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Clinically Competent Peers and Support for Education: Structures and Practices That Work

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PRIME POINTS

- Competent performance is manifested in autonomous clinical decision making, prioritizing and multitasking, interpersonal competence, technical skills, knowledge, and patient outcomes.

- Structures that foster clinical competency include annual reviews, educational support, recognition, patient-care review sessions, and evidence-based, best-practice teams.

- Support for education includes adequate staffing so nurses can attend sessions; financial reimbursement; specialized, unit-based educators; on-site clinically focused programs; and more.

"By your actions they will know you."

"My goal is to provide the best care possible to each of my patients, based on knowledge that flows from my brain to my fingertips with compassion."

"The signs were subtle, but I knew this patient was going to get into more trouble, so I bugged them [physicians] until they did something."

"We take pride in being superbly competent; it's "in the water" here—part of our culture. And the hospital backs up this expectation by providing resources, educational programs, tuition and fees, and time so that you can go. The physicians in PACU [postanesthesia care unit] provided review courses for our national specialty certification exams."

"I wish there was some way that I could learn and could help others meet all our responsibilities at once."

The preceding excerpts from interviews with staff nurses in magnet hospitals reflect the key messages reported in this article. (Unless otherwise stated, all excerpts are from staff nurses who were interviewed for this study. The professional role of the speaker is cited for physicians [MDs] and nurse managers [NMs].) Competency is multifaceted and evident through actions. *Clinically competent peers* is all about competent performance, not the potential for performance. Both performance and potential are important for quality patient care, but here we focus solely on what others see or hear that leads to the judgment or conclusion that nurses on the front line in acute care hospitals are clinically competent.

We describe what clinical nurses have to say about 2 elements that staff nurses identify as essential to a healthy work environment: *clinically competent peers* and *support for education.* This article is based on the last of the 3 structure-identification studies (Table 1) in which we interviewed 244 staff nurses, 105 managers, and 97 physicians on 101 clinical units in 8 magnet hospitals selected because staff nurses on these units had previously reported satisfying, productive work environments. In other words, we interviewed experts to find out what works. What are the structures and best practices that foster competent performance? That support education?

Working with other nurses who are clinically competent has long been cited by staff nurses as a key feature of a satisfying and productive unit work environment, that is, an environment in which personal needs can be met and in which clinical nurses at the front line can give quality patient care. The AACN Standards for Establishing and Sustaining Healthy Work Environments[1] define such an environment as one that is healthy. Since 1984, when the characteristics of an excellent work environment were first measured using the 65-item Nursing Work Index constructed from the original magnet hospital criteria,[2] thousands of staff nurses in magnet, community, county, Veterans Affairs, and academic hospitals have consistently cited *clinically competent peers* as the No. 1 attribute of a satisfying unit work environment in which nurses can give high-quality patient care.[3]

In 2001, when the criteria of a magnetic work environment were shortened to those 37 attributes most often selected by thousands of staff nurses who completed the Nursing Work Index, staff nurses in 14 magnet hospitals cited *clinically competent peers* as the most important of the 8 attributes essential to a healthy work environment.[4] We labeled these 8 attributes the Essentials of Magnetism (EOM) and designed the EOM tool to measure them.[5] Each of the 8 essentials has a subscale and a score; the aggregate score of the 8 essentials is a measure of a healthy work environment. Using the same instrument, home health nurses in 9 states selected *clinically competent peers* as the fourth highest essential attribute.[6] Competency is also one of the Baldrige criteria for performance excellence.[7]

Support for education, another of the 8 essentials, is based on the "availability" of educational programs, opportunities, and practices that foster development of competency, but an environment that "supports" education is a necessity. The question investigated and answered in this article is, How is support for education manifested? Support for education is also one of the Baldrige criteria for improving performance excellence[7]; it is included as an aspect of the Professional Development Force of Magnetism[8]; and it is identified by the American Organization of Nurse Executives[9] as 1 of the 9 elements of a healthy work environment.

What Is Competent Performance? How Is It Demonstrated?

Competent is usually equated with adequacy, with accepted

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Table 1 The structure-identification studies

Structures and "best practices": "Putting the right things into place." Job of nurse administrator.

Work processes, relationships, interventions: "Doing the right things right." Job of staff nurses.

Outcomes for patients: "Having the right things happen." Patient outcomes tell us whether the right things are in place and are working.

Only staff nurses can confirm whether the right things are in place and are working.

The right things, work processes that staff nurses say they need to give quality care, are working with clinically competent peers, support for education, collaborative/collegial nurse-physician relationships, clinical autonomy, adequate staffing, nurse manager support, control of nursing practice, and patient-centered culture. These can be measured with the Essentials of Magnetism tool.

To put the right things into place, we need to know what they are.

Consult the "experts." The people most knowledgeable about right things and whether they work are clinical nurses working in the front line on units and in hospitals where they or their counterparts confirm an excellent, healthy, satisfying, and productive work environment.

Learn from our successes, from people "in the know."

The major work environment of interest to clinical nurses at the front line is that of the clinical unit. But the unit is part of the whole—the department, the hospital. So, we need a departmental and hospital perspective as we concentrate on the unit work environment.

Whom did we study in the 3 structure-identification studies?

For nurse-physician relationships: The 5 highest scoring hospitals: 3 magnet and 2 nonmagnet. Conducted Spring through Fall of 2004.

For clinical autonomy: A total of 8 high-scoring magnet hospitals: 4 community and 4 academic. Conducted Spring through Summer of 2005.

For remaining 6 structures: A total of 8 magnet hospitals with the highest or second highest confirmation of a productive, healthy work environment by region of the United States. Conducted late Winter through mid-Summer 2006.

Clinical units: In all 3 studies, units with the highest confirmation of healthy work environments were selected for study and interviews.

Experts: Staff nurses, managers, and physicians from each unit, nominated or selected by peers or manager; also chief nurse executive, chief nursing officer, and 4-5 representatives from other professional departments in each hospital.

How were they studied?

Individual interviews: With approximately 50% staff nurses, 25% managers, and 25% physicians on high-scoring units.

Participant observations: Investigators observed and participated in central and unit interdisciplinary patient care rounds, unit operations meetings, evidence-based-practice team meetings, and day-to-day work of the staff, and they observed in central and unit council meetings.

What did we find out?

Structures, systems, and practices "in place that work." Also, found out "things," structures and practices, that are missing and could be considered for improvement.

standard of practice. Webster's dictionary[10(p253)] defines it as the quality or state of being functionally adequate or having sufficient knowledge, judgment, or skill. The professionals we interviewed—nurses, managers, and physicians—talked about competent performance as more than baseline performance or adequacy. Baseline performance or adequacy produces safe care; competency produces quality care.

To find out "what works," we wanted to be sure that we were interviewing experts, that is, professionals who were knowledgeable about the competency of the nurses and would be able to identify and describe organizational structures and best practices that helped nurses develop and maintain this exquisite competence. At the beginning of each interview, we used a 1 to 10 rating scale (10 = high), similar to the pain rating scales that nurses use daily. We asked, What number would you select to indicate the level of competent performance of the nurses on this unit? The mean rating for all 446 professionals interviewed was 8.7. Physicians rated staff nurses' competency as 8.9, significantly higher (P=.004) than did nurse managers (8.4). Staff nurses rated their peers' competency as 8.7. These ratings are very high, even higher than the ones we obtained when we asked the same question of 279 staff nurses in 14 magnet hospitals in interviews in 2001.[4]

Most of the nursing literature is about core competencies and educational programs to promote or develop the capacity for competent performance. After reviewing studies on nursing core competencies from 1990 to 2000, Zhang et al[11] identified multiple different, but overlapping, classifications of core competencies and concluded the following:

1. Some agreement exists that the triad of interpersonal competence, critical thinking, and technical skills embody the essential characteristics of a nurse's competency.

2. However, none of the categories has been adopted as a model for nursing.

3. With the rapid changes in health care, of more significance than possession of knowledge and skills is the ability to transform competence into effective performance in the complex world of hospital nursing.

To obtain descriptions of effective performance, we asked each interviewee, How do you know that a nurse is competent; what do you see or hear that tells you that a nurse (one of your peers) is performing competently? The 446 interviewees generated 749 descriptions and examples of competent performance. Using constant comparative analyses,[12] we first independently analyzed the descriptions and examples and nominated potential categories. Then we reanalyzed the data as often as necessary to ascertain categorical fit and to broaden the categories into 6 competency performance domains. Responses that fit more than a single domain were assigned on the basis of context; a few that fit no domain were eliminated. Table 2 lists, in order of frequency, the competency domains described by interviewees in all 8 hospitals. The domains are

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Table 2 Competency performance domains, in order of frequency, beginning with most frequent

1. Autonomous clinical decision making
2. Prioritizing and multitasking
3. Interpersonal competence
4. Technical skill competence
5. Knowledge competence
6. Quality of patient outcomes

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not necessarily new or different. However, the relative importance and performance manifestations may differ from those usually found and reported, and some may be a surprise. The excerpts given here have some similarities to examples cited by Benner[13]; this situation is not surprising, because we were interviewing nurses who were clinical experts. By analyzing and thoroughly understanding what interviewees were describing in each performance domain, we can learn not only what organizational structures and best practices promote competent performance but also what additional educational programs and practices may be needed for the development of competent performance in each domain.

Competency Domains
Autonomous Clinical Decision Making

Making independent, quick and correct decisions and acting "out of the box" in the best interests of the patient were responses given by 58% of the staff nurses, 16% of the managers, and 93% of the physicians. This domain includes commitment, a desire and zeal to acquire the knowledge, competence, and self-confidence necessary to make independent decisions (in the nursing unique sphere of practice) and interdependent decisions (in that sphere of practice where nursing overlaps with medicine and other disciplines).

A competent staff nurse is an independent thinker who sees things, particularly subtle changes not yet manifested in vital signs; she can describe

and process them and make recommendations for care. The recommendations and the descriptions are the visible signs of competence. (MD)

A competent nurse will "go out on a limb" for the patient. They know what I want and what is best for the patient and will see that the patient gets it. How I know this is that I'll get a call when I come out of OR [the operating room] and the nurse will say, "Your patient needed thus and so, so I did it, because we have discussed this and I know that this is what we both considered best for the patient." You can't imagine how much I trust and respect that nurse's knowledge, judgment, and decision making. (MD)

Commitment and patient advocacy were the primary aspects of competency in the autonomy domain described by nurses.

A clinically competent nurse is able to assess the level of acuity, pick up subtle changes in the patient's condition, effectively communicate this, and deliver the proper treatment and care with compassion and understanding.

A competent nurse displays commitment to the patient (directly) and indirectly through the ethos and

culture of nursing, which is "wanting to make a difference" . . . I will hear Janie on the phone calling first doctors on one level and then on the next level until she gets what she knows the patient needs. (NM)

Competent nurses are passionate learners, constantly wanting to expand their knowledge. They will place themselves in positions, take on assignments, seek out people who know, so that they can bring back and utilize the latest in nursing and medicine so that the patient gets the best and most advanced care. (NM)

Structure and "Best Practice." Interviewees described 5 structures or best practices that enable staff nurses to develop competent performance. Some of the best practices are specific to a domain, whereas others span several or all domains. Table 3 lists, in descending order of frequency, the best practices that promote competency development and performance and also the domains most affected.

Table 3	Structures that foster clinical competency and the domains affected
Structures	**Domains affected**
Annual, mandatory competency reviews and demonstrations	Technical and knowledge skills, interpersonal competence
Educational programs, practices, and facilities	All
Organizationally sanctioned expectations, recognition—culture	All
Patient-care review sessions	Autonomous clinical decision making, quality of patient outcomes
Evidence-based and best-practice teams	All

Autonomous clinical decision making is facilitated through patient-care review sessions. These sessions are regularly scheduled reviews and updates of clinical practice and pathways, are often interdisciplinary, are an inherent aspect of collaborative practice programs,[14,15] and are an integral part of the renegotiation of scope of practice[16,17] essential to clinical autonomy. Some hospitals had interdisciplinary updates on each patient's condition and plan of care 3 times per week. Patient-care review sessions often resulted in the formation of evidence-based practice teams. The primary contribution of these teams in enabling clinical competency was through an increase in knowledge. Perceived clinical competence, a necessary precursor to autonomous practice, has been described before[18] and was also often cited by interviewees in this study.

Prioritizing and Multitasking

Responses related to prioritizing and multitasking, the second most cited domain, were given by 59% of the nurse managers, 27% of the staff nurses, and 1% of the physicians. Prioritizing means putting activities in their proper sequence and order as dictated by patients' care needs. Multitasking is the mental process of prioritizing care/cure activities for multiple patients and doing so calmly, with concern and empathy and without losing sight of any patient's needs. As in popular literature and context, multitasking is thinking and doing, or thinking and listening, at the same time. Both nurses and managers repeatedly emphasized that the word *tasking* does not quite capture the essence of this domain: "It's not just the physical tasks; it's a whole array of activities, thought, and work processes that have to be juggled and prioritized, and for multiple patients." Some described multitasking as follows:

. . . Using the nursing process to develop a plan

Analysis and understanding of competent performance manifestations (domains) enable identification of structures and best practices that promote competent performance and supportive educational programs and practices.

Meaningful educational programs support competent performance; enough competent staff and financial assistance enable clinical nurses to utilize the educational programs offered.

of care for each patient, or thoroughly knowing the plan of care that has been developed for your patients. Then you have to decide what needs to be done for each patient, when, in what order, when you need to reassess, what is low priority and might be delegated to a patient care technician, what is high priority and needs to be done now.

Multitasking is doing the critical things and at the same time assessing the results and patient responses, and you have to do this for all the patients you are responsible for.

Speed is involved, but it's more than that; it's setting priorities among the care and cure activities for all your patients.

People who lack knowledge or skill cannot prioritize. In an emergency, they just stick to what they are comfortable doing, even if it is not the most important of all the things to be done for your patients. (NM)

Some nurses can do this [multitask] and some can't, or can't do it as well. You're not taught this in school.

Acquiring the capability to multitask is undoubtedly a slow and arduous process, particularly for new graduates. But as the following excerpts illustrate, once the capability is acquired, competent performance appears to be a rather startling transition.

> New graduates pass the competency hurdle when they can multitask for multiple patients.

> It's a "passing through" phenomenon. I don't know how they learn it because it's not specifically taught, but all of a sudden, one day, the light bulb goes on. (NM)

Experienced nurses also encounter difficulties in multitasking and prioritizing, but from different sources. Experienced nurses are the ones who are most often called on to take care of the most difficult and acutely ill patients, patients being treated with new technologies, and to assume the increasing array of professional responsibilities and activities—acting as preceptors to new staff members, attending council meetings, and participating in interdisciplinary meetings to develop protocols. A relatively new concept, identified and labeled by researchers in Minnesota as complexity compression,[19] is a way of analyzing the competencies demanded by multitasking and, more importantly, of devising methods for mentoring and teaching new and experienced nurses how to develop this competency. Complexity compression is defined as "what nurses' experience when expected to assume additional responsibilities while simultaneously conducting their multiple responsibilities in a condensed time frame."[19]

Complexities described by our interviewees varied among clinical units. Nurses in intensive care units most often cited patient care and system complexities such as increased patient acuity, limited system resources of critically ill patients, sensory overload for the nurses, technology bombardment, and rapid institution of multiple, new therapies (drugs, robotics). Nurses in other units described complexities due to multiple patients; rapid assessments, triaging, and treatment demanded by multiple and almost constant patient admissions and discharges; and increasing age and numbers of patients with latent or active comorbidities. Comorbidities make high demands on competency because "you have to be alert as to when latent might become active, so that you can do the proper thing in a timely fashion." Nurses on all units noted "planned and unplanned additional responsibilities" such as emergency admissions, orientation of new nurses, increased expectations of involvement in research and evidence-based practice teams, council activities, interdisciplinary meetings, and working with physicians and others on development of critical pathways, autonomous decision-making reviews, and reviews of collaborative or nursing orders. As one interviewee stated, "With increasing professionalism comes increasing demands on your time, your expertise, your knowledge, your judgment, and your areas of competency."

The compression aspect of complexity compression almost always boils down to time. For new nurses, the compression is primarily the time it takes to develop, execute, and prioritize plans of care for multiple

patients. For more experienced nurses, the compression factor is the time and mental alertness required to weave demands of patient care with multiple professional activities. For all, the continued short length of patients' stays means that a larger number of work processes such as patient teaching must be done in shorter periods. Other compression factors are shortages in staffing, which are often due to increased acuity of the patients, or shortages of "the right kind of staff—not numbers, but skill and preparation."

Structure and "Best Practice." Of all the structures and best practices needed to facilitate competence development and competency performance, the one cited most often as missing was how to teach and mentor nurses to prioritize and multitask. This competency domain is the only one for which no structures or practices were identified or described by interviewees in at least half of the 8 hospitals. Several preservice interventions that could be taught to students in schools of nursing have been described. Multitasking for multiple patients and how to decide what to delegate can be taught by having students identify and translate patients' needs into active and inert tasks or activities on the basis of expected resistance.[20] This strategy could also be used for graduate nurses and residents. In an interdigital professional competency model,[21] students can be taught to develop care plans and activities for 3 patients and then interdigitize these plans and activities on a priority basis.

In 3 hospitals, interviewees described some methods used by their in-service education depart-ment to teach multitasking and prioritizing. A preceptor described a "thinking out loud" technique that she uses to teach nurses how to multiprocess, prioritize, and plan care and cure activities for the patients for whom the preceptor and the newcomer are responsible. In another hospital that has a well-developed nurse residency program, residents present their patient assignment and how they prioritized and managed it for critique and analysis by their peers. This approach could also be used in orientation sessions. Two nurse managers in intensive care units described what they called a program for teaching multitasking to new hires. They send new nurses out to the general medical-surgical unit before orientation to the intensive care unit; the nurses in the general medical-surgical unit "know how to prioritize and multitask, and hopefully they can teach it. It's better to learn this in a less acute environment."

We suggest development of analytical seminars or critique sessions to identify the complexities extant and prevalent on particular units. The knowledge base and strategies needed to handle these complexities could then be formulated, and anecdotal accounts could be used to analyze, plan, and prioritize the multitask needs of the patients and situations. Computer-based programs have been designed to teach critical thinking. Simulation formats could be used to develop similar programs to teach prioritizing and multitasking.

Interpersonal Competence

A total of 15% of the 727 interview responses fit the domain of interpersonal competence; they were almost equally divided among nurses, managers, and physicians. How well does a nurse interact with a patient and the patient's family? Is the nurse attentive to their needs? Are questions appropriately answered to the patient's level of understanding? How well does the nurse interact with peers, physicians, and other team members? Is there evidence of an ongoing respectful relationship? Answers to these questions produce the evidence that leads to a peer's judgment that a nurse is clinically competent. Interpersonal competence requires interaction, but it goes beyond observing 2 or more people talking and listening. Interpersonal competence is how well the interaction ensues, the rapport established, and whether people hear, listen, and respond appropriately.

> It's the looks on the faces of patient and family as the nurse answers their questions. (MD)

> I witnessed the way this very competent nurse was able to defuse an intense situation [anger] between mother and daughter over the use of contraceptives. (MD)

Another aspect of interpersonal competence is the method and approach the nurse uses in approaching the physician and advocating for the patient. "The competent nurse lays out the patient's condition, provides supporting symptoms and signs, but does not overload with irrelevant information." (NM) In the structure-identification study[14,15] on nurse-physician relationships, physicians particularly noted that they

appreciated when nurses gave them report in "bullets," not "narratives."

Interpersonal competence also includes 3- or more-way interactions.

> It's the quality of participation in interdisciplinary rounds—not just standing there, but presenting and yes, sometimes, arguing the uniquely nursing insights and representing the patient's viewpoint in the plan of care. It's what we depend upon nurses to do. (MD)

> A competent nurse watches the patient/family when I am explaining something and knows what the patient understands and what is "blowing by." Many nurses on this unit can address a question to me that tells me the patient's level of understanding and what I need to do to be sure that the patient is following what I'm trying to explain. (MD)

Personal demeanor or behavior, another aspect of interpersonal competence, "telegraphs to patients whether the nurse is competent and in control of the situation" (MD). A competent nurse relates to the patient, the patient's family, the physician, and peers and handles situations in a calm, self-confident, professional manner.

Technical Skill

A total of 15% of the responses were in the technical skill domain, more from staff nurses (31%) and physicians (21%) than from managers (11%). Examples include handling technological equipment, taking control in a code, mastering different dialysis machines, and intubating patients during transport. Assessment and teaching skills are also included in this domain.

Structure and "Best Practice." Agreement was virtually universal that the mandatory annual competency reviews and demonstrations keep technical skills honed. Day-to-day care of patients also helps maintain this competency.

Knowledge

The distribution of responses for the knowledge domain was similar to that for technical skills; more from staff nurses (22%) and physicians (16%) than from managers (3%). Knowledge competency is evidenced primarily by questions asked and how questions are answered.

> Questions are thoughtful, nonrepetitive, show intellectual command of relevant knowledge, understanding, and meaning of lab results. (MD)

> Knowledge competence is evident when the nurse can differentiate between indications of latent and active comorbidity. For example, a known COPD [chronic obstructive pulmonary disease] patient had surgery this morning; respiratory rate is in the high 30s, wheezing, O_2 sats [oxygen saturation levels] are lower than they were preoperatively, work of breathing has increased. The nurse doesn't want to turn up the oxygen; patient is a known carbon dioxide retainer; puts patient on nebulizer first, then draws blood gases (least invasive first); gets results and then considers BIPAP (bilevel positive air pressure). (NM)

Structure and "Best Practice." Many interviewees inferred depth of knowledge and corresponding potential competence from personal attributes such as national certification, years and type of experience, and level of education. National certification increases expectations or presets others to expect a specialized body of knowledge and corresponding competent performance.[20] Many interviewees (nurses and physicians) indicated, "It [certification] is the single best indicator of clinical competence." Almost all interviewees agreed that structures (funding, review courses, study groups) supportive of national certification and recertification were instrumental in increasing competence that led to more competent performance.

Quality of Patient Outcomes

A total of 17% of staff nurses, 4% of managers, and 1% of physicians gave responses that were categorized as fitting the patient outcome domain. The small number of examples and descriptions in this area should not be construed as lack of importance of this domain.

> Nurses judge the competency of physicians by patient outcomes and lack of complications, by

interpersonal skills (with patient, family, and staff), and by technical skills. To some extent, the same is true for nurses, only in reverse. Since many nurses on many shifts care for a specific patient, it is difficult to ascribe successful patient outcomes to any specific nurse's competence. It is easier to do this in ICUs [intensive care units] than on the floor [general units].

Competency in the patient outcome domain is judged on the basis of a patient's physical appearance, condition, and progress and by what the patient knows. Does the patient look anxious, are his or her facial features drawn and stressed, does he or she look comfortable, is he or she recovering properly, and does he or she look cared for?

I judge the competence of the nurse by patient outcomes: no adverse events, recovering properly and in a timely manner, what does the wound look like? Is he overmedicated or undermedicated for pain? Does level of ambulation meet or exceed expectations for the procedure done? Does the patient know what needs to be done to care for himself at home? (MD)

I judge the competency of my coworker by the shape the patient is in at handoff. If the patient doesn't look "cared for" or doesn't know about his treatment and care plan, I know that I

have to give feedback to the nurse who handed him off to me.

Structure and "Best Practice." The patient-care review sessions and evidence-based practice teams described earlier as best practices for autonomous clinical decision making were also described as best practices for the patient outcome domain.

Best Practices Relevant for All Domains

Physicians and staff nurses were more alike in their descriptions of competency domains than were physicians and nurse managers or nurses and nurse managers, except for multitasking, where nurses and managers were in agreement. The physicians' perspective is that nurses synthesize relevant observations and bits of clinical data and then act to rescue or prevent harm by functioning autonomously or by communicating the synthesized data to multiple audiences (physician, patient, patient's family, nurse peers). Physicians may have a limited understanding of the full scope of the work of nurses and may not appreciate the additional tasks, activities, plans, and thought that go into a multiple patient assignment, responsibilities for teaching, research, and the self-regulation and self-determination of the profession. Despite these differences in perspective, all experts agreed that an organizational culture that expects and demands clinical competency makes a difference.

In this study, physicians' definition of competent performance included the expectation that nurses make recommendations for care. This area is one in which additional education

and mentoring would be beneficial to develop competent performance. Nurses cited many examples of making recommendations without fear of reprisal. This finding is in opposition to the findings of Thomas et al,[22] who contended that nurses are uncomfortable making recommendations for care to physicians because the nurses feel they have been "put in their place" by physicians when doing so in the past. The difference between our findings and those of Thomas et al may be the pattern of nurse-physician communication in quality practice environments. The nurse interviewees in our study were very experienced. Perhaps in these magnet hospitals, physicians' reactions to nurses' making recommendations about care were a result of the physicians' judgment and trust in the nurses' competence, rather than a reaction to nurses' practicing in the physicians' domain. The situational briefing model of SBAR (situation-background-assessment-recommendation),[23] was well embedded in the system in almost all of the participating hospitals in our study and may be helpful to others in teaching nurses how to make appropriate recommendations.

Support for Education
Educational Programs Available

Other than a program to develop and mentor others in prioritizing and multitasking, the number and quality of educational programs offered by the 8 hospitals in the sample were extensive and well recognized as supportive. The mean rating of support for education on the 10-point rating scale (10=high) by the 446 interviewees was 9.0, with

a mode of 10. This very high rating makes further exploration and analysis redundant and unnecessary. Brief descriptions of educational programs available are presented in Table 4. The programs are listed in order of frequency, but the difference in frequencies between the first and the last cited programs was very small.

The degree to which the educational programs were implemented differed among the 8 hospitals. All hospitals had extensive preceptor programs for new graduates and new hires. Among the hospitals, 1 had a nationally renowned nurse residency program, and 2 others had dedicated education units. These units were dedicated to a clinical placement configuration that maintains quality patient care, fosters student relationships, provides an environment where students and academics are accepted as members of the clinical team, and increases the collaborative relationship between clinicians, students, and academics.[24] Some interviewees emphasized the extensiveness, importance, and educational value of product and drug demonstrations, although others did not mention these programs. The extensiveness and financial support for degree education varied from one hospital that offered fully funded on-site registered nurse to BSN and BSN to MSN programs described as supportive by almost every nurse and physician interviewed, to other hospitals that reimbursed nurses for 1 or 2 courses a year. Another hospital offered an on-site, fully funded program for licensed vocational nurses to become registered nurses that was heavily subscribed to and that had retained all of its graduates on staff.

Table 4 Educational programs available in excellent work environments

Program	Description
Computer and online continuing education	Computers were available centrally as well as "on wheels" in the unit or in patients' rooms
Orientation, internship, residency, preceptor training	Programs differed in extensiveness and degree of development
In-house, unit-based in-service, and continuing education	Programs differed mainly in the extent of physician and interdisciplinary participation and involvement
Conferences and seminars with national speakers	Programs included regional and national specialty conferences and evidence-based practice "boot camps"
Review sessions and fee programs fostering national certification	Physicians offered recertification classes; provisions were made for on-site examinations
Degree courses, reimbursement	Courses were often on-site; financial support was usually provided; sometimes attendees were given paid time off

Table 5 Structures and best practices that support education

Structures and best practices	Description
Adequate staffing so nurses can attend sessions	Includes adequate numbers of competent staff but also paid time off, flex scheduling, repeated programs
Financial reimbursement	Includes tuition, travel, fees, registration; often travel funds were received from special groups in the hospital or community
Specialized, unit-based educator	Must be visible, available, and approachable; fills need for on-the-spot information and education
On-site (or in-city) national-level, clinically focused programs	Fulfill need while recognizing personal and family responsibilities; require no overnight stays
On-site library facilities	Are unit or centrally located; librarians are skilled in "best practice" literature searches
Regularly scheduled, usually combined, education and operational program or meeting	Are often held quarterly, are half-day programs, and are repeated so all can attend; dinner and journal clubs usually held monthly
Posting and critique of educational programs	Posted in a prominent place; evaluation by nurse manager or previous attendee is particularly helpful

Structure and Best Practices That Support Education

Descriptions of the best practices that support education, listed in order of frequency, are presented in Table 5. The educational support described most often by interviewees in all hospitals continues to be "adequate, competent staffing so that I can attend in-services, conferences, and seminars without feeling as though I am deserting my peers or my patients." On-site national-level educational programs were described as a hospital's way of "helping us to meet our educational

needs while recognizing that we have family responsibilities." The nurse managers figured prominently in ensuring that sufficient competent and qualified staff were present to care for patients on the unit so that staff could attend meetings and programs during scheduled work hours. Although these organizations made every effort to provide educational support, interviewees also freely commented that "as professionals, we have a responsibility to keep up-to-date and to further develop and increase our clinical competency through continuing education and seminars."

Summary

The structure-identification studies upon which this article is based are all about what an organization needs to do to improve the capability and performance of the staff nurse workforce. Staff nurses also have the responsibility of availing themselves of the opportunities offered, and every indication suggests that in these staff-confirmed healthy work environments, the nurses do so. We found considerable agreement among the 446 expert interviewees on all interview questions—the competency performance domains, educational programs available, and the best practices supporting competency and education—although in a few instances, physicians put more (autonomy) or less (multitasking) emphasis on some competency domains than did nurses. The competency domain of prioritizing and multitasking was the only one described in which insufficient educational or mentoring services were provided. The suggestions offered here will be useful to staff and nurse leaders in planning strategies to improve the environmental attributes of 2 Essentials of Magnetism: *clinically competent peers* and *support for education.* In the next article in this series, we report on, analyze, and offer improvement strategies for the essential of *clinical autonomy*. **CCN**

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Clinically Competent Peers and Support for Education: Structures and Practices That Work

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