to the expert judgment of the registered nurses with whom they worked. The students, as employees of the hospital, were answerable for more than their formal assessments. Aspects of care, such as attitudes towards patients, demonstrated by a range of behaviours over time, were subject to ongoing scrutiny, and not just for a brief period. Students found wanting were challenged and, if they failed to address perceived shortcomings, could have their employment at the hospital terminated and would consequently be excluded from the course.

If nurses who teach, mentor, preceptor and assess students are to feel confident about their ability to meet obligations that ensure the quality of their graduates, there needs to be open recognition of the difficulties they experience and respect for the credibility of their qualitative judgements. How this can be done in an environment that places such a high emphasis on the quantitative, measurable aspects of assessment is difficult to see.

Some of the questions raised in this discussion remain unanswered and, indeed, some of them have not been explored to any depth. This

is a task for nurse educators, and as the overburdened health care systems in the developed world are demanding both more nurses and higher levels of skill in their nurses, the following questions will demand attention:

- Is the nature of competence visible?
- Is competence measurable using standardised competency-based assessment tools?
- Who should be the assessors and guardians of the profession?
- Do we need to explore other means of assessing the ability of nursing students to render safe, effective and compassionate care?

TAKING A STAND

The intent of this article is to revive and bolster the debate on a topic central to the practice of both nursing practitioners and academics. An overview of the available literature on nursing competencies has been presented in order to establish the context and baseline for debate. The next step is to begin the process of engaging in the debate by taking a position. Thus, a caveat to this section is that it solely reflects the views of the authors, all of whom found common ground in their stance on nursing competencies.

The competency standards in their current form have the potential to be a reasonable tool for assessing students but there are problems with their use. The use of competency standards as a framework for the assessment of minimum competencies in practice is appropriate, however, we believe they are not well understood and therefore not well used. Under the pressure to operationalise assessment, the competency standards evolved from a broad framework into a tool for measuring clinical performance, which we believe undermines the intention of the standards. Reified as an every day tool, the original spirit of the competencies was forgotten along with an in-depth appreciation of the broader nature of their conceptualisation. We believe it takes education and experience to use them appropriately. A major concern that the

authors have about the measurement of competencies is the tendency to overlook those aspects which are more abstract and more difficult to quantify and measure. In the busy, at times hectic, clinical arena there is a natural tendency to put assessment efforts into evaluating readily measurable behaviours and consequently to ignore those factors which are more difficult to assess, such as attitudes. This tendency is compounded by the need to demonstrate the validity of any claims that a student has failed to achieve the standard expected of them. Our concern lies with the potential for a decline in professional nursing standards because the minimum requirement has been taken as sufficient. In the clinical environment, where competency standards are increasingly complex for nurses, the group suggests that the lack of education on the use and pressures inherent in the health system tends to perpetuate their misuse.

In summary, we believe that the competency standards need to remain as the foundation for assessment but that preceptors need to have a more in-depth appreciation of the purpose and the process of operationalising the conceptual framework. It is essential that we keep this debate ongoing and alive to ensure that the tool does not become the driver of the process.

CONCLUSION

Professional accountability asserts that the process of registration for graduate nurses and the demonstration of standardised competencies is the best avenue for ensuring the promotion of safe and effective nursing care. Standardising competence is said to give health care consumers and employers more information about the qualifications of nurses to assure an appropriate standard of skill and care. This paper, while affirming the importance of the notion of competency standards, highlights the problems associated with an unqualified acceptance of competency-based assessments. It has been argued that because of limited time and resources, coupled with the positivist dominant

discourse of bio-medicine, competence assessments focus on the quantifiable dimensions and ignore the important but less measurable, intangible aspects of the nursing profession such as character attributes, caring, honesty and advocacy. As such, they fall far short in testing the many significant aspects of nursing that do not easily lend themselves to such psychometrically framed methods.

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