

Development and Evaluation of a Toolkit to
Support **Nurse and Midwife Clinical
Competency Determination** and
Competency Development Planning

Final Report



*National Council for the
Professional Development
of Nursing and Midwifery*

*An Chomhairle Náisiúnta d'Fhorbairt
Ghairmiúil an Altranais agus
an Chnáimhseachais*

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Mission Statement of the National Council

The purpose of the Council is to promote and develop the professional roles of nurses and midwives in partnership with stakeholders in order to support the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

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Foreword

The Irish health service is driven by policy direction aiming to provide more services within primary, community and continuing care. A programmatic approach to change is being taken by the Health Service Executive with an initial focus on chronic disease. The current healthcare environment within which nurses and midwives now work has intensified working processes and increased patient complexity. Patient populations are ageing, those with chronic diseases are living longer, hospital stays are shorter with increased use of technology and invasive treatments, patients present with co-morbidities and multiple pathologies, patient turnover and subsequent admissions and discharges are increased and care in the community is expanding. Patient safety and risk controls necessitate on-going clinical audit, utilization of evidence-based practice, adherence to clinical guidelines, introduction of care pathways and peer review. This means that processes for determining and attainment of competencies for nurses and midwives building on identified core clinical competencies are required with due regard to scope of practice and service need. Modern developments such as service needs analysis, the maintenance of portfolios, engagement in clinical supervision and clinical audit and other continuing professional development processes provide support for clinical competency determination and attainment.

To this end the National Council commissioned the School of Nursing and Midwifery, Trinity College Dublin, through an open tender process to develop and test a toolkit to assist service managers, nurse and midwife managers and nurses and midwives in clinical competency determination and competency development planning. The research team worked in partnership with a clinical team and a National Council steering committee to develop the toolkit.

This report details the process involved in developing the toolkit. The development of the toolkit was informed by a literature review, examination of grey literature and piloting of a toolkit. It built upon current competency frameworks for nurses' and midwives' and documents published by the National Council. The final piloted toolkit includes information on: competence determination for service need, identifying and writing clinical competencies for practice; competency development planning and assessment and competency frameworks in Nursing and Midwifery.

The toolkit was evaluated using a mixed-method approach in sixteen pilot sites. A purposive sample of 455 registered nurses or midwives, to ensure representation of discipline, profession, grade and area of practice, were recruited to participate in the survey aspect of the pilot. In total 208 questionnaires were returned representing 46% of the total number distributed. The questionnaires sought experiences of using competencies, and opinions on the structure, content, relevance and utility of the toolkit, plus feedback on using the tools provided within the toolkit. Participants were also given the opportunity to provide opinions on how to improve the toolkit in an open response section, a demographic section was also included. In total, 45 people (73% response rate) also participated in six focus group interviews. A semi-structured interview schedule developed by the team was used to guide the discussion. The schedule addressed the areas of relevance, credibility, readability, helpfulness, and user friendliness. The *Development and Evaluation of a toolkit to*

Support Nurse and Midwife Clinical Competency Determination and Competency Development Planning is published in Tandem with *Nurse and Midwife Clinical Competency Determination and Competency Development Planning Toolkit*; and is available to download from our website: www.ncnm.ie

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Yvonne O'Shea
Chief Executive Officer

Executive Summary

Introduction

Nurses and midwives work within highly complex clinical environments, with high levels of patient dependency and acuity. The increased emphasis on patient safety, the reconfiguration of services towards primary and community care, the development of Clinical Care Programmes within the Health Service Executive, together with government policy on health, all impact on traditional ways of working, locations of care delivery and modes of intervention. Nurses and midwives are responding to national and international trends and developments in science, technology and health care. Nurses and midwives are expanding their role, developing nursing and midwifery-led services, changing location of care delivery and implementing new practices. Consequently, competence determination and development at service, team and individual level is necessary to ensure good quality care and improved health care outcomes.

Nurses and Midwives as key stakeholders in health care can contribute positively to this change process and support the whole health care team in ensuring the highest quality of care. This evolving landscape within the Irish health service will challenge nurses and midwives to determine and develop new competencies for care delivery. To support service managers, nurse and midwife managers and nurses and midwives to respond to these changes the National Council for the Professional Development of Nursing and Midwifery commissioned through an open tender process the School of Nursing and Midwifery Trinity College Dublin, in conjunction with clinical staff, to develop and test a resource pack (toolkit), to provide guidance for the determination and development of clinical competencies to support effective clinical outcomes for patients and clients.

Determining and developing nursing and midwifery competencies to meet service needs is a process that requires an understanding of the:

- competencies required to deliver current and future service needs,
- competencies available within the nursing or midwifery team and
- competency development planning at service, team and individual level and clarity of desired clinical outcomes for patients/clients.

Competency development planning occurs at three levels: service, team and individual, it occurs also in the context of service planning, standards and guidelines and ongoing clinical audit. Competence determination and competency development at these three levels is essential for an innovative and responsive service and workforce that is responsive to the changing context of health and health care delivery.

Development of toolkit

The development of the toolkit was informed by a literature review, examination of grey literature and by the piloting of a toolkit. It built upon current competency frameworks for nurses' and midwives'

and documents published by the National Council. The final piloted toolkit includes information on: competence determination for service need, identifying and writing clinical competencies for practice; competency development planning and assessment and competency frameworks in Nursing and Midwifery.

The toolkit is divided into four colour-coded sections to assist people in identifying the section most relevant to their needs. Throughout the toolkit, case studies and processes used to determine and assess competencies are provided. A number of templates are provided within each section to assist the user to determine and assess competencies, and develop competence development plans at service, team or individual level. These templates are intended as guidelines and may be modified by users to suit their specific needs.

The literature that explores competence determination and development at a service level was sparse. Similarly, there was little evidence on the effect of competence on service outcome, and no studies emerged evaluating the relationship between competence, patient need and clinical outcomes. However, many authors held the view that nursing and midwifery competence is a vital component of effective clinical outcomes and studies that explored nurses' and midwives' views suggest that they view their ongoing competence to be central to safe, effective patient/client care. While there was much evidence, within the literature, of the development of competence assessment frameworks, little evidence emerged in terms of toolkits for self assessment.

The toolkit was evaluated using a mixed-method approach in sixteen pilot sites. Ethical approval to conduct the evaluation was granted from the Faculty of Health Sciences Ethics Committee in Trinity College Dublin and the local research ethics committees for the services involved. Data were collected using a questionnaire and focus group interviews. A purposive sample of 455 registered nurses or midwives, to ensure representation of discipline, profession, grade and area of practice, were recruited to participate in the survey aspect of the pilot. In total 208 questionnaires were returned representing 46% of the total number distributed. The questionnaires sought experiences of using competencies, and opinions on the structure, content, relevance and utility of the toolkit, plus feedback on using the tools provided within the toolkit. Participants were also given the opportunity to provide opinions on how to improve the toolkit in an open response section, and a demographic section was included. In total, 45 people (73% response rate) also participated in six focus group interviews. A semi-structured interview schedule developed by the team was used to guide the discussion. The schedule addressed the areas of relevance, credibility, readability, helpfulness, and user friendliness.

The findings from the survey suggest that the majority of the participants were familiar with some concepts associated with competence; however, a substantial minority were unfamiliar with using competencies as a basis for service development planning or had never completed a self assessment of their own competence. Participants were strongly in agreement that reading the toolkit and participating in the activities increased their knowledge and motivation towards competence assessment and development. Overall, participants were of the view that the content was relevant, user-friendly and up to date. The majority of participants felt that the toolkit was well assembled.

Following the pilot phase and feedback recommendations, a number of modifications were made to the toolkit, and these are outlined within the report. The usefulness of the toolkit to guide the writing of competencies also became evident after the pilot phase, as some services used it as a guide to write clinical competencies and behavioural indicators for inclusion with the toolkit.

Conclusion

In conclusion, the need for nurses and midwives to maintain and develop their competence on an ongoing basis has never being greater. To assist nurses and midwives to respond to these changes, the National Council for the Professional Development of Nursing and Midwifery commissioned staff at the School of Nursing and Midwifery, Trinity College Dublin, in conjunction with clinical colleagues, to develop and test a toolkit, to aid health services and nurses and midwives in determining and developing clinical competencies to support effective clinical outcomes for patients and clients. Over a period of six months the toolkit was developed and tested within a number of clinical sites. Overall, participants were very positive; they were of the view that the content within the toolkit was helpful, relevant, user-friendly and timely, and that it would assist them in the determination and attainment of clinical competencies at service, team and individual level.

Recommendations

Based on the team's experience and feedback from the participants the following recommendations are put forward for consideration.

- Each section of the toolkit should be published as a separate booklet but contained in one folder. This would allow people to use the relevant section(s), without making the toolkit cumbersome and overwhelming to use.
- Consideration be given to the process used to launch the toolkit so as to maximise the motivation developed in the clinical sites; for example, asking services to name a key person(s) who will champion its introduction. This may prove beneficial in its long term use.
- Services should communicate and network with each other so that the work of identifying competencies and behavioural indicators for particular roles is not duplicated throughout the country.
- Given the effectiveness of the academic and clinical collaboration in achieving a high level of participation from clinical sites and achieving the objective in a timely manner, this model of collaboration should be considered for future projects of a similar nature.
- The development of a toolkit or framework for the development of practice standards should be considered.

Chapter One

Introduction and literature review

1.1 Introduction

Nurses and midwives working in contemporary health settings face a variety of challenges on a daily basis. In addition to working within a highly complex clinical environment, with high levels of patient dependency and acuity, nurses and midwives function within a complex macro environment that is constantly undergoing advancement and change. Nurses and midwives are required to respond on an ongoing basis to national and international trends and developments in science, technology and health care. Consequently, continuous competence determination and development at service, team and individual level is necessary to ensure good quality care and improved health care outcomes.

This project is focused on assisting service managers, nurse and midwife managers and nurses and midwives to meet the challenge of competence determination and development by developing a toolkit that will act as a step by step resource in the continuous determination and attainment of clinical competencies. This toolkit is not intended to form part of any mandatory updates for registration.

This chapter provides an outline of the aims and objectives of the study and a detailed literature review.

1.2 Aim and objectives

The aim of this study is:

- To design, develop and test a toolkit document (resource pack), which will aid health services and nurses and midwives in determining and attaining clinical competencies.

The objectives of the study are:

- To carry out a desktop review on the national, European and global literature, guidance and trends on clinical competencies focusing on determination, attainment and testing of clinical competencies for nurses and midwives.
- To develop a draft toolkit document that will provide an accessible, easy to use procedural guide and step by step resource to support the determination and attainment of clinical competencies required by nurses and midwives in all areas of practice based on service need.
- To test the draft toolkit for appropriateness and ease of use with the target population, including the midwifery profession and the disciplines of general, children's, neonatal, public health, mental health and intellectual disability nursing, at all levels and grades of staff.

- To provide a final, tested version of the toolkit to the National Council in hard copy and DVD format.

1.3 Phases of the study

The development and testing of the toolkit involved 4 phases:

- Phase 1: Literature review
- Phase 2: Development of toolkit
- Phase 3: Testing toolkit in the field
- Phase 4: Finalising toolkit

1.4 Overview of literature review methodology

A systematic review of the literature was conducted to inform the development of the toolkit. The literature review focused on determination, attainment and testing of clinical competencies for nurses and midwives. The literature was identified through a number of methods.

Searches of electronic databases (CINAHL, Cochrane, EMBASE, Internurse, MIDIRS (Midwives Information and Resource Service), Pubmed, Science Citation Index, Science Direct, Social Science Citation Index and Scopus) were undertaken for the years 1990 – 2010. The following key word terms were used: competence, competency, competencies, expertise, evidence based practice, skill acquisition, measuring and testing competencies, self assessment tools, competence assessment, professional competence, competence attainment, team competency, and capabilities. Additional terms used included service needs analysis and patient activity. These were combined with 'competency' and 'competencies' to ensure that literature on competency determination was linked to service needs.

The initial search yielded 563 articles. Following initial review 450 articles were deemed not relevant as they were outside the scope of the review or were published in a language other than English. When the remaining articles were reviewed, 15 were found to be duplications, consequently 98 articles were reviewed. In addition, a number of other articles were sourced that did not appear in the original systematic search but were cited in a publication and deemed relevant. Core texts on competencies and competency development were also reviewed.

Websites of professional nursing and midwifery organisations and other relevant health care websites (international and national) were searched for relevant documentation. Findings from this aspect of the review produced examples of core competence frameworks for nurses and midwives working in a particular country, and examples of competence frameworks for nurses working with particular patient/client groups within that country.

A search of the grey literature was also undertaken using the following strategies: the Directors of Nursing and Midwifery (DoNs/DoMs), Directors of Nursing and Midwifery Planning and Development units (NMPDUs) and Nursing or Midwifery Practice Development Co-ordinators (NPDCs/MPDCs) were written to requesting information regarding local development in relation to clinical competency and any documents

developed locally. In addition, the Head of the School of Nursing (and Midwifery) in each of the third level academic institutions in Ireland was written to requesting information on any postgraduate research conducted on competencies in nursing and midwifery practice. The outcome of this aspect of the review yielded fourteen responses from the DoN/DoMs, Directors of NMPDUs and NPDCs/MPDCs. A summary of the data submitted is included at the end of this chapter. A list of the people who contributed to this aspect of the review is included in Appendix 1.

1.5 Review of the literature

The review revealed both guidance and trends on clinical competence determination and assessment. Papers originated from the United Kingdom (UK), United States (US) and other countries. Other than professional policy/guidelines and local development there was little literature emerging from the Republic of Ireland. Interest in competence arose primarily from those educators involved in undergraduate education. Many literature reviews describing competence in this setting were identified. More recently increasing interest in the concept of competence for registered nurses/midwives arose. This was in the context of post graduate education and continuing professional development needs. Several studies were identified that tested the validity and reliability of competence assessment tools. A smaller proportion of literature focused on competence within the midwifery profession. The literature on competencies and service planning was sparse. There was little empirical testing of competence or competency frameworks, and little consistency of approaches used either nationally or internationally in competence determination and assessment.

Emergent themes from the review were as follows:

- *Origins and definitions of competence.*
- *Continuous competence assessment and development.*
- *Continuing competence development and patient safety.*
- *Competence development and service/patient outcomes.*
- *Competence frameworks: role and development.*
- *Self assessment of competence, including development and psychometric testing of tools to support nurses' and midwives' self assessment of performance/competence.*
- *Direct observation and portfolio assessment.*
- *Rating systems for competence assessment.*
- *Patient/client involvement in competence assessment.*
- *Factors influencing competence development among registered nurses and midwives.*

1.6 Origins and definitions of competence

Nursing and midwifery became regulated professions in the first half of the last century (Butler et al 2008). In addition to ensuring the ongoing development of both professions, regulation ensured public confidence in nursing and midwifery, as high standards are maintained through regulation systems. To this end, historically, national regulatory bodies prescribed and outlined the core content required of nurses' and midwives' training syllabi. More recently these requirements and standards for nurse and midwifery education

programmes have focused on competence attainment (ABA 2005a, 2005b, ABA 2010).

While acceptance of the terms competence and competency is evidenced by the vast emergent literature, the concept of competence has caused considerable disconcertion in the published literature. Some authors contend that it is poorly defined within both practice and literature and that this in turn leads to confusion with its use (Watson 2002). Furthermore terms such as competence and competency are used inconsistently and interchangeably. Indeed, Watson's et al (2002) systematic review of competence assessment in nursing reveals confusion between use of the two terms, compounded by lack of national definitions of terms by statutory bodies. This emergent confusion and lack of consensus can further cause difficulties for practising nurses and midwives as they struggle to come to terms with the concepts.

According to Manley and Garbett (2000) there is distinct difference between competence and competency. Competence and competences are job related, being a description of an action, behaviour or outcome that should be demonstrated in performance. Competency and competencies however, are person-orientated referring to the individual's underlying characteristics and qualities, which produce effective or superior performance in a job (McMullan et al 2003). McConnell (2001) differentiates between competence and competency as follows:

"Competence refers to an individual's capacity to perform job responsibilities.

Competency focuses on an individual's actual performance in a particular situation".

In the Republic of Ireland recognition of the attainment of nurse and midwife competence at the outset of registration with An Bord Altranais forms the basis for safe and effective practice and patient outcome. The accepted definition of competence in this context is as follows:

"...a complex and multidimensional phenomenon and is defined as the ability of the Registered Nurse to practise safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice" (ABA 2005a).

Competence in five specific domains is required for entry to the nursing register. These are:

- professional/ethical practice,
- holistic approaches to care and the integration of knowledge,
- interpersonal relationships,
- organisational and management of care and
- personal and professional development (ABA 2005a).

Similarly, An Bord Altranais recognises and supports the distinct professional identity of midwives and has recently published competencies related specifically to the profession of midwifery entitled *The Practice Standards for Midwives* (ABA 2010). Nine practice standards are identified and each standard includes relevant competencies and practice guidelines. The nurse or midwife upon application to ABA to have their name entered on the relevant division of the register must satisfy the Board that competencies have been attained in each of these domains. Third level educational institutions involved in the preparation of undergraduate nurses have a responsibility to provide programmes that facilitate the development of these competencies (ABA 2005a, 2010).

To this end, despite arising confusion within the literature, professional bodies in the Republic of Ireland provide clear up to date guidance on operational definitions and understandings of competence and competency. One further example is existent understandings of core concepts for practitioners who practise at Clinical Nurse/Midwife Specialist (CNS/CMS) and Advanced Nurse/Midwife Practitioner (ANP/AMP) level (NCNM 2008a, 2008b). For CNSs/CMSs competence comprises five core concepts:

- clinical focus,
- patient/client advocate,
- education and training,
- audit and research and
- consultant (NCNM 2008a).

The ANP/AMP role comprises four core concepts:

- autonomy in clinical practice,
- expert practice,
- professional and clinical leadership and
- research (NCNM 2008b).

1.7 Competence assessment and development

Competence assessment has gained increasing popularity in use over the past 35 years (Watson 2002). Its use extends not only to requirements for nurses and midwives attending undergraduate and post graduate education programmes, but is now also receiving increasing attention as a mechanism for demonstrating ongoing competence in countries such as the US and Australia, where evidence of competence is required by regulatory bodies. Although historically a nurse or midwife was “*determined to be competent when initially licensed and thereafter unless proven otherwise*” (Vandewater 2004), the demands of a rapidly changing healthcare environment and associated changes in knowledge and practice leads to the suggestion that a periodic re-examination of an individual's competence is necessary in the context of safe practice (Vandewater 2004). This view was echoed in Shallow's (2001) paper, where midwives expressed both fear and lack of confidence with regard to their competence, which deemed satisfactory at registration, was not sufficient to support them in their ongoing changing roles.

Technological and pharmacological advances, changing demographics, and increased international mobility mean that the nature of illness and disease, and consequently the modes of care delivery and management of patients/clients are changing. Within the Republic of Ireland the Transformation Programme 2007-2010 (HSE 2006), the Integrated Workforce Planning Strategy for the Health Services 2009-2012 (HSE & DoHC, 2007), the HSE National Service Plan 2010 (HSE 2010) coupled with economic constraints are all impacting on the traditional ways of working. In addition, there is greater emphasis on patient safety, and the general public's knowledge about, and expectations of, a quality health care service are rising (DoHC 2008, Health and Social Care Regulatory Forum 2009, NCNM 2010, HIQA 2010). Consequently competence assessment and development is necessary to ensure effective, safe and quality health care (NCNM 2010). In this context,

the notion of fixed competence is thus dispelled in favour of:

“a dynamic and evolutionary process, as the profession of nursing is constantly evolving to meet consumer needs, technological advancement, professional responsibilities, and expanded knowledge” (Byrne and Waters 2008).

Schroeter (2008) also highlights that continuing competence is a requirement in terms of patient safety and defines continuing competence as “the application of knowledge and the interpersonal, decision making and psychomotor skills expected for the nurse’s practice role, within the context of public health and safety”.

In some countries, such as the UK, ongoing evidence of continuing professional development is required through a process known as ‘Post-registration education and practice’ (PREP). This is a set of Nursing and Midwifery Council (NMC) standards and guidance (NMC 2006) designed to help provide the best possible care for patients and clients. In addition to undertaking at least 450 hours of practice within the three years prior to registration, in order to re-register as nurses and midwives, all staff must have undertaken at least five days (35 hours) of learning in the same period. An outline of the latter is provided to the NMC upon re-registration every three years. However, specific evidence of competence is not a mandatory requirement, although a ‘profile’ of practice may be requested.

A similar situation operates within the US whereby, in order to renew certification, evidence of both clinical practice and continuous professional development (CPD) are required (ANA 2007). Similarly, nurses and midwives in Australia are obliged to self-declare competence and fitness to practice when renewing annual practice certificates (Emden et al 2003).

In addition, the NCM (2010) suggest that nurses and midwives ought to become involved in competency assessment and competency development at individual, team and service level to promote patient/client safety and quality of care. More recently, nurses and midwives have been identified as key stakeholders in the organisation, delivery and evaluation of the HSE Clinical Care Programmes (CCP), with one of the objectives of the Director of Nursing/Midwifery Reference Group being *‘to advise on the educational preparation and competencies required of nurses and midwives for the CCP nationally’* (ONMSD 2010).

Notwithstanding international trends related to compulsory continued professional development as described above, nurses and midwives are becoming increasingly interested in competence assessment as a mechanism for ongoing professional development. One reason for this is, rather than considering competence as a fixed entity, there is increasing recognition by practitioners of its fluid and “evolving” nature (Flanagan et al 2000). Interviews with registered children’s nurses in Australia (n=6) confirmed the multifaceted nature of competence. Nurses experienced competence as a continuously evolving concept incorporating knowledge, performance of clinical skills and self management of time and workload (Ramritu and Barnard 2001). In Bassendowski and Petrucka’s (2009) Canadian study, nurses (n =123) reported a strong belief that competency is a professional imperative (93%), and when asked about the necessity of continuing competence for professional practice, nearly 97% of participants either agreed or strongly agreed that they have a moral commitment to continuing competency. However, the majority of participants (95%) were also of the view that continuing competence development is possible only within a collegial and organisationally supportive

context. Midwives in Laszlo and Strettle's (1996) study revealed that desire for ongoing competence was their motivation for continuous professional development.

1.8 Competence development and patient/client safety

Patient safety and concerns about safer health care are high on policy makers' agendas (HIQA 2010). To this end there are a range of standards required of health professionals to ensure not only quality care, and a satisfactory patient experience, but to ensure safe delivery of care (HIQA 2010). Concerns about nurse/midwife competence or lack of it, therefore, are of great concern for those who advocate for safe patient care and outcomes. Fundamentally, organisations concerned with ongoing competence for registered nurses and midwives are concerned with patient safety, effective patient outcomes and upholding the standards of the nursing and midwifery professions (Schroeter 2008). Moreover it is incumbent upon health service employers to *"recruit people with the required competencies to provide high quality and safe care"* (HIQA 2010), thus safe care delivery and competence are contemporarily inextricably linked. There is also growing concern, with changes to the fundamentals of education of nursing and midwifery students, that fitness to practice is assured (Bradshaw and Merriman 2008). As Bradshaw (1998) points out:

"unlike many other autonomous professions, if a nurse makes a mistake because of lack of knowledge and skill or an overestimation of her own attainment and capability the consequences could be lethal."

Consequently, the need to prioritise the prevention of errors and ensure patient/client safety places the competency of healthcare professionals "in a spotlight" (Minarik and Lyon 2005). Citing the American Nurses Association Expert Panel (1999), Vandewater (2004) highlighted that it is the public's rightful expectation that nurses and midwives continue to maintain competence in order to protect the public from poor and harmful standards of care. In the US, the American Association of Colleges of Nursing (AACN, 2006) described how the US placed patient safety as the central tenet of health reform and, as a result, engaged a task force to identify key competencies required by graduate nurses to ensure high quality, safe patient care. Within the Republic of Ireland, patient safety is also a key feature of recent publications on safety in health care (DoHC 2008, Health and Social Care Regulatory Forum 2009) and a national discussion paper on nursing and midwifery (NCNM 2010).

Patient safety emerges as a constant theme in nurses' and midwives' articulations on competence determination, with safe practice described as "essential to being a competent registered nurse" (Flanagan et al 2000). Indeed, newly qualified graduate nurses termed a competent nurse as one "who is safe in what they do, someone who knows their limitations [and will] ask someone else" (Ramritu and Barnard 2001). These nurses' definitions of safe practice included:

- following standards/policy/procedures,
- awareness of limitations of knowledge and expertise,
- asking for assistance,
- utilising strategies that prevented harm and
- being aware of principles supporting nursing actions (Ramritu and Barnard 2001).

Interestingly, Smythe's (2005) study of midwives explored their experiences of 'being safe'

as opposed to the dominant discourse of competence. Thus safe practice and competence determination are inextricably interlinked and ultimately contribute to quality service/patient outcomes.

1.9 Competence development and service/patient outcomes

Meeting patient/client needs requires an assessment of the competencies required to deliver the service and a dynamic competence development planning approach to ensure that the nursing or midwifery team have the required competencies to meet current and future needs. Khomeiran et al (2006) suggested that competence development activities, if adopted effectively within organisations can ultimately lead to high quality care delivery, more cost effectiveness in health care systems and more importantly improved patient outcomes. The view that nursing competence is a vital component regarding positive clinical outcomes is also supported by a number of other authors (Bradshaw 1997, McConnell 2001). However, no studies evaluating the relationship between competence, patient/client need and clinical outcomes were located in this review. While seemingly an omission and gap in current literature on the topic, this fact is not surprising, and reflects a rather broader issue in nursing and midwifery research related to a predominance of descriptive studies, preponderance of small scale research and limited focus on outcome related measures. While at the heart of nursing and midwifery practice is optimal patient/client care, from a research perspective this aim often becomes diluted within the operational, cultural and organisational constraints that exist.

One factor that heavily influences trends within research is the relative novelty of nursing and midwifery within University settings in Europe. University education, in particular PhD attainment, is synonymous with research growth and development within the nursing and midwifery professions (NCNM 2006, Treacy and Hyde 1999), and to this end, the Republic of Ireland and indeed many other European countries are still in neophyte stages. However, this situation is changing, both nationally and internationally, with an increased focus on outcome-based and clinically-focused research. There is also a steadily increasing research output among Irish nurses and midwives (NCNM 2006, Mac Lellan and Condell 2005) and increased support for nursing and midwifery research (DoHC 2003). Initiatives in the UK such as the UK Clinical Research Collaboration facilitate and promote high quality research for the benefit of patients (<http://www.ukcrc.org>), and there have been increasing opportunities for clinically based research in the Republic of Ireland.

This changing emphasis, from both a national funding and operational perspective will undoubtedly influence future research trends in this area, and it is hoped that studies to identify the relationship between competence and patient need/clinical outcomes as well as studies on service needs will be undertaken.

Similarly, literature that explores competency determination at a service level was sparse. Although Whiddett and Hollyford (2003) refer to the importance of organisational competencies and describe them as “the things that organisations are best at”, their main emphasis within this text, like many writers in this area, was on competency determination and development at the individual level. The NCNM (2010) does identify a competence mapping process that includes both service and individual level. This process involves:

- Defining competencies required by the service with reference to short, medium and long term goals.
- Identifying the competencies required by the nurse or midwife specific to the clinical environment and role within the multidisciplinary team and overall service goals.
- Assessing individual, team and/or service level competencies to analyse strengths and identify areas where needs exist.
- Developing competencies through targeted education and training based on assessment of competencies.
- Evaluating and sustaining competencies through the establishment of appropriate key indicators and standardised processes.

Waddell (2001) also suggests it may be prudent when considering mechanisms for continuous competence development, that organisations identify the competencies specific to the client group or role and not rely solely on the core competencies that may exist across settings. In their view, relying solely on core competencies may not indicate competence to practice in all clinical situations. This view would be supported by other authors who highlight the need to acknowledge the specific context and skills required to practice in specialist areas (Carberry 1998, Hanley and Higgins 2005a, 2005b). In addition to identifying competencies specific to the settings, Waddell (2001) also encourages the selection of appropriate competence assessment and development methods, bearing in mind that any system needs to be meaningful, cost effective and time efficient.

1.10 Competence frameworks: Role and development

Bradshaw (1997) asserted that for any competence development activity there must be prescribed standards and defined competencies open to objective criteria of assessment and scrutiny to enable a nurse to demonstrate the relevant knowledge and skill to be safe to practise. In nursing and midwifery these standards and competencies are usually published as competency frameworks. The RCN (2009a) describes a competence framework as a term applied to a complete collection of competencies and behavioural indicators that are central to and set the standards of effective performance. Findings from professional nursing and midwifery organisations and other relevant healthcare websites identified a large number of competence frameworks in the area of nursing, with a lesser number within midwifery. The frameworks identified included:

- common or core competence frameworks in nursing and midwifery, which contain competencies that are appropriate to all nurses or midwives, across all organisations and at all levels,
- role-specific competence frameworks, which identify core competencies that are applicable to all nurses and midwives within a particular role, such as advanced practitioners or clinical specialists,
- competence frameworks for nurses and midwives working with a particular client/patient group and
- competence frameworks for nurses and midwives who take on an expanded role. Table 1 provides some examples of the frameworks identified within this desktop review.

Table 1: Examples of competence frameworks

Focus	Examples from the Republic of Ireland	Other examples from outside Ireland
Common or core competence framework	Domains of Competence for Nurses and Midwives (ABA 2005a) Domains of Competence for Midwives (ABA 2005b) Practice Standards for Midwives (ABA 2010)	Essential competencies for midwifery practice (ICM 2002)
Role-specific competence frameworks	Clinical Nurse and Midwife Specialist competencies (NCNM 2008a) Advanced Nurse and Midwife Practitioner competencies (NCNM 2008b)	Midwifery Leadership in Scotland: A Competency Framework (NHS Education for Scotland 2004) Midwifery Leadership Competency Model (RCM 2006)
Competence frameworks for a particular client/patient group	Professional Guidance for Nurses working with Older People (ABA 2009)	Competencies: A competency framework for nurses working in Parkinson's disease Management (RCN 2009a)
Competence frameworks for an expanded role	Requirements and Standards for Education Programmes for Nurses and Midwives with Prescriptive Authority (ABA 2007)	Maintaining Competency in Prescribing. An outline framework to help nurse prescribers (National Prescribing Centre, NHS 2001)

Schreoter (2009) suggested that for comprehensive professional competence determination in any area of clinical practice, a variety of sources and methods needs to be incorporated into the competence identification and determination process. These include collaborating with nurse/midwifery practitioners with varied clinical experience and from all practice areas; relevant stakeholders from education; regulatory bodies; nurses' associations and patients/clients. Without this, the competencies identified may lack relevance, specificity and meaning. Whiddett and Hollyforde (2003) also contend that consultation and collaboration are essential, regardless of whether the competence framework is being developed from scratch or an existing framework is being extended.

Following review of the competence frameworks some common methodological processes were identified. However, in many cases the competence frameworks were published without any specific reference to the processes used to identify or validate the competencies. Of those that did identify the processes used, the main methods detailed were:

- extensive literature reviews,
- reviews of competence frameworks developed elsewhere,
- use of expert opinion either within the nursing and midwifery professions or with other healthcare professionals,

- consultation with patients/clients and carers and
- consultation with relevant professional bodies.

The data collection processes used included both quantitative and qualitative methods, including focus groups, workshops, individual interviews, critical incident analysis and surveys.

In 2009, the Royal College of Nursing (RCN), the Parkinson's Disease Society (PDS) and the Parkinson's Disease Nurse Specialist Association (PDNSA) collaborated as one body to produce key competencies for qualified nurses caring for people with Parkinson's in any healthcare setting (RCN 2009a). The framework was developed following extensive consultation with PDNSs and nurses with a special interest in Parkinson's, through the use of a postal questionnaire (n=245). In addition the views of 240 patients and carers on what they valued from their interactions with a PDNS were accessed through the use of focus groups and a postal questionnaire. Using a similar collaborative approach the RCN (2009b) also produced a competency framework spanning sexual and reproductive health nursing practice across all of the UK. In addition to reviewing existing national and international competence frameworks to identify competences relevant to sexual and reproductive health, there was widespread consultation involving nurses, doctors, and educators with a wide variety of expertise and experience in the areas of sexual health, family planning and reproductive health, and genito-urinary medicine. In order to develop a competency framework in Perioperative Practice for Operating Department Practitioners and Nurses, the National Health Service (NHS) in Scotland (NHS 2002) set up a working party of senior practitioners in the area of preoperative care with representatives coming from a range of NHS trusts and independent hospitals.

The Centre for Clinical and Academic Workforce Innovation in the UK in 2006 published a capabilities (competence) framework for mental health practitioners working in the area of dual diagnosis and substance misuse. The author described the process used to develop the framework. Drawing on relevant research and best practice guidelines a draft of the capabilities was developed by a small working party. A national working party was then established to review the draft. This group had representatives with expertise in the area from all areas of dual diagnosis and substance misuse practice, including nurse consultants, third level educators and representatives from key organisations involved in the provision of care (Hughes 2006).

In the Republic of Ireland, McCarthy and Fitzpatrick (2009) also incorporated a variety of quantitative and qualitative methods and sources to develop a competence framework for nurse managers. These authors carried out an extensive review of relevant literature and drew on the contributions of more than 300 nurse managers and 80 other service stakeholders. Several methods were used to determine the management competencies, which included role analysis (n=165), individual interviews (n=43) and future scenario focus group workshops with nurse managers (n=10), and a stakeholder survey. The framework was then validated by nurse managers at four workshops (n=257).

Also in the UK, Butler et al (2008) identified three categories of essential competencies required of a midwife at the point of registration using a case study approach. The competencies were identified as an outcome of interviews with a triad of key informants, involving student midwife, newly qualified midwife; assessor/midwife; and midwife teacher/supervisor of midwives in the UK. Thirty-nine students were interviewed across four

time points: 3 months before completing the programme, on exit from the programme, 6 months and one year after registration. In addition, interviews with 20 experienced midwives were conducted to explore their views on the aspects of competence that are most important at the point of registration. Although the competencies identified were not developed into a detailed framework, the study indicates that midwives are also engaging in collaborative processes in the identification of competencies. Early studies reveal the midwives lacked confidence in some clinical roles and reported that they required additional education post-qualifying in areas such as research, clinical skills, counselling and communication skills and general issues related to professional practice (Pope et al 1996).

Zhang et al (2001) developed nursing competencies in Hong Kong, using a critical incident technique exploration with 50 nurses. Following analysis of the critical incidents received, the following ten competencies were identified:

- interpersonal understanding,
- commitment,
- information gathering,
- thoroughness,
- persuasiveness,
- compassion,
- comforting,
- critical thinking,
- self-control and
- responsiveness.

In arguing for the importance of organisations and teams to identify competence frameworks and competencies relevant to specific client groups and roles a number of authors express the view that competence frameworks can assist in areas such as learning and development, performance management, recruitment and selection, and grading of a role (McAllister 1998, Lenburg 1999, Zhang et al 2001, Whiddett and Hollyford 2003, Vandewater 2004, Kalb et al 2006). They suggest that competence frameworks will assist nurses and midwives in learning and personal development by: facilitating the individual nurse, midwife or manager to review and identify the development, education and training needs of staff; informing services in the commissioning, and evaluation of education and training and by guiding and supporting educators in the design, delivery and evaluation of education programmes (Whiddett and Hollyford 2003, Vandewater 2004, Kalb et al 2006).

In relation to performance management they contend that competence frameworks communicate to nurses and midwives a shared understanding of the competence set required to fulfil his/her professional responsibility within his/her scope of practice by:

- focusing on behaviours that are required to perform a role,
- identifying how those behaviours are to be measured and assessed,
- assisting in rating performance,

- providing structure and scope to the setting of development objectives and
- assisting in planning for future performance development (Zhang et al 2001, Whiddett and Hollyford 2003).

In addition, competence frameworks will assist nurses and midwives in recruitment and selection by: describing the organisation's aspirations and the behaviours required for a particular role, for example, in a job advertisement and job description; providing criteria to design and assess candidates using competence-based interviews and providing criteria to structure assessment feedback to help describe where people have or have not met the selection criteria (McAllister 1998, Lenburg 1999, Whiddett and Hollyford 2003).

1.11 Self assessment of competence

There is a growing body of anecdotal literature on self assessment in the context of competence determination and development. Self assessment of competence by nurses is linked to the principles of encouraging lifelong learning and self development (Cowan et al 2005). Cowan et al (2008) suggest that the development of lifelong learning has become ingrained in the 'fabric of nursing practice', with self assessment techniques being an essential feature. While acknowledging that there is no gold standard in existence for assessing clinical competence, Watson et al (2002) is of the view that self assessment must form part of an overall assessment and development strategy. In the context of professional practice, registered nurses and midwives are expected to be autonomous reflective practitioners capable of assessing their own performance. Others highlight that the more skilled and autonomous nurses and midwives become the less likely they will be assessed by others, therefore the greater the need for self assessment skill (Gopee 2000).

Benefits of self assessment include: being less costly than other forms of assessment; helps participants to "maintain and improve their practice by identifying strengths and areas that may need to be further developed" and gives individuals "control" over their practice (National Education Framework for Cancer Nursing (EdCan) 2008). Waddell (2001) suggests that self assessment will provide nurses with the opportunity and rationale to request resources to address perceived skill deficits. Gopee (2000) in a discussion paper outlined the benefits of self assessment. These include encouragement of self-development and honesty; encouragement of self-identification of own learning needs and may be less onerous than other more traditional methods.

Self assessment is not without its critics. Potential issues associated with self assessment include subjective nature of self assessment, time constraints, lack of skill to assess their own performance and the tendency for practitioners to rate themselves too harshly or to over inflate their ability (Giroit 1993, Meretoja et al 2004). Bartlett et al's (2000) study, however, suggests that the consistency of competence scores between student and mentors indicates that student practitioners have no false illusions of their ability and are capable of self assessment and identifying areas for improvement.

Despite the EdCan report (2008) suggesting that self-assessment is the most common form of competence assessment, there is a paucity of research studies that explore self assessment in the context of competence development. Apart from three studies that developed a self assessment competence tool and are discussed later (Cowan et al 2007, Goodlin et al 2007, Cowan et al 2008), the current review only identified one study that focused on qualified practitioners' experiences of self assessment. Dellai et al (2009) explored registered nurses' perceptions (n= 10) following the use of the Nurse Competence

Scale (NCS) developed by Meretoja et al (2004). Although some participants expressed a wish for the items within the scale to be more context-specific to their patient group, all indicated that the tool was easy to use and beneficial in identifying areas for further competence development. Some participants commented negatively on the time it took to complete the scale and indicated a lack of confidence with self assessment.

1.12 Development and psychometric testing of tools to support nurses' and midwives' self assessment of performance or competence

The review highlighted a number of studies that reported on the development and psychometric testing of competence assessment tools but nothing that is universally accepted. Indeed, Watson et al (2002) conclude that there is very little in terms of a systematic approach to the development of competence assessment tools. Three of the studies focused on developing tools to assess generic competencies (Schwirian 1978, Meretoja et al 2004, Lui et al 2007). One study focused on competencies for a specific area of practice (Goodlin et al 2007) and another developed a tool to be used across countries by European nurses (Cowan et al 2008, 2007). All of the tools were developed to aid nurses in their self appraisal of competence and they used a variety of different methods such as following a literature review, collaborations with practitioners and experts and/or panel reviews in their development. Similar format, with areas of performance/domains of competence and behavioural indicators being identified were evident within all the tools.

Following review of the literature and consultation with expert nurses Schwirian (1978) developed the Six-Dimension Scale (6 D Scale), which consists of a series of 52 nurse behaviours grouped into six performance subscales: teaching/collaboration, planning/evaluation, interpersonal relations/communications, leadership, critical care, and professional development. Following pilot testing, 587 new nurse graduates used the tool to appraise their performance, using a four point numerical rating scale. Tests for reliability and validity indicated that the tool is a valid and reliable instrument to measure performance. Although the tool was developed to self assess performance, the authors suggest that it may be used by employers or educators to appraise performance. Since then the 6 D Scale has also been tested for validity and reliability in other studies (Bartlett et al. 2000).

Meretoja et al (2004) developed a 73-item Nurse Competence Scale (NCS) for the self assessment of nurses' competence. The tool was developed following a literature review and consultation though the use of semi-structured questionnaires with expert groups involving nurses and managers from all specialities with a hospital in Finland. The items generated from this consultation were reviewed for logical consistency by 12 doctoral students in nursing science, overlapping indicators were deleted. After pilot testing with 30 nurses and nurse managers, psychometric testing was undertaken with 498 nurses working in medical and surgical environments of a hospital. The NCS consists of the following seven categories or domains:

- helping role,
- teaching/coaching,
- diagnostic functioning,

- managing situations,
- therapeutic interventions,
- ensuring quality and
- working role.

Participants were asked to rate their competence using a visual analogue scale from 1 to 100 and to indicate on a four point scale the frequency of using the competencies. Nurses' self assessment indicated a high level of competence across categories and high frequency of use of the competencies. The higher the frequency of using competencies, the higher was the self-assessed level of competence. Age and length of work experience had a positive but not very strong correlation with level of competence. According to the item analysis, the categories of the NCS were found to have good internal consistency. In the final testing phase of the study the NCS was also found to be more sensitive for differentiating nurses on Benner's (1984) novice to expert continuum than the 6 D scale developed by Schwirian in 1978.

Lui et al (2007) developed a 58-item instrument to assess the generic competencies of Chinese registered nurses, using a 5 point Likert scale, in eight subcategories or domains:

- leadership,
- clinical care,
- Interpersonal relationships,
- legal and ethical practice,
- teaching/coaching,
- professional development,
- critical thinking and
- research aptitude.

The methodology used to develop the Competency Inventory for Registered Nurses (CIRN) consisted of two phases; the first involved the identification of critical components of competence, which was done through a combination of open ended questionnaires with a range of Chinese nursing professionals (n=97), consultation with the Chinese nursing regulatory body and an extensive literature review. This phase of development generated 112 items, which were then reviewed by six experts, five within nursing and one doctoral-prepared person in medicine. Following further assessment for appropriateness, clarity and comprehensiveness of items by 12 registered nurses, the CIRN was then tested with a sample of 815 nurses from two University hospitals using a questionnaire. The final instrument demonstrated evidence of internal consistency, reliability, content validity and construct validity. The authors suggest that the CIRN provides an objective tool for assessing registered nurse competencies in the various domains identified and can be used as an assessment and feedback tool by nurses to assess themselves, by managers as part of a performance appraisal or by educators to direct competency development education.

In the US, Goodlin et al (2007), in collaboration with nursing and medical experts, developed a 54 item competence self assessment tool for nurses working with patients who have heart failure (HF). The tool assessed five main areas: assessment, symptom

severity, prognostication, HF management, and palliative care, using Benner's (1984) model of skills acquisition as the framework for assessment judgements. Following piloting the tool was distributed to hospice and palliative care nurses (n=22), advanced practice (HF expert) nurses (n=36) and hospice (novice) nurses (n=85). Findings indicated that participants' self assessment of competence correlated with knowledge scores. The tool also demonstrated the ability to discriminate between novice and experienced HF nurses.

Another study developed a self assessment tool that could be used by nurses across Europe. Cowan et al (2008, 2007) following an extensive review of the literature on generic competencies in nursing and a synthesis of competency statement by 5 partner countries developed the European Healthcare Training and Accreditation Network (EHTAN) questionnaire tool (EQT). The 108 item instrument included behavioural indicators within the following eight domains:

- assessment,
- care delivery,
- communication,
- health promotion and illness
- prevention, personal and professional development,
- professional and ethical practice,
- research and development and
- teamwork.

Competencies were rated by asking post registered nurses to rate on a 4 point scale (ranging from never to always) how frequently they performed each of the listed competencies. The tool was tested for validity and reliability with a convenience sample of 588 post-registration nurses from acute hospital settings in the partnering countries. Psychometric testing deemed the tool to have an acceptable level of reliability, construct validity and content validity (Cowan et al 2008). The authors are currently developing a web version of the EQT. They also highlight the importance of developing and agreeing a working definition of competence, suitable for international utilisation.

Although all the competence assessment tools identified can be regarded as starting points for making judgements on practice and the range of roles and duties competent practitioners can be expected to assume, these studies are not without their critics. Quantitative approaches have been described as reductionist and task oriented, with some authors expressing concern that aspects of competence that cannot be easily measured by quantitative measures, such as compassion, caring and decision making may be overlooked (Barlett et al 2000). In Cowan et al's (2008) opinion this may lead to 'undesirable reductionism, manifested by endless task lists' or behavioural indicators. Cutler (2000) criticises many of these studies for their failure to distinguish between specialist and generic competencies; and for their over reliance on the opinion of expert practitioners and literature rather than observing actual practice or seeking input from patients/clients.

1.13 Direct observation methods

EdCaN in 2008 highlighted several issues in relation to the use of direct observation in the assessment of competence. These include the need for reliability and validity (termed accuracy and consistency), the need for awareness by nurses of the range of variables that can influence competence in the practice setting and the need to consider personal factors in both assessor and the person being assessed.

Other factors that are said to influence and possibly bias direct observation in relation to competence assessment are:

- occupational socialisation,
- familiarity between assessor and the person being assessed,
- nervousness in the person being assessed,
- lack of assessor knowledge or familiarity with competence requirements and
- lack of assessor practice experience (Cowan et al 2005).

In the UK, Fitzpatrick et al (1997) developed and tested the “King’s Performance Scale” to measure clinical performance of senior student nurses. The scale drew heavily on relevant literature, the involvement of expert opinion and the Slater Nursing Competencies Rating Scale (Wandlet and Stewart 1975). The tool consisted of 67 individual items that were clustered under the following seven domains of competence:

- physical,
- psychosocial,
- professional,
- promotion of health and teaching skills,
- care management skills and organisation of workload,
- communication with clients and
- planning and delivery of care.

Bondy’s (1983) five levels of performance were adopted as the rating scale. To test the tool, non participant observation of 99 senior students was undertaken. The authors acknowledged that further refinement of the tool is necessary to enhance validity and reliability and that significant training in non participant observation skills would be needed to use the tool.

In the US, Ramirez et al (2006) developed and tested an 89 item competence assessment instrument for nurses working in emergency settings. The Nurse Practitioner Treatment Competency Instrument (NPTCI) was developed by the researchers following review of other competence documents in the area of family and acute care developed by the National Organisation of Nurse Practitioners Faculties. Similar to other studies the tool consisted of behavioural indicators grouped under the following areas/domains:

- implements clinical treatment plans,
- implements holistic treatment plans,
- incorporates health promotion, prevention and education and
- performance of invasive procedures.

The tool was found to be reliable and valid following analysis of the data received from 582 family, acute care and emergency nurse practitioners but the authors do not report any findings for its use as a self assessment tool.

Kalb et al (2006) described the development of a competence based assessment tool for public health nursing. The competence tool was to function as a component of performance appraisal and replace another tool that managers felt left little room for feedback. Following a review of national guidelines related to Public Health Nursing (PHN) competence and job descriptions, the authors incorporated the following eight domains of competence into the tool:

- assessment,
- policy development/programme planning,
- evaluation,
- communication,
- cultural competence,
- partnership and collaboration,
- health promotion and
- leadership/systems thinking.

The tool was used by supervisors to assess PHN's competence in practice, and each item was weighted according to a numerical rating scale. This rating formed the basis of their ongoing professional development plan, within the performance appraisal model.

Supervisors and nurses in this study found the tool easy to use and it reflected areas of their practice. Supervisors also identified how direct observation provides the opportunity for communication between employee and supervisor.

1.14 Portfolio methods

The portfolio is an increasingly common mechanism for storing information about competence. More commonly used as part of holistic competence assessment in undergraduate students (Endacott et al 2004), its use as an accompaniment to nurses' and midwives' self assessment of competence is gaining popularity (Joyce 2005). The literature is replete with discussions about nurse and midwife portfolios. While at a basic level they are a simple collection of documents that demonstrate learning achievements (Joyce 2005, Hilliard 2006), they provide not only evidence of previous experiences, but can also serve as a dynamic record of personal growth and professional learning (Price 1994). There are accounts of a variety of uses including accreditation of prior learning, developing practice learning and personal and professional development. More recent interpretations suggest that a portfolio is an account of learning based on practice and critical reflection as a record of continuing professional development (Timmins 2008):

"A portfolio is a collection and cohesive account of work based learning that contains relevant evidence from practice and critical reflection on this evidence. Its primary purpose is to display achievement of individual or organisational learning goals and knowledge development" (Timmins 2008)

Emerging firstly within the early 1980s (Cole et al 1995) as a means of demonstrating

evidence of holistic learning achievements for students, professional bodies have now embraced the portfolio and suggest that nurses and midwives maintain and develop a portfolio as part of their professional development (NCNM 2009a). Although the portfolio is not a compulsory requirement of PREP within the UK, it is suggested that a “profile” (a portion of the portfolio) may be requested by the NMC as proof of ongoing continuous professional development. Similarly, in the Republic of Ireland the portfolio is viewed as a mechanism to store and develop evidence of continuous professional development and ongoing work based learning (NCNM 2009a). Nurses and midwives are strongly encouraged to develop and use a portfolio in practice, and several uses for portfolio have been outlined:

- storage of documents,
- demonstration of critical thinking skills,
- demonstration of teaching skills,
- demonstration of learning,
- evidence of continuous practice,
- confirmation of professional development,
- writing a CV,
- reviewing performance,
- career planning,
- personal development planning and
- preparation for promotion (NCNM 2009a).

At ANP/AMP level however, a portfolio is a compulsory requirement in the Republic of Ireland, for accreditation purposes (NCNM 2008b). This latter accreditation was previously within the remit of the National Council for the Professional Development of Nursing and Midwifery but more recently it is operated under the auspices of An Bord Altranais.

Joyce (2005) reported using the portfolio to assess practice based learning in Masters students in the Republic of Ireland. Similarly nurses and midwives can use such a document to store competency information and requirements and outcomes in addition to other relevant personal and professional information. Similarly, in Australia, Mills (2009) described how the portfolio may be a useful mechanism to demonstrate competence, suggesting that it is an important tool: “for nurses to demonstrate their competence against the standards required for licensure”.

Thus, although not explicitly stated for registered nurses (other than the aforementioned ANP/AMP portfolio), the portfolio is a useful mechanism both to store information about competence and to determine competence. It is important that such a portfolio follow an organised structure such as that recommended by the NCNM (2009a), as one criticism of portfolios emerging within the literature is that they can become very unmanageable. Without careful selection of material and organisation it becomes a mere receptacle, termed ‘shopping trolley’ by Endacott et al (2004).

A number of authors have published literature reviews relating to the use of portfolios in nursing education. Specific themes that were explored in McCready’s (2006) review of the

literature regarding competence and nurse education, related to portfolios and the assessment of competence, and issues relating to reliability and validity in portfolio assessment. This author concluded from her review that while portfolio assessment can enhance learning, it was inconclusive whether or not it can measure competence. McMullan et al (2003) produced similar findings following a comprehensive literature review relating to a portfolio as a tool for the assessment of competence in nurse education. Thus a portfolio is a useful adjunct in terms of storage of competency information, and as part component of an holistic assessment of competence. However, evidence of its direct impact or usefulness for self assessment of competence has not yet been fully explored.

1.15 Rating systems for competence assessment

A review of the literature indicated that a number of different types of rating systems have been utilised within competence assessment tools. They include numerical scoring systems, categorical scoring systems, or use of behavioural statements that represent positive/negative indicators of competency. Generally there appears to be an even spread between numerical and categorical systems, with one study reporting the use of positive/negative behavioural statements.

Numerical scoring system

A number of authors used numerical Likert scales, ranging from 4 to 5 points (Schwirian 1978, Tzeng 2004, Liu et al 2007). In addition, many of the authors combined a descriptor to the numerical rating. Tzeng (2004), using the following descriptor: 1-need to strengthen very much, 2-need to strengthen part of the ability, 3-neutral, 4-mostly equipped, 5-completely equipped. Dellai et al (2009) measured level of competence of registered nurses using a visual analogue scale 0-100, where 0-25 indicated very low competence, 25-50 indicated rather average level, 50-75 represented a good level and 75-100 indicates a very good level of competency.

Categorical scoring system

A number of authors (Meretoja et al 2004, Goodlin et al 2007) used Benner's (1984) five level continuum to assess the competence of nurses. Benner (1984) asserts that a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. One study originating in the Republic of Ireland reported assessment of practice in critical care using only three of Benner's (1984) five categories (novice, advanced beginner, competent) (Hanley and Higgins 2005b). These authors reported that inexperienced nurses in their study found Benner's categories a useful yardstick. However, experienced nurses felt they lacked opportunity to record subsequent improvement beyond competent. The authors suggest that omitting the last two categories may act as a de-motivator for learning.

Benner's continuum is also utilised within a number of UK competence frameworks for nurses as a basis for outlining the various levels of practice (RCN 2007, RCN 2009a, 2009b). Each identified competency is subdivided into four levels and given a descriptor, which is aligned to Benner's work. Level one represents basic knowledge and skills through to level four, which represents the highest level of knowledge and skills for the identified competency.

Other categorical scoring systems have been utilised to support the assessment and

learning of nursing and midwifery students, such as Bondy (1983) and Steineker and Bell (1979). Redfern et al (2000) described Bondy's framework (1983) as a *"landmark in the search for valid criteria against which to assess clinical performance of nursing students"*. Bondy (1983) developed a five point competence rating scale; dependant, marginal, assisted, supervised and independent. Within the Steineker and Bell (1979) framework, a student progresses through five taxonomic levels, exposure, participation, identification, internalisation, and dissemination.

Other types of binary competence categories have also been used. The Australian Nursing Federation (2005) competence assessment documentation asks individuals to state whether they are confident that they meet each element of identified competence using two categories, 'yes' or 'no'. An Bord Altranais (2003) within their competency assessment documentation for nurses educated and trained overseas in non-EU Countries included just two categories: 'competent' and 'not competent'.

Positive/negative Indicators

McCarthy and Fitzpatrick (2009) developed a competence framework for nurse managers in the Republic of Ireland which includes examples of effective or ineffective behaviours that an individual can reflect on to ascertain whether or not they are competent. However, the use of this framework to assess the competence of nurse managers has not been published.

1.16 Patient/client involvement in competence assessment

Although very little research exists that measures the effectiveness of patient/client involvement on learning and practice, the consensus view internationally is that it should be encouraged (Livingston and Cooper 2004, Rush and Baker 2006). Within the Republic of Ireland the National Strategy for Service User Involvement in the Health Service 2008-2013 proposes that:

"the service user should be central to their own care and to the design and delivery of health and personal social services" (Health Service Executive 2008).

This refers to user involvement at individual, community and national level. Despite this, a recent review of the literature revealed that there is little evidence of patient involvement in competence assessment of health professionals (Repper and Breeze 2007). In the two cases cited within the review patients/clients were involved in the assessment of students in social work and mental health nursing. Within this review the involvement of patient/clients in the determination of competencies was the exception as opposed to the rule with only one framework being developed in association with patients (RCN 2009a).

Calman (2006), using a grounded theory approach, conducted twenty seven interviews with patients in one teaching hospital in Scotland and identified some issues related to using patient views as a measure of nurse competence. Participants in the study were cautious about their involvement in assessment as they did not see themselves as privy to the full spectrum of the nurses' care delivery and thus considered that they were not well placed to make a sound judgement. They were keen to stress that they could only judge the care that they alone received, and to judge a nurse on one incident or skill would not be a true reflection of their ability.

1.17 Factors influencing competence development among registered nurses and midwives

Two studies were located that have explored factors that influence registered nurses' and midwives' competence development. Khomeiran et al (2006), following interviews with 27 registered nurses in Iran, found that the nurses identified several factors that influenced their ongoing competence. These included:

- experience,
- opportunities,
- clinical environment,
- personal characteristics and
- motivation and theoretical knowledge.

Participants were of the view that repeated practice was essential in gaining expertise in both technical and non technical skills, as were work opportunities that forced them to rely on their own abilities, such as working alone on nights or during a busy shift. In addition, the quality of the learning environment where colleagues challenged and inspired them in a supportive manner facilitated competence development. Data also suggested that the personal characteristics of the individual such as their curiosity, motivation and desire to learn also influenced their competency levels. Hundley et al (2007) explored the views of midwives (n= 72) working in rural and central locations in relation to competence and confidence with respect to core competencies required for intrapartum care.

Midwives in the rural group were more likely to report competence for breech delivery, where midwives in an urban setting report competence in skills such as IV replacement and initial and discharge examination of the new born, suggesting that location and context of practice is an influencing factor on competence development. In relation to CPD, lack of time was a greater barrier for urban midwives whereas distance to training was a greater barrier for rural midwives. Flanagan et al (2000) also acknowledge the importance of providing sufficient time for practitioners to participate in assessment of competence and the need for practitioners to be creative in selecting work related competence development activities and sources of evidence for achievement of competencies. The impact of the environment and the importance of a collegial and supportive learning environment has also been highlighted (Bassendowski and Petrucka 2009). Vandewater (2004) points out that ensuring continued competence development is a shared responsibility of the profession, regulatory bodies, employers and individual nurses and midwives. However, Waddell (2001) stresses that the ultimate responsibility resides with the individual practitioner. In view of the limited research in this area Schroeter (2008) recommends further investigation into the factors that influence competence among registered nurses and midwives

1.18 Conclusion to literature review

The information obtained from this review assisted in informing the development of a toolkit to support nursing and midwifery clinical competence development in the Republic of Ireland. There is increasing recognition of the need for continuous professional development and ongoing competency determination in light of the changing face of

health care, complex caseloads and ongoing technological, population, and therapeutic changes that affect nurses' and midwives' confidence to deliver high quality care. The need for practising nurses and midwives to identify, maintain and update their clinical competence and skills, through continued professional development, has never been greater. In addition to working within a complex clinical or social environment, with high levels of client/patient dependency and acuity, nurses and midwives function within a multifaceted macro environment that is constantly undergoing significant change, requiring major adaptation. Changes in healthcare delivery will see nursing and midwifery at the forefront in managing care in unfamiliar settings and taking on many new roles and responsibilities.

The literature indicates that there are many definitions and interpretations of competency and competence in nursing and midwifery, with resultant confusion emerging regarding consistency of terms used, and consensual definitions. However, more recently a lot of work has been done towards standardised definitions of competence and competency both nationally and internationally. Competence standards recommend expected levels of knowledge, attitudes, skills and behaviours, and many nursing and midwifery regulatory bodies have produced competencies using a variety of different methodologies, in order to ensure that registered nurses and midwives are equipped upon registration with those competencies necessary to continuously ensure the quality and safety of the health care systems in which they work.

Furthermore, literature that explores competence determination and development at a services level was sparse. Similarly, there was little evidence on the effect of competence on service outcome, and no studies emerged evaluating the relationship between competence, patient/client need and clinical outcomes. However, many authors held the view that nursing or midwifery competence is a vital component of effective clinical outcomes, and studies that explored nurses' and midwives' views suggest that they view their ongoing competence to be central to safe, effective patient/client care. Indeed, patient/client safety and effective clinical outcomes lie at the heart of competence determination and assessment. There was little empirical testing of competence or competence frameworks, and little consistency of approaches used either nationally or internationally in competence determination and assessment.

The assessment of competence for nurses and midwives can be undertaken in a variety of ways. Common methods include direct observation and self assessment. Competence assessment needs to include an honest appraisal of individual/group strengths and needs, and provide a basis for individual continuous professional development and that of the team. However, there is very little in terms of a systematic approach to the development of competence assessment tools.

It is understood that competence determination and development may present a challenge in a time-pressured environment. Nursing and midwifery are practice based professions, and in order to facilitate meaningful assessment of competence in the practice environment it is necessary to develop a clear understanding of exactly what is to be assessed. Competence determination needs to be based on agreed definitions and frameworks, underpinned by evidence based practice and local patient/client needs. Competence determination can follow agreed frameworks, or be adapted for use locally as needs arise or in accordance with stakeholder views. Future recommendations include actively involving nurses and midwives from all practice areas in decisions about professional competence

determination within their own practice settings. Also, for true collaboration in the determination of competencies for clinical practice, a variety of sources need to be incorporated into the competency determination process. These may include relevant stakeholders from education, regulatory bodies, nurses/midwives, associations and consumers in identifying core competency expectations.

1.19 Outcome of the grey literature review

Of the fourteen responses received, three services offered assistance in relation to care plans and needs analysis but had not developed competence documentation. Of the remaining eleven, ten provided examples of competency assessment documentation that they had developed locally and one NMPDU forwarded a public health nursing research report which included a section on future competence development for public health nurses.

The competence assessment documentation provided had a number of similar characteristics and format. The general format included an information pack for practitioners, which included an explanation of the purpose of the documentation and directions for completion. The competencies were then listed together with the assessment strategy to be used. The majority of the documentation related to students or induction competencies for newly qualified staff. In all cases the assessment section of the documentation involved a process of self assessment by the practitioner/student followed by assessment/review/validation by an assessor, generally a senior nurse or midwife.

The vast majority of the competencies addressed within the documentation related to adult nursing with a small number focusing on areas of children's nursing and midwifery. Competencies were generally grouped within specialties or departments such as surgical nursing competencies, operating theatre competencies, peritoneal dialysis competencies, or perineal repair competencies. The majority of competencies identified included specific performance criteria or critical elements to be used in making a judgement. While eight of the ten submissions included the An Bord Altranais definition of competency and six referred to the domains of competence (ABA 2005a), only four integrated the domains of competence within their assessment document.

A number of numerical and categorical rating scales were used to inform the assessment process. Benner's (1984) novice to expert continuum was used in three documents. In others, Benner's (1984) continuum was modified, for example, to include a numerical rating in each category (the novice category was scored as 1-2 where as the expert practitioner category included a numerical score of 9-10). Another document used Steineker and Bell's (1979) framework. Some used two levels to assess competence, for example: 'competency achieved' or 'competency not achieved'. Others used various types of Likert rating scales ranging from five points to three points, with some combining a numerical score and a statement, the rating scale below is an example:

- 1 = no knowledge/experience
- 2 = some knowledge/experience
- 3 = competent
- 4 = competent with additional experience
- 5 = competent, experienced and able to teach others

The importance of reflection as a self assessment process was discussed in three documents, one document described a model of reflection and another source asked practitioners to complete a questionnaire to assist them to reflect on their practice before completing the competence assessment documentation

All documents included competence development sheets for practitioners to complete, which included a section to record any supportive evidence to validate their learning. However, only four provided examples of accepted methods of competence development activities. The activities identified are outlined in Table 2.

Table 2: Competence development activities



- | | | |
|-------------------------------|----------------------|--------------------------|
| • Document review | • Study days | • Critical reflection |
| • Observation in a skills lab | • Clinical visits | • Portfolio |
| • Observation in practice | • Conference/seminar | • Clinical demonstration |
| • Discussion | • Reading log | • Questions and answers |
| | • Journal club | |

The procedure or process used to identify the clinical competencies was not outlined in any of the documents; however, those involved in the process were indicated in some. The main people involved in collaborative efforts appeared to be: senior and experienced nurses, members of nurse practice development units, relevant nurse/midwife managers and physicians. All of the sources included a review period for the competencies developed to be evaluated. It is important to acknowledge that the above description is just an examination of the documentation that the research team received.

Chapter Two

Methodology used to evaluate the toolkit

2.1 Introduction

Within this chapter an overview of the methodology used to develop and pilot the toolkit is provided. Information on the team involved in developing the toolkit, pilot sites, access, ethics, sample, the pilot study, data collection and data analysis are provided.

2.2 Development of the draft toolkit document

The draft toolkit was developed by a collaborative team from clinical practice in selected sites and academic colleagues. The clinical team represented nurses and midwives from Director/Assistant Director, Nursing and Midwifery Practice Development, Clinical Specialists, and Staff Nurse/Midwife grade. The initial team members represented midwifery, general (including nurses working in palliative care), intellectual disability, mental health, children's and public health nursing. Prison nurses and nurses working with older people were subsequently invited to join the team.

The review of literature and websites did not yield any example of a toolkit. Therefore a toolkit was developed by the team through consultation during meetings and email communication. Monthly meetings were held with the full project team, including the clinical staff involved in the project. These meetings were very helpful and productive in providing rich and insightful ideas for the toolkit. They also generated immense synergy between the clinical and academic environment and helped to ensure that the toolkit reflected the needs of clinical staff. The clinical team were involved in providing ongoing feedback on each stage of development of the toolkit through email communication. A subgroup of the team, including members of the clinical team met monthly with the NCNM Steering Committee. A full list of the team members who contributed to the development of the draft toolkit is included in Appendix 2.

The draft toolkit was informed by the literature and builds upon current frameworks for nurses' and midwives' competence (ABA 2005a, 2005b, 2010, NCNM 2008a, 2008b), and other documents published by the National Council for the Professional Development of Nursing and Midwifery (NCNM 2009a, 2009b). The draft toolkit included a variety of clinical scenarios, case study examples and templates of documentation. The overall introduction to the toolkit emphasised its relevance and utility and provided a colour coded guide to ease navigation to the relevant sections. The draft toolkit was divided into the following sections:

- **Competency Determination for Service Need**
- **Writing Competencies and Behavioural indicators**
- **Competency Development Planning and Competency Assessment Processes**
- **Competence Frameworks in Nursing and Midwifery**

2.3 Recruiting sites to pilot the toolkit

The original tender proposal indicated that 14 sites would be recruited to represent midwifery, general (including nurses working in palliative care), intellectual disability, mental health, children's and public health nursing. In total, 18 sites around the country were recruited to test the toolkit. Unfortunately, two sites subsequently withdrew; one due to the short time frame required for ethical approval, and a second site withdrew due to workload demands. Approval for access was granted by the Director of Nursing and/or Director of Midwifery in the remaining 16 sites (see Appendix 2 for list of sites and clinical lead in each site). Ethical approval was granted from the Faculty of Health Sciences Ethics Committee in Trinity College, Dublin and the local research ethics committees for the services involved.

2.4 Methodology

The evaluation employed a mixed-method approach using quantitative and qualitative approaches. Data were collected using a questionnaire and focus group interviews.

Questionnaires were completed by a purposive sample of registered nurses or midwives from all areas of practice following review and use of the toolkit. The questionnaire was developed by the clinical and academic team, and consisted of both closed Likert-style questions and an open response section (Appendix 3). The information gathered in these questionnaires sought experiences of using competencies, opinions on the structure, content, relevance and utility of the toolkit, plus feedback on using the tools provided within the toolkit. Participants were also given the opportunity to provide opinions on how to improve the toolkit in an open response section and a section on demographics was also included.

In addition, a series of focus group interviews (n = 6-12 participants) was undertaken in the 7 sites represented on the original research team. Focus group interviews enabled the researchers to explore participants' perceptions of the toolkit and discuss in greater detail areas for change and improvement. A semi-structured interview schedule developed by the team was used to guide the discussion (Appendix 4). The schedule addressed the areas of relevance, credibility, readability, helpfulness, and user friendliness.

2.5 Recruiting participants

Following ethical approval from the sites information packs were provided to the 16 clinical leads for distribution within their site. The information pack, developed by the clinical and academic team, enclosed an invitation to take part in the survey, outlined the purpose of the study and detailed the nature of participation. In seven of the sites an invitation to take part in a focus group was also included. Participants who wished to take part in the study informed the clinical lead in person or by returning an opt-in form.

2.6 Sample

Participants who were willing to participate in a focus group indicated this wish by returning an opt-in form. A purposive sample of 455 registered nurses or midwives, to ensure representation of discipline, profession, grade and area of practice, were recruited to participate in the survey aspect of the pilot (Table 3).

Table 3: Study sample

Children's	General	Midwifery	Intellectual disability	Mental Health	Public Health	Prison services	Care of the older person	Total
45	170	80	20	75	20	30	15	455

To ensure representation of grade a purposive sample of registered nurses or midwives were invited to each focus group. The draft toolkit and questionnaire was distributed by the clinical lead to each participant who indicated a willingness to participate. Due to time demands participants were given only 2 weeks to review the toolkit and return the survey in the envelope provided to the clinical lead. In total 62 people were invited and agreed to participate in the focus groups. As an incentive to take part in the pilot of the toolkit and increase the response rate participants' names were entered into a draw for four prizes.

2.7 Response rate and profile of survey participants

In total 208¹ questionnaires were returned representing 46% of the total number distributed. All sites involved returned some surveys. Table 4 gives the overall breakdown of responses.

Table 4: Response sample

Children's	General	Midwifery	Intellectual disability	Mental Health	Public Health	Prison services	Care of the older person	Site not known	Total
19	63	48	11	28	8	16	11	4	208

Professional group

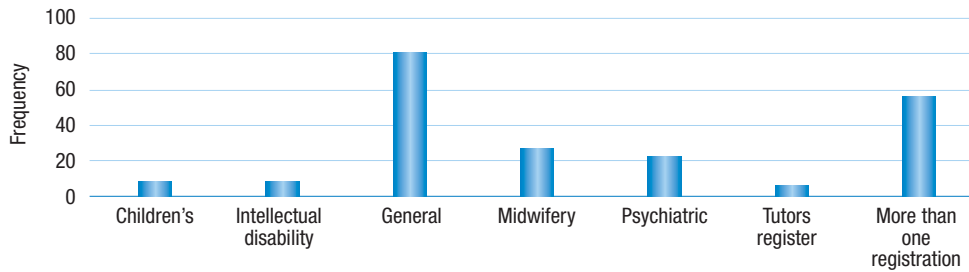
Participants were asked to indicate to what professional group they belonged. A total of 150 (72%) of 201 participants who responded to this question indicated that their profession was a nurse, 42 (20%) ticked the midwifery category and 9 (4%) ticked both the nurse and midwife categories. Seven (3%) did not respond to this question.

Professional registrations

Participants were also asked to indicate what divisions of ABA register they were registered on. Of the 202 participants who answered this question, 147 (71%) indicated that they were registered on only one division and 55 (26%) registered on more than one division. Of the 147 participants registered on one division, a total of 81 (39%) respondents had a general registration, 25 (12%) had midwifery registrations, 21 (10%) had psychiatric registrations, 8 (4%) had children's registrations, 8 (4%) had intellectual disability registrations and 4 (2%) were registered on the tutor's register. (NB: The four respondents on the tutor's register did not indicate what other division they were registered on; judging by their responses to other questions it seems they also had general registrations). A total of six (3%) did not respond to this question (Figure 1).

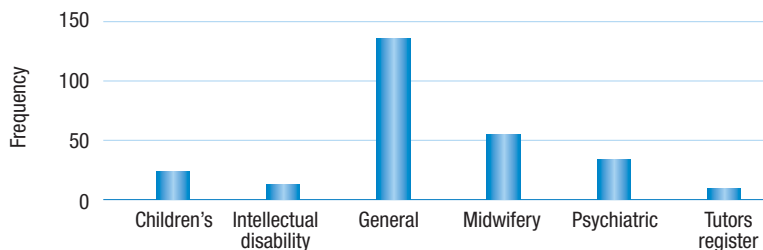
¹ Seventeen surveys were received after the closing date and were not included in the final analysis, but participants were entered in the draw.

Figure 1: Registrations on one or more divisions



Of the participants who indicated that they were registered on more than one division of the register, registrations were split across general, midwifery, psychiatric, children's and intellectual disability. When the responses were analysed there were a total of 257 registrations held. Over half of participants (52%, n=132) held a general nursing registration, 53 (21%) held midwifery registrations, 31 (12%) held psychiatric registrations, 22 (9%) held children's registrations, 11 (4%) held intellectual disability registrations and 7 (3%) were registered on the tutor's division of the register (Figure 2).

Figure 2: Total number who were registered on each division



Current Grade

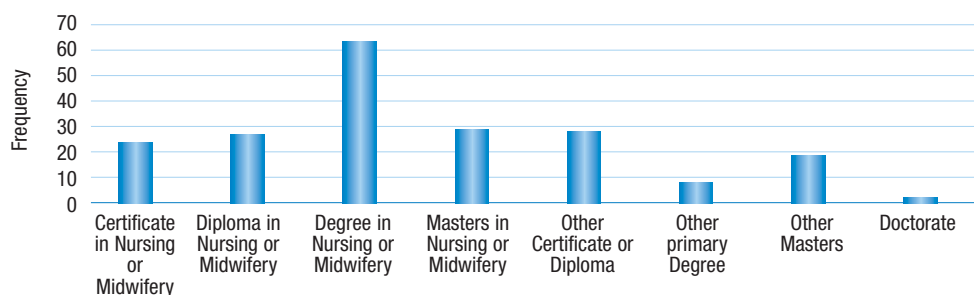
Out of 199 participants who indicated their current grade, a total of 68 (33%) were CNM/CMMs, 62 (30%) were staff nurses or midwives, 4 (2%) were public health nurses and 2 (1%) were community nurses. Seventeen (8%) of the participants were clinical facilitators/clinical placement coordinators or some other educational role and 6 (3%) were practice development coordinators. Seventeen (8%) participants were in senior management positions: 13 (6%) were ADoN/ADoM/ or ADPHNs and 4 (2%) were DoN/DoMs. Clinical specialist roles were also included: 18 (9%) were CNS/CMSs and 5 (2%) were ANP/AMP grades. Nine (4%) did not respond to this question (Table 5).

Table 5: Current grade

Grade	Frequency	Percentage
CNM/CMM	68	33%
Staff Nurse or Midwife	62	30%
CNS/CMS	18	9%
Clinical facilitator/ placement coordinator or other area of education	17	8%
ADoN/ADoM/ADPHN	13	6%
Nurse or Midwife Practice Development Coordinator	6	3%
ANP/AMP	5	2%
DoN/DoM	4	2%
Public Health Nurse	4	2%
Community Nurses	2	1%

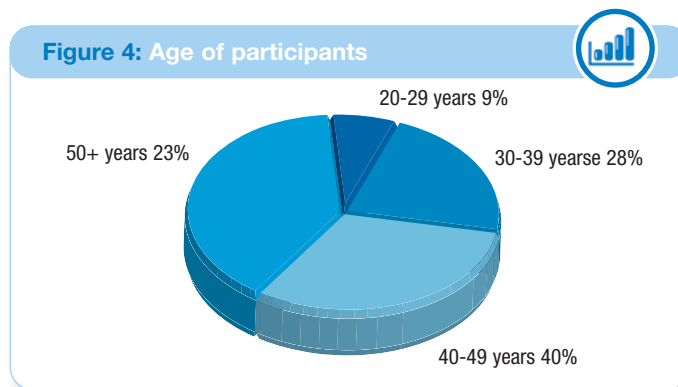
Highest Qualification

Of the 202 respondents to the question of their highest qualification, 63 (30%) had a degree in nursing or midwifery, 28 (13%) had a diploma in nursing or midwifery, 28 (13%) had a masters in nursing or midwifery, 28 (13%) had some other diploma or certificate, 25 (12%) had a certificate in nursing or midwifery, 19 (9%) had some other masters, 9 (4%) had some other primary degree and 2 (1%) had a doctorate. A total of 6 (3%) did not respond (Figure 3).

Figure 3: Highest qualification

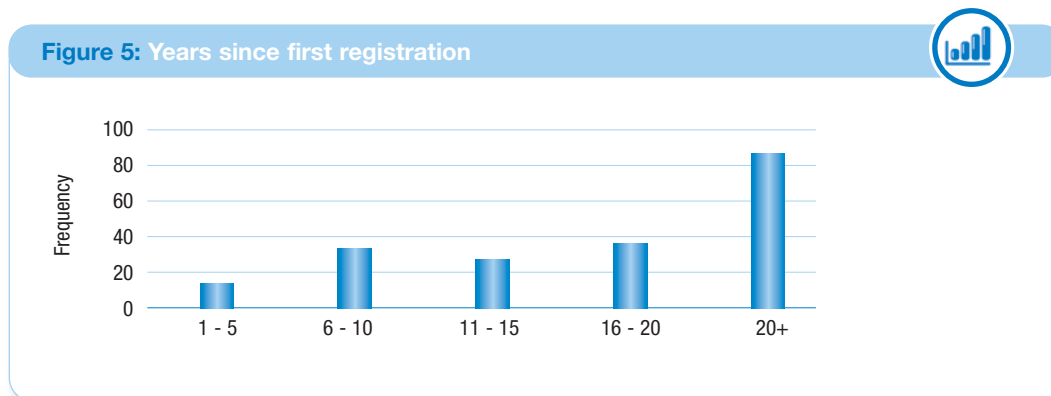
Age

Respondents to the questionnaire were asked which of the following age brackets they fell into; 20-29 yrs, 30-39 yrs, 40-49 yrs or 50+ yrs. Of the 203 responses, 81 (40%) were between the ages of 40 and 49, 57 (28%) were between the ages of 30 and 39, 47 (23%) were over the age of 50 and 18 (9%) were between the ages of 20 and 29. A total of 5 (2%) did not respond (Figure 4).



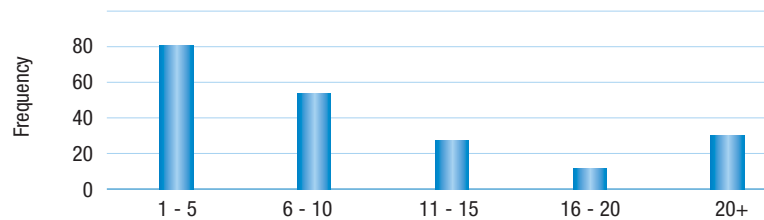
Years since first registration and working in current area

Out of 200 participants who indicated the duration since first registration, the highest number were registered over 20 years ($n=88$, 42%), 38 (18%) were registered between 16-20 years, 27 (13%) were registered between 11-15 years and 34 (16%) were registered between 6-10 years. The smallest number of participants ($n=13$, 6%) were registered between 1-5 years. Eight participants (4%) did not respond to the question (Figure 5).



Of the 202 participants who responded to the question on how long they had been working in their current area: 79 (38%) said 1-5 years, 55 (26%) had been working 6-10 years in their current area; 29 (14%) had been working for 11-15 years; 29 (14%) had been working for over 20 years in their current area; and 10 (5%) had been working for 16-20 years in their current area. Six (3%) did not respond to this question (Figure 6).

Figure 6: Years in current area



Country most studied in

Of the 202 participants who responded to the question on where they completed most of their nursing or midwifery education, the majority (n=162, 80%) indicated Ireland. A total of 29 (14%) completed their studies in the UK, 3 (1%) completed their studies in the Philippines, 3 (2%) completed their studies in India, 2 (1%) completed their studies in Australia and 1 each (0.5%) completed their studies in the USA, Poland and South Africa.

2.8 Response rate and profile of focus group participants

In total, 45 people (73% response rate) participated in the six focus group interviews (the children's and general nursing groups requested to combine into one joint group). Attendance varied between 5 and 12 participants in each group, with a variety of grades represented. Table 6 provides an overview of the profile of the participants in the focus groups. The average duration of the focus group was 50 minutes, the range was 38-70 minutes.

Table 6: Profile of group participants



Focus Group	Number of participants	Grade
Midwifery	10 invited, 9 attended	DoN/M (1), ADoN/M (1), CMM (3) Staff Midwife (2) Midwifery Practice Development (1), CPC (1)
Intellectual Disability	8 invited, 7 attended	CNM (3), Staff Nurse (2), Nursing Practice Development (1), CPC (1)
Public Health	7 invited, 6 attended	DPHN (1), PHNs (3), Community Nurses (2)
General Nursing	10 invited, 6 attended	ADoN (1), CNM (1), CNS (3), Staff Nurse (1)
Psychiatric Nursing	10 invited, 5 attended	CNM (1), CNS (2), Staff Nurse (1), CPC (1)
Children's and General Nursing	17 invited, 12 attended	CNM (5) Staff Nurse (2) ANP (1), CPC (1), Clinical Facilitator (2), ADoN (1)

Each focus group was facilitated by two members of the research team, the clinical lead within the site and an academic member of the research team. One person acted as a facilitator with primary responsibility to ensure a flow of discussion and the other person acted as the moderator, taking notes and supporting the facilitator.

2.9 Data analysis

Quantitative data were entered into the Statistical Package for the Social Sciences version 16 (SPSS) for analysis. Both descriptive and inferential statistics were generated.

All focus group interviews were audio recorded, however, due to time constraints they were not transcribed prior to analysis. Analysis of the focus group interviews was completed using a combination of written notes taken by the facilitator and moderator during the focus group interview and listening to the recordings immediately for emerging themes. Selective transcription of the emerging themes from each focus group was completed by the facilitator and returned to the moderator for confirmation that all the emerging issues were captured. Following completion of analysis for all focus groups the themes were compared across the groups and merged as appropriate.

2.10 Ethical approval and participants' rights

Ethical approval was granted from the Faculty of Health Sciences Ethics Committee in Trinity College Dublin. In addition, application was also made to each local research ethics committee for the services involved. A small number of services accepted the ethical approval granted from the Faculty of Health Sciences Ethics Committee.

The rights and dignity of participants were respected throughout by adherence to models of good practice related to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice. An initial letter and information brochure was given to all potential participants, seeking their support and informing them of the purpose, process, potential benefits and harms, data collection procedures, time commitment, voluntary nature of participation, the right to withdraw, confidentiality, contact details for additional information and an offer to answer any questions. Return of the anonymous questionnaires was taken as consent for that aspect of the study. Prior to conducting the focus group interview, written consent to participate and permission to tape record the interview was obtained from each participant.

Participants were reassured that information that might identify them would not be used in any presentation or publication resulting from the study. They were also reassured that their non-participation in the evaluation would not jeopardise them in any way. Permission to acknowledge the clinical leads and the sites involved, in the final report, was granted by all the services.

Chapter Three

Findings from the survey

3.1 Introduction

Within this chapter an overview of the findings from the questionnaire is provided. Findings from the closed Likert-style questions are reported first and this is followed with a discussion of the responses to the questions posed in the open response section of the survey.

3.2 Findings from the quantitative aspect of survey

The questionnaire distributed was designed to elicit information on participants' prior familiarity and experience of competence determination and assessment, impact of toolkit on knowledge, views on readability, clarity and assembly of the toolkit, usefulness of tasks and case studies, desire for further information and support to use the toolkit and general overall approval. Participants were asked to indicate their level of agreement with a number of statements in each category on a five point Likert scale ranging from *Strongly Agree* to *Strongly Disagree*.

Prior familiarity with central concepts

Participants were asked to indicate their familiarity with five central concepts involved in the area of competence determination and assessment, and their personal familiarity with using competencies as a basis for service development planning, prior to reading the toolkit. The topics asked reflected the main content of the toolkit. In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16, and a *Cronbach's Alpha* of 0.839 was obtained. This represents a high level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing extensive prior knowledge of the main topics and 5 representing little or no prior knowledge, the average score of the participants was 57.5. This means that the majority of participants had some prior familiarity with competencies and related topics.

The questions asked and percentages of each response given can be seen in Table 7 with the highest percentage response for each question highlighted in bold. The results suggest that although a high proportion of participants were familiar with the majority of the concepts, a substantial minority (25%) were unfamiliar with using competencies as a basis for service development planning. In addition, for none of the questions was "strongly agree" given the respondents' highest percentage response.

Table 7: Prior familiarity with concepts



Prior to using this toolkit I was familiar with...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
Competencies	46%	50%	2%	1%	1%
Competence Framework	29%	46%	16%	5%	4%
Domains of Competence	38%	41%	14%	6%	1%
Self-Assessment of Competence	26%	52%	13%	7%	2%
Behavioural Indicators	17%	40%	27%	10%	5%
Using competencies as a basis for service development planning	16%	37%	22%	18%	7%
Using competencies as a basis for personal development planning	28%	48%	12%	8%	4%

Prior experience of competence determination and assessment

The next series of questions was asked to ascertain a person's prior experience of competence determinations and competency assessment. The participants were asked to indicate whether they *Strongly Agreed*, *Agreed*, were *Unsure*, *Disagreed* or *Strongly Disagreed* with each statement claiming prior experience of each area of competence determination and assessment. In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.729 was obtained. This represents an acceptable level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing extensive prior experience of competence determination and assessment and 1 representing little or no prior experience, the average score of the participants was 52.37. This means that the participants were split fairly evenly among those who had prior experience of competence determination and assessment and those who did not. The questions asked and percentages of each response given can be seen in Table 8. These results indicate that the majority (82%) had been involved in formal assessment of the competence of student nurses or midwives and some had been involved in competence assessment for service roles or other registered nurses or midwives. A substantial minority, however (43%), had never completed a self-assessment of their own competence (Table 8).

Table 8: Prior experience



Prior to using this toolkit...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
I was involved in the process of determining competencies for a service/role	28%	29%	10%	18%	15%
I had completed a self-assessment of my own competence	26%	26%	5%	29%	14%
I was involved in formal assessment of the competence of other registered nurses or midwives	32%	36%	0.5%	16%	15%
I was involved in formal assessment of the competence of student nurses or midwives	50%	32%	3%	9%	7%

Impact of toolkit on knowledge

A number of questions were asked to identify whether or not participants' knowledge of competences had increased after reading the toolkit. The participants were asked to indicate whether they *Strongly Agreed*, *Agreed*, were *Unsure*, *Disagreed* or *Strongly Disagreed* with each statement related to improved knowledge. In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.928 was obtained. This represents a very high level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing high levels of improved knowledge and 1 representing knowledge not improved at all, the average score of the participants was 61.41. This means that the majority of participants felt that the toolkit had increased their knowledge (Table 9).

Table 9: Impact of toolkit on knowledge



With regards to outcome...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
The toolkit increased my knowledge of the concept of competence	32%	54%	7%	7%	0%
The toolkit increased my knowledge of competence frameworks	30%	54%	9%	6%	1%
The toolkit increased my knowledge of competence determination	27%	60%	9%	3%	1%
The toolkit increased my knowledge of competence assessment	28%	57%	7%	7%	1%
The toolkit increased my knowledge of personal development planning	27%	58%	7%	7%	1%

Readability and clarity of toolkit

With regards to the structure of the toolkit, a number of questions were asked to check for clarity and ease of navigation. The participants were asked to indicate whether they *Strongly Agreed*, *Agreed*, were *Unsure*, *Disagreed* or *Strongly Disagreed* with each statement related to clarity of structure. In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.875 was obtained. This represents a high level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing extremely clear and easy to use and 1 representing very unclear and difficult to use, the average score of the participants was 59.78. This means that the majority of participants felt that the toolkit was clear and easy to use. The questions asked and percentages of each response given can be seen in Table 10 below.

Table 10: Readability and clarity of structure



With regards to the structure of the competency toolkit...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
The toolkit looks attractive/appealing	29%	54%	11%	6%	1%
Explanations within the toolkit are clear	21%	68%	6%	5%	0%
The toolkit is easy to read	26%	52%	12%	9%	1%
The toolkit is easy to understand	22%	57%	11%	9%	2%
The depth of content is sufficient	26%	60%	11%	3%	0%
The content is sequenced in an orderly manner	25%	63%	8%	3%	2%
The toolkit is easy to navigate	19 %	58%	16%	5%	2%

Usefulness of content

A set of six questions was asked to ascertain the usefulness of the examples and tasks within the toolkit. In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.839 was obtained. This represents a high level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing extremely useful examples and tasks and 1 representing useless examples and tasks, the average score of the participants was 65.69. This means that the majority of participants felt that the content of the toolkit is useful. The questions asked and percentages of each response given can be seen in Table 11 below. None of the participants expressed the view that the templates provided were not useful.

Table 11: Usefulness of content



With regards to the content and tasks within the competency toolkit	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
The tasks required within the toolkit are clearly outlined	21%	66%	10%	2%	1%
The case studies are helpful	52%	40%	5%	1%	2%
The toolkit is appropriate to my role/grade	32%	53%	13%	2%	1%
The templates provided are useful	39%	54%	6%	0%	0%
The clinical examples provided are useful	51%	44%	4%	1%	1%
The content is up to date	43%	51%	5%	0%	1%

Poorly assembled

With regards to the structure of the toolkit, a number of questions were asked to check whether or not participants thought the toolkit to be poorly put together. In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.512 was obtained. This represents a low level of internal consistency indicating that the items may not form a scale. Although this level of *Cronbach's Alpha* is outside the range of usability, we will nevertheless report the results of the scale as a benchmark for further analysis. From this we find that on a scale of 1 to 100, 100 representing extremely poorly assembled and 1 representing very well assembled, the average score of the participants was 31.89. This means that the majority of participants felt that the toolkit was well assembled. However, 14% of the participants agreed that the toolkit was confusing, 30% thought it was repetitive, and 37% considered it to be bulky. The questions asked and percentages of each response given can be seen in Table 12 below.

Table 12: Poorly assembled



With regards to the structure of the competency toolkit...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
The toolkit is confusing	2%	13%	9%	50%	27%
The content is repetitive	7%	23%	16%	45%	9%
The toolkit is bulky	11%	26%	14%	40%	10%

Information on use and further support required

The next set of questions was asked to determine whether or not there was sufficient information given on the use of toolkit and if any additional instruction is required. The participants were asked to indicate whether they *Strongly Agreed*, *Agreed*, were *Unsure*, *Disagreed* or *Strongly Disagreed* with each statement related to information given and further support. The questions asked and percentages of each response given can be seen in Table 13 below.

Table 13: Information and further support



With regards to the information received on using the competency toolkit...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
I expected to find more information in the toolkit	2%	11%	18%	48%	21%
I believe that more written instructions within the pack on the use of the toolkit is required	4%	17%	17%	47%	14%
I believe that additional one-to-one instruction on the use of the toolkit is required	15%	28%	21%	29%	7%
I believe that additional group instruction (in the form of a study day) on the use of the toolkit is required	25%	46%	14%	13%	4%
I believe that more support within the organisation is required when using the toolkit	27%	51%	12%	8%	1%
I believe that more support from colleagues is needed when using the toolkit	24%	50%	18%	7%	1%

In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.7 was obtained. This represents an acceptable level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing further instructions required and 1 representing no further instructions required, the average score of the participants was 44.67. This means that the participants were split fairly evenly on whether further instructions and support are required. From the results presented in Table 13, it would appear that the first two items regarding the need for more information and written instructions in the toolkit were disagreed with, and for the third item re additional one-to-one instruction, opinion was split fairly evenly. Agreement was strongest for the last three items regarding the need for more support and group instruction within the organisation.

General approval of the toolkit

The next set of questions was asked to examine participants' overall feelings on the future of the toolkit and whether or not they approve of it. The participants were asked to indicate

whether they *Strongly Agreed*, *Agreed*, were *Unsure*, *Disagreed* or *Strongly Disagreed* with each statement related to general approval. The questions asked and percentages of each response given can be seen in Table 14 below.

Table 14: General approval



With regards to outcome...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
I believe that using this toolkit will be useful to assess my own competence and identify my learning needs	34%	53%	12%	2%	0%
My motivation towards competence assessment and development has improved since reading this toolkit	27%	47%	16%	10%	1%
I would recommend the toolkit to other nurses/midwives	35%	51%	11%	3%	0%

In order to measure the internal consistency of this scale, the variables were analysed with SPSS 16 and a *Cronbach's Alpha* of 0.753 was obtained. This represents an acceptable level of internal consistency. From this we find that on a scale of 1 to 100, 100 representing high levels of general approval and 1 representing low levels, the average score of the participants was 61.3. This means that the majority of participants generally approved of the toolkit. A large percentage of participants (87%) agreed that the toolkit was useful in identifying learning needs and the assessment of competence. A similar number (86%) indicated that they would recommend the toolkit to other nurses and midwives.

Questionnaire participants were not asked if they believed that the toolkit would be useful to assist them in determining competencies based on service need. Its benefits, however, in this area was reflected in the responses in the open section of the questionnaire and within the focus groups.

Miscellaneous

A number of other questions were asked which do not fit readily into any of the sub-scales above; it was therefore not appropriate to conduct measures of internal consistency. From Table 15 below it can be seen that participants were generally of the view that the toolkit related well to other Irish publications (84% agreement), represented their discipline adequately (70% agreement), and is emerging at the right time (70% agreement).

Table 15: Miscellaneous questions



With regards to the toolkit...	Strongly Agree	Agree	Unsure	Disagree	Disagree Strongly
The toolkit relates to other publications about competence published in Ireland	30%	54%	15%	1%	1%
I believe this toolkit is emerging at the right time	32%	38%	23%	7%	1%
My discipline was adequately represented in the toolkit	31%	39%	14%	13%	3%

3.3 Findings from the qualitative aspect of survey

At the end of the survey participants were invited to add comments about three areas: ways of improving the toolkit, main challenges to its use and what they considered were the benefits of using the toolkit.

The main issue that participants raised in response to the question on ways of improving the toolkit was the size. Numerous people requested that it be made more concise. Separating the sub-sections into individual booklets was suggested both for ease of use and as a way of removing the daunting appearance of the single large toolkit. Many people commented favourably on the examples and case studies and suggested including more, especially examples that related to their own speciality or area of practice. To give the toolkit prominence and get 'buy-in' a number of participants suggested a group discussion or one hour instructional input to launch the toolkit. Other suggestions included: a short summary of each chapter, perhaps bullet points to be included in a prominent position for quick reference; greater linkage between Figure 1 in the introduction and the subsequent case study; and removing technical or academic wording. One participant with dyslexia found the white lettering in the coloured boxes *"most annoying and difficult to see"*.

In relation to the main challenges to its use, time constraints were by far the most frequently mentioned challenge for example, *"Staff are already overworked and motivating buy-in would be difficult"* especially *"at a time when time constraints impact on all work practices"*. Others felt that some *"staff may be defensive"* or feel *"challenged and threatened"* by a language of competence and competence assessment. Fear of change was also cited as a possible challenge to its use, with *"some feeling that they may not measure up"*. Others were of the view that *"competence assessment in Ireland is decades overdue"*. Some participants suggested that although the toolkit *"is not mandatory to complete, it would benefit from being incorporated into hospital policies to encourage its use"*. Others commented on the need for *"support within their organisation and protected time"*. The education gap between apprentice trained staff and degree/diploma students was also cited as a possible challenge. The older generation of nursing/midwifery staff were

considered to be “not as familiar with the concept of self-assessment”.

Despite the concerns expressed many commented on the professional benefits of using the toolkit. These included:

- provide clarity and focus in identifying needs and planning a service,
- improving patient care and the preparation of new services,
- assisting with continuing professional development,
- allowing for audit and positive feedback,
- encouraging staff to be more reflective and
- having consistency across hospitals.

Other participants commented on the personal benefit they achieved from using the toolkit as part of the pilot. In relation to providing clarity and focus in identifying competencies based on service needs, the following are some of the written comments:

‘A structured approach to determine goals, plans and action to improve services and a clear pathway to help staff identify competencies to meet needs’

‘Good preparation for new services and assessment of needs’

‘The toolkit provides a building block for planning services, it is clearly organised in easy to read language. The tools and concepts to meet service needs are clearly written’.

‘I will now feel competent to become involved in the process of determining competencies for a service role’

‘It will help to identify specific needs within my area and the steps I can take to develop a plan to ensure staff competency in these areas’

Other comments included:

‘Personal competency development is easier to articulate and negotiate with manager and clinical colleagues’

‘I feel that it will help me enormously with updating my portfolio’

‘I am better able to identify gaps in my own knowledge and skills base using the toolkit and now having a planning process and development plan to develop the competencies required in my area of practice’

‘I feel I am more inclined to reflect on my own practice and I am more self-aware of areas I need to personally develop in’

‘It improved my confidence in my current abilities and encouraged me to become competent in other areas’

‘Excellent piece of work-lifts standards and raises the bar professionally’

3.4 Summary

The findings from the survey suggest that the majority of the participants were familiar with some concepts associated with competence. However, a substantial minority were unfamiliar with using competencies as a basis for service development planning or had never completed a self assessment of their own competence. Participants were strongly in

agreement that reading the toolkit and participating in the activities increased their knowledge and motivation towards competence assessment and development. Overall participants were of the view that the content was relevant, user-friendly and up to date. The majority of participants felt that the toolkit was well assembled. The major criticism was the size, and repetition within the toolkit. Numerous people requested that it be made more concise. Separating the sub-sections into individual booklets was suggested both for ease of use and as a way of removing the daunting appearance of the single large toolkit. Many people commented favourably on the examples and case studies and suggested including more of them, especially examples that related to their own speciality or area of practice. Many commented on the professional benefits of using the toolkit, these included:

- provide clarity and focus in identifying needs and planning a service,
- improving patient care and the preparation of new services,
- assisting with continuing professional development,
- allowing for audit and positive feedback and
- encouraging staff to be more reflective.

Chapter Four

Findings from the focus groups

4.1 Introduction

This chapter provides an overview of the findings from the focus group interviews. A list of modifications made to the toolkit as a result of the feedback from both the survey and focus groups is included at the end of the chapter.

4.2 Findings from the focus groups

Overall, participants were very positive about the toolkit and welcomed its introduction. They were of the view that it was both a timely and important document in moving the competence agenda forward. They also complemented the NCNM for their vision and willingness to develop it in collaboration with the clinical areas.

'I actually think that something being developed that is inclusive of the people that are using it, getting their view is very positive, I think that is important that opinions are heard... up to now documents just appear with no input.' (FG 3)

Some participants commented on how pleasing it was to have an “Irish” product, for once.

'It referred to Bord Altranais and the MidU study...it made local sense...you felt it was Irish.' (FG 5)

Despite the fact that participants considered the timeframe too short for the pilot phase, overall, the findings concurred with the positive survey results. Participants were of the view that the toolkit was beneficial at a number of different levels:

Simplifies the process of competence determination

Firstly, participants were of the view that it simplified the process of competence determination and development, put structure on the process, and demystified some of the language.

'It puts structure on the process of what to do and how to go about things.' (FG 2)

'It gave a really structured process on how, if you were planning a new service...it was just so detailed, what we need to do...the process was so clearly outlined for us, I thought it was excellent.' (FG 5)

'To do all that is required (determine competencies) is a massive job, a massive amount of work in identifying the competencies [for a service], it is that aspect that I feel it is really helpful...it provides a guide.' (FG1)

'If someone says where are you going [with competencies], it is clear, there in front of you, what you need to do.' (FG 3)

Some participants welcomed the fact that language was explained in a simplified manner.

'It explains the terminology, competencies, behaviours and indicators really well, the three different ways to assess competency was helpful.' (FG 2)

'I felt there was really good clarity and it was concise.' (FG 6)

'This brought the whole area of competency down to a level that we could all understand.' (FG 5)

Participants who had been involved previously in the process of competence development were of the view that the toolkit would be helpful to people new to the process.

'As a person involved in developing competencies, if I had this at the beginning it would have really helped me..., it brings everything together.' (FG2)

'We designed competencies for staff nurses a number of years ago and, had we had this tool, it would have made life a lot easier for us...it was reassuring to see that we followed a very similar format...we would have been delighted with it, had it been available at the time.' (FG 4)

Situates competencies within the wider context

Participants commented on the helpfulness of the document at a strategic level. In particular they commented on its usefulness for service development and service planning.

'The emphasis on service development is very good... it put all the work on competencies within a wider organisational framework and service need, what is good for the patient, what do we need to do to meet the needs of the patient... also see how it relates to multidisciplinary team competency ...what the patient wants is to know people have the knowledge and skills to do the job.' (FG 2)

'In the [names services] we are in a state of flux, things are changing rapidly, something like this would be very beneficial to help us ask questions about where services are going and what competencies are needed.' (FG1)

'I liked the emphasis on service development, the bigger picture, starting from that perspective was very helpful to me as a manager, as a manager the emphasis on the service is helpful.' (FG2)

'I think it is good from a service planning point of view, I think it guides your practice in a way.' (FG 6)

Some participants were of the view that the document would assist in shifting thinking from the individual practitioner level of competence determination and development to team and service need.

'People often think of competencies at an individual level and don't think where they sit in service needs.' (FG1)

'You can use it at a most basic level, if you're newly qualified, or if you are planning a new service, that is the beauty of the document.' (FG 5)

'It's good let's say for self evaluation, but also I think for teams to evaluate each other. I think it could be very useful to reflect on each other's competencies, you could use it in that way.' (FG 6)

Others commented on its usefulness in getting people to consider the importance of relating any competencies developed to existing nursing and midwifery professional frameworks.

'The emphasis on relating competency development to the frameworks for nursing is important, I think there is no point in developing competencies if we don't relate back and integrate with the domains ,... need to relate everything back to them in a unified way.' (FG2)

'... you have to have the domains to write a competency... it is important to hitch competencies to professional frameworks.' (FG 2)

'I thought it drew your attention too to the decision-making framework within our scope of practice and sometimes we forget about those tools.' (FG 6)

Some considered it as a document that would trigger a much needed dialogue on competence development and assessment within the professions.

'It will open up a huge debate on competencies and competency assessment ... there is a huge opportunity to build on this ... build on the ideas of assessment, who should assess, how often should people be assessed ...so I hope that doesn't get lost.' (FG 2)

'You could use it in conjunction with professional development planning... acknowledging achieved competencies.' (FG 4)

'Even though I said some negative things, I think it is important and it will be an important document for the future... a opportunity to say what it is we do and look for opportunities to develop.' (FG 3)

Emphasis on continuous professional development: A positive

Participants in all groups and at all levels commented favourably on the emphasis on continuous professional development, and the role of the toolkit in helping them focus on their own practice.

'I like the idea of competency and helping me to look at my own practice... I would have looked around for years in relation to my own area and tried to find competencies but hard to find, so like the idea of a guide to help develop competencies.' (FG 3)

'I think it would be good for induction onto a new ward...staff coming into a different area.' (FG 4)

'Certainly when I was doing the management part it would guide me in certain directions and areas that I would need to improve on myself.' (FG 6)

Other commented on the usefulness of the document to people who were qualified for a period of time or moving to a new role or area of practice.

'I think for people who are longer qualified it will be good, as it will get them to think about their practice...you can be qualified for a long time but change where you work and may need to develop your skills.' (FG 3)

'I feel it made me think about my own competency, and as I say if I went into different areas or if a new role was developed within my area, I would have to question myself, you know, what knowledge I have, and you know an update I'd have to do.' (FG 6)

Overall, the introduction of this toolkit was viewed as a positive encouragement for improvement.

'It's not punitive, and it's giving people a chance to...set their objectives and they can get there.' (FG 5)

'It'll be very good for staff that are on development plans...if everyone's doing it, (people on) staff development plans won't be so scared....' (FG 5)

'I think it would be excellent for our junior [names discipline] nurses coming out.... because here you have clearly marked out the evidence that's required and where they can find this evidence to achieve your goals for yourself and I found that really good.' (FG 6)

'.. sometimes people they might be in an area for a long long time and then they might think I don't mind moving and they can feel so much pressure. ... but this will put it in concrete for them so it is not seen as a threat...' (FG 6)

Others, in particular those in managerial positions, regarded it as a useful tool to assist in practice development, performance review and in identifying those who might need some assistance to develop their roles.

'You could use it for people that would underperform on the ward.' (FG 4)

'Does the document do anything for the person who's not performing?...the purpose of any competency document is to manage the staff who are not performing as well as to encourage those who are... consistent failure to perform has to lead to (some action).' (FG 5)

'.. what I would hope.., that we just don't participate in this and then it's a report that we leave on the shelf, that we put it to use. When we're doing the PMD, setting it up next year, I'll use this to guide me'. (FG 6)

Relevance and focus on staff nurses/midwives

There were mixed views on its relevance to nurses and midwives working at a staff grade. Some participants were of the view that the document was aimed at the managerial grade and service development, whereas others were of the view that it was focused toward staff grade but positioned individual competence within team and service competencies. This view was summed up by one participant who described the toolkit as a 'two tier system.'

'I see it as a two tiered system, once the competencies are developed, the staff nurses will then dip into it and use it to help them self assess and plan development.' (FG1)

Participants who were not as involved at managerial level spoke positively about the self assessment section and its importance for continuous development and portfolio development for the individual practitioner.

'I liked a lot the section on self assessment, it will be very useful and once the competencies are defined I think people will use it more.' (FG1)

'It is a tool to help me assess myself, I like that section a lot' (FG1)

'It is good for professional development and for maintaining portfolios.' (FG 2)

'I think that people who are 20 years qualified can say 'I need to develop this area of my practice.' I think the opportunity to approach someone and say 'I need help in this area' is positive, not negative.' (FG 3)

'It's not that you're fail or just at pass level...to see that there is progression...you can't be an expert at everything.' (FG 5)

'...it would motivate you to look at your own practice.' (FG 6)

Competence determination and development: A daunting task

Despite the positive comments about the toolkit there was a view that the whole process of competence determination and development could be a very 'daunting' for staff, especially those who were not as familiar with competence determination, development and assessment.

'I am working in an environment where we are achieving a Nursing Practice Development Unit, so we are working on personnel development planning and improving our own practice, if you are not working at the level it will be daunting for people, very daunting.' (FG1)

'I know I said it could be daunting, overwhelming but it is also comprehensive for those who have not done competencies before... we are used to them but if you weren't it would be helpful.' (FG2)

However, some felt that, with continued use, the task would become easier.

'I think it's going to be one of those things that's going to be daunting the first time...but it won't be as daunting to come back to, and that's where the benefit will be.' (FG 5)

The complexity of the task required for competence determination at a service, team and individual level was reflected in people's comments on the amount of information within the document and the need to read the whole document more than once to become familiar with all the ideas presented.

'The more you read it, the easier it gets.' (FG 5)

'You need all the elements... you need to read it all to get the overall picture' (FG1)

'I would advise people to read it all.' (FG 6)

The document was considered as a resource that people would return to at different times and one that they would dip into depending on which phase or stage of the competence determination and development process they were at.

'It is something you will have to come back to at different times' (FG2)

'I think that every time you go through it you will get different things from it' (FG1)

'I think it is useful for building on what you already have from previous training and work, but I think it would also be very useful for newly qualified, for initial induction, and then we could go back to it a few months later, it will guide me because I learnt a lot.' (FG 6)

Constraints within practice: Barriers to use

During the focus group participants commented on the numerous constraints within the practice environment that might impact on the clinician's ability to engage fully with the process described within the toolkit. Participants were of the view that getting 'buy-in' from staff was going to be a challenge.

'Bringing it in is fantastic...but...it would be a big change...getting them (staff) on board could be very hard.' (FG 4)

Participants were concerned that competing workload demands within practice and not having sufficient time to engage in the process would hamper its introduction.

'I think it will be used more by managers, Directors of Nursing and people in practice development, I see a real need for it for management, but people on the ground with time

constraints [they] will not have the time' (FG1)

'Given time constraints will it be more paperwork that never gets looked at' (FG 2)

Others were concerned about the amount of paperwork required.

'There is a concern, is this just more paperwork? ... the importance of having time to do this, to identify competencies and assess' (FG 3)

'I would worry that we will just write the competencies and they will be in a book until we are being reviewed... don't see them from one year to the next' (FG 2)

There were mixed reactions to the language of competencies and behavioural indicators. Some people commented on the technical nature of the language.

'I think the language of behavioural indicators is off putting, it put me off...so I found that difficult...' (FG 3)

Participants who were longer qualified tended to see the language as new and sometimes off putting. More recently qualified participants were of the opposite opinion, having grown up with this language embedded within their education and training programmes. This difference of opinion is reflected in the following quotes:

'I suppose for some of us [longer qualified] it is a lack of familiarity with the language, so we need to get used to that...' (FG 2)

'I am just 3 years qualified so I found it easy to follow as we were looking at behavioural indicators all the time, so I see them as what you see... what are the evidence based interventions that you do...then using them to reflect on your own competency your own practice and what do I need to do to improve...' (FG 3)

'The use of the domains and all would not have been used in my training ... student nurses it would make more sense to them but for ordinary people who wouldn't have done courses in a long time I think they would have been lost with some of the wording they really wouldn't know what you are talking about, but it was really very good like the explanations.' (FG 6)

Relevance and user friendliness of the content: Areas for improvement

Overall participants were of the view that all the information within the toolkit was relevant and important. In particular participants liked the case studies and the colour coding system.

'The case studies are very good ... brings everything together and you can relate to your area of practice' (FG 2)

'The case studies are important... the graphs as well, instead of reading pages and pages they are helpful, and the examples of action plans' (FG 3)

'The introduction is well explained, why we would use the toolkit and why it would be relevant to our practice' (FG 6)

'I liked the examples... things that put it into practice...I like how it was broken down into colour, the boxes with examples...helped to put it into perspective' (FG 3)

'I liked the colour coding of the sections, it makes it easy to follow... you can go to the section you want' (FG 1)

'I suppose the fact that it was colour coded, after reading it straight away you could go to

whatever section you liked, it was nice to be able to go to the one that was relevant.' (FG 6)

Others felt that the document was user friendly and non-prescriptive.

'The different scales the toolkit advises, it doesn't stick to one scale, which is very good.'
(FG 4)

'It has managed not to be too prescriptive, while giving good guidance.' (FG 4)

'Services are left to choose what is best for them ... not every context is the same.' (FG 2)

Many of the participants commented on the size of the document, and worried that the 'bulkiness' may put people off using it.

'It is very bulky and could be off-putting so need to see if it can be made smaller, reduced, without losing the ideas' (FG 2)

When asked what needed to be removed it was clear that participants considered that all areas were relevant. As the discussion progressed within the focus groups participants expressed a wish for other additions, such as examples of 'non technical competencies' and examples to demonstrate how to link competencies to professional frameworks and competence domains already in existence. The following are some comments:

'I think it is an opportunity to look at the non technical competencies, decision making, team work, and leadership ... the examples are very technical and I would like a non technical example ... they are hard to identify and assess but others are doing it and we need to take the challenge.' (FG 2)

'I think you need an example in the last section [framework]' (FG 5)

Other suggestions related to the inclusion of more case studies to represent their discipline, although some participants felt that there was good representation already.

'Intellectual Disability Nursing is not represented well enough. It needs more to reflect the core of ID clinical nursing' (FG1)

'That's brilliant to see because usually for nurse/midwife...we see minimal stuff for midwifery and lots for nursing...to have so much midwifery in it was really, really good...there's stuff in there for mental health, ID, children's and of course general...' (FG 5)

'Most of them (examples) were ward based, from an inclusion perspective from public health nursing there wasn't anything there.' (FG 6)

When asked how the toolkit could be improved a number of recommendations were made. Overall participants were of the view that the introduction section needed to be reduced, as did the introductions to each subsequent section.

'Try and reduce the introduction... don't need the 2 examples... page 4 and 6' (FG 2)

'The introduction part needs to be much shorter, the figure on where to go needs to come much earlier, so rather than trawling through 2 pages put that first, as you could very well be put off by the long introduction... don't have it unwieldy' (FG 3)

Others were of the view that more information on the concept of competencies or a definition needed to come earlier. The following are indicative of some of the comments made:

'If you are reading the green section, you are a little in the dark without some reference to what competence is, need to put something about competence into the beginning' (FG1)

'Need something on competence at the beginning of the green section to help the logical flow' (FG1)

Other suggestions were:

'Put more on needs assessment for those who don't know about a needs assessment of the service' (FG 2)

'Maybe some advice on how to audit your competencies...?' (FG 4)

'Could you concisely name those four sections?... (on Figure 2)...two words, like, 'service need'...(FG 5)

When participants were asked about the tools and templates they made some recommendations for improving.

'I think you need some more prompting in the task tools, so it saves me having to go back (into the document). When I was using them I had to keep going back...you address all the issues in the sections but need to put more directions into the tasks sections' (FG1)

'Could you put a short example on the template on page 43?' (FG 5)

'Need to review to ensure the traffic light system is not confusing' (FG1)

'Need more specific directions and more explanation and cues in what to do in the tools as some are a bit vague' (FG 2)

'I just thought in page 47 the competency development planning process, I just wonder would it be an idea to put step 1, step 2, that correspond to the steps to make it easier to read.' (FG 6)

One group recommended the inclusion of another assessment framework and another mentioned including some discussion on the frequency of competence assessment.

'Need to include Steineker and Bell's framework, as people will be familiar with that, services use that for students' (FG1)

'Is there a need to put in and discuss assessment and how often people should be assessed, annually or less frequently....also how often should I self assess myself... how many chances do you give someone before enough is enough' (FG 2)

Divided views and mixed opinions

Within the focus groups there were divided views on a number of issues. The following is indicative of the type of conversation that occurred in many of the focus groups.

Speaker 1: *'I thought the green bit was a little bit full-on...I had to read it a second time.'*

Speaker 2: *'I absolutely LOVED the green section, that was my favourite.'*

Chorus: *'...yeah, yeah (laughter).'*

Speaker 3: *'That was mine as well, because that was the service need bit...'*

Speaker 4: *'The green part prepared me to read the rest of it, it gives you the language.'*
(FG 5)

There was divided opinion between where to place the section on competence frameworks, some were of the view that it should come at the beginning, whereas others were of the

opinion that it would put people off if that section came first. This difference of opinion is captured in the following:

Speaker 1: *'I think the framework part should have come first, with description and information on competencies, it should be chapter 2, after introduction...'*

Speaker 2: *'I disagree that the framework part comes first, if I read that first it would have put me off.'* (FG 2)

Speaker 1: *'I think the purple section on frameworks needs to come first, as it is the macro view and you need the macro at the front.'*

Speaker 2: *'I think the purple section (frameworks) needs to stay where it is... If you want to read that section you can go to it.'* (FG 3)

Similarly there were divided views regarding the positioning of the templates within the document. Some favouring their inclusion in a section as an appendix, while others wanted them left within their relevant section.

'The templates need to be in the relevant section, you need to have them with what you are reading and doing at that time.' (FG 3)

'Put templates at the back in the appendix.' (FG 2)

'I like the idea that they stand alone as chapters (with the templates included).' (FG 4)

'I like that the templates are colour coded but you could put them together at the end.' (FG 6)

'I would rather have the templates after the chapter I've read because I do things after I have read about them, but it really comes down to the individual in the end, you know it depends on how you learn and how you do things really doesn't it.' (FG 6)

Some were of the view that it should be published in individual sections whereas others wanted it published as a complete document.

'I suggest that it comes in sections and people only have the sections that are relevant to them.' (FG 3)

'I think it needs to be one document... I would like the whole thing.' (FG 2)

Mandatory competency development

Participants in one focus group expressed their concerns and fears around competence development being changed from a voluntary process to something mandatory.

'One of the concerns will be will it become law, will it be tied up with your registration every year...how will it be monitored... another thing that we are not doing... these are some of the concerns I have heard around...it might affect your registration.' (FG 3)

Some participants supported the idea of mandatory competence assessment by another person.

'I don't know how anybody can judge their own competence by themselves; it has to be someone else that does that if there is a question mark over somebody's competence. I think the people who wouldn't want to be involved with this would need to have their competence assessed.' (FG 6)

In the event of mandatory competence assessment becoming a reality, participants stressed

the importance of managerial support.

'If it does become compulsorily and mandatory, it's important that at managerial level we get the support to develop our skills.' (FG 3)

Recommendations for the future

Although participants were of the view that the toolkit provided sufficient information and guidance to enable staff to work through the document and determine and assess competencies at a service, team and individual level, they did make a number of recommendations for how the toolkit should be introduced into the organisation. These recommendations were about generating interest in competency development and increasing staff commitment, buy-in and motivation.

In keeping with the findings of the survey, participants in the focus groups were of the view that some form of orientation would be helpful.

'I think a group session when it is introduced, to get people started.' (FG 3)

'We could do with a 2 hour study to introduce it, get people motivated.' (FG 2)

'This is such a valuable document it would be worth putting that resource and national support in place...run (national) workshops...' (FG 5)

Some participants recommended that a special interest group be formed in each service to support the process of competence determination and development, and stressed the importance of managerial support in the identification of competencies at service level.

'I think this is excellent opportunity and wonder will there be a special interest group formed afterwards to advance this in every area, I think that will be important.' (FG 3)

'Unless you get the buy-in from the senior establishment from the beginning and they are identifying the competencies needed, from the top down it needs to happen... getting the whole thing to match service development and the individual nurse.' (FG 3)

Although the toolkit is aimed at nurses and midwives, participants were of the view that it was important to involve other members of the multidisciplinary team in the process.

'I think it would be important if we are doing this ...to invite other disciplines, such as occupational therapy and physios, not immediately until we are familiar with it ourselves, but that would be important because the concept of teamwork competence comes up when you read information on Primary Health Care.' (FG 6)

Others suggested that the NCNM needed to plan their introduction of the toolkit in a phased format.

'The National Council need to plan their publication... this is about introduction of change, so need to be saying to people 'have you thought about competency?'... building people up before they publish so they don't put people off... if it is not introduced properly people will run from it.' (FG 3)

4.3 Summary

Overall the feedback from the focus groups was very positive and in keeping with the findings from the survey. Participants welcomed the introduction of a toolkit that simplified the process of competence determination and assessment and demystified some of the language. They were of the view that the toolkit provided them with an accessible step by step resource to support competence determination and assessment at service, team and individual level. Participants commented favourably on the emphasis on continuous professional development and the positive tone around improvement within the document.

While there were mixed views around the sequencing of information, participants were very positive about the usefulness of the information provided, especially the case studies, examples of competencies and templates, and believed that they helped ground the concepts in the reality of practice.

Despite the positive comments some participants were of the view that competence determination and assessment could be a daunting task for some staff, and that competing demands on people's time could negatively impact on people's willingness and motivation to engage with the process. The usefulness of the toolkit to guide the writing of competencies also became evident after the pilot phase, as some services used it as a guide to write competencies and behavioural indicators for inclusion with the toolkit. The example within the toolkit on relating competencies developed to existing frameworks was also developed by participants from one of the sites. To protect the anonymity of sites some minor modifications were made to the competencies and behaviour indicators submitted.

4.4 Modifications to the toolkit in light of feedback

To improve the toolkit, participants put forward a number of recommendations regarding content and structure. Following discussion with the NCNM it was decided not to change the sequence of the document or the location of the templates. The following modifications, however, were made to the toolkit in response to the recommendations of the participants:

- The toolkit was edited to reduce any unnecessary repetition.
- The toolkit was reviewed to ensure adequate representation of all the disciplines.
- An example of a competency and behavioural indicator for a less technical skill was included.
- An example of how a competency might be linked to the core competence framework produced by An Bord Altranais was included in the section on competence frameworks.
- The case study in the introduction was linked to each colour coded section in Figure 3.
- Definition of competence, competency and competencies was included earlier within the document.
- The introductory sections were revised and reduced.
- The tools and templates at the end of each section were reviewed and clearer guidelines given on their use.
- A short section on how often an assessment of competencies should be carried out was included.

- Steineker and Bell's taxonomy was included.
- The toolkit was reviewed in light of the guidelines on dyslexia.

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Appendix 1

Services that submitted examples of competency development activities

Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Adelaide and Meath Hospital, incorporating the National Children's Hospital, Dublin

St James's Hospital, Dublin

Roscommon County Hospital

Waterford Regional Hospital

Connolly Hospital, Blanchardstown, Dublin

Mental Health Services, Dublin South East

Cork University Hospital

South Tipperary General Hospital, Clonmel

Waterford Institute of Technology

Mid-Western Regional Hospital, Dooradoyle, Limerick

Mayo General Hospital

Ballyshannon, Co. Donegal, HSE West - NMPDU

HSE Dublin North- NMPDU

Appendix 2

Clinical sites and clinical leads

Site	Discipline	Clinical Lead
The Children's University Hospital Temple Street Dublin 1	Children's	Caroline O'Connor Nursing Practice Development
The Adelaide and Meath Hospitals Incorporating The National Children's Hospital (AMNCH) Tallaght Dublin 20	Children's	Rachel Howe Clinical Facilitator Child Health
The Adelaide and Meath Hospitals Incorporating The National Children's Hospital (AMNCH) Tallaght Dublin 20	General	Phillippa Ryan Withero Acting Nurse Practice Development Advisor Elizabeth O'Neill Acting Clinical Nurse Manager
St James Hospital Dublin 8	General	Sandra Delamere ANP
St Francis Hospice Station Road Raheny Dublin 5	General	Kevin Connaire Director of Education
Galway University Hospital Newcastle Road Galway City	General	Edel Mannion Nursing Practice Development Hannah Kent Practice Development Coordinator
Mayo General Hospital Westport Road Castlebar Mayo	General	Justin Kerr Assistant Director of Nursing

Site	Discipline	Clinical Lead
COPE Foundation Bonnington Montenotte Cork	Intellectual Disability	Deirdre Burns Early Intervention Team Leader
St Patricks University Hospital James Street Dublin 8	Mental Health	Toni O'Connor ANP Eating Disorders
MHS, Dublin South West HSE Dublin Mid-Leinster 2nd Floor, Block E Westland Park Nangor Rd, Dublin 12	Mental Health	Martina McGuinness Nurse Practice Development Co-ordinator
Coombe Women's Hospital Dublin 8	Midwifery	Angela Dunne Divisional Director
Our Lady of Lourdes Hospital Drogheda	Midwifery	Miriam Kelly, Midwifery Practice Development Co-ordinator
Area 3 Dublin South West Dublin South City 21/25 Lord Edward Street Dublin 2	PHN	Julie Lynch Director of Public Health Nursing
Area 5 HSE Dublin West Public Health Nursing Dept. Local Health Office Area Dublin West Cherry Orchard Hospital Ballyfermot, Dublin 10	PHN	Anne Lynott Acting Director Public Health Nursing
St Mary's Hospital Phoenix Park Dublin 20	General and care of the older person	Michelle Russell Assistant Director of Nursing- Nurse Practice Development Co-ordinator
Irish Prison Service Irish Prison Service HQ	General and Mental Health Nursing	Frances Nangle-Connor Director of Nursing

Appendix 3

Toolkit evaluation questionnaire

INTRODUCTION

Thank you very much for agreeing to be part of this study, funded by the National Council for the Professional Development of Nursing and Midwifery (NCNM), to test the draft toolkit developed to support nurse and midwife clinical competency development. To assist us, we would like you to read the document enclosed and complete the questionnaire. Your responses will enable the research team to modify the toolkit and provide a final version to the NCNM.

Time taken to read the toolkit will vary and will depend on peoples' previous knowledge and experience in competency development. The survey, however, usually takes about 10-15 minutes to complete. Anonymity and confidentiality are guaranteed. Participation is entirely voluntary. Completion and return of the questionnaire is interpreted as consent to participate.

The study is being undertaken in order to find out your views on the Competency Toolkit. Please circle the number which most corresponds to **your level of agreement** with these statements (**see answer guide**).

Answer guide:

- 1 = Strongly Agree
- 2 = Agree
- 3 = Unsure
- 4 = Disagree
- 5 = Strongly Disagree
- 6 = Not Applicable

Please 'tick' which sections you reviewed and are commenting on. We would appreciate you assessing as many as you can.

☐	Blue- Introduction
☐	Green - Competency Determination for service need
☐	Orange - Identifying and writing competencies for practice
☐	Red - Competency development planning and assessment for the individual nurse or midwife
☐	Purple - Competency frameworks in Nursing and Midwifery

Section 1 – Please indicate whether you Strongly Agree (1), Agree (2), are Unsure (3), Disagree (4) or Strongly Disagree (5) with each statement below, by circling the appropriate number. Please indicate (6) if not applicable.

Prior to using this toolkit I was familiar with:													
1. Competences	1	2	3	4	5	6	2. Competency framework	1	2	3	4	5	6
3. Domains of competence	1	2	3	4	5	6	4. Self-assessment of competence	1	2	3	4	5	6
5. Behavioural indicators	1	2	3	4	5	6	6. Using competencies as a basis for service development planning	1	2	3	4	5	6
7. Using competencies as a basis for personal development planning	1	2	3	4	5	6							

Prior to using this toolkit:													
8. I was involved in the process of determining competencies for a service/ role	1	2	3	4	5	6	9. I had completed a self assessment of my own competence	1	2	3	4	5	6
10. I was involved in formal assessment of the competence of other registered nurses or midwives	1	2	3	4	5	6	11. I was involved in formal assessment of the competence of student nurses or midwives	1	2	3	4	5	6

Section 2 – Please indicate whether you Strongly Agree (1), Agree (2), are Unsure (3), Disagree (4) or Strongly Disagree (5) with each statement below, by circling the appropriate number. Please indicate (6) if not applicable.

With regard to the <i>structure</i> of the competency toolkit:													
12. The toolkit looks attractive/appealing	1	2	3	4	5	6	13. Explanations within the toolkit are clear	1	2	3	4	5	6
14. The toolkit is easy to read	1	2	3	4	5	6	15. The toolkit is easy to understand	1	2	3	4	5	6
16. The toolkit relates to other publications about competence published in Ireland	1	2	3	4	5	6	17. The toolkit is confusing	1	2	3	4	5	6
18. The depth of content is sufficient	1	2	3	4	5	6	19. The content is sequenced in an orderly manner	1	2	3	4	5	6
20. The content is repetitive	1	2	3	4	5	6	21. The toolkit is bulky	1	2	3	4	5	6
22. I expected to find more information in the toolkit	1	2	3	4	5	6	23. The toolkit is easy to navigate	1	2	3	4	5	6

With regard to the <i>content and tasks</i> within the competency toolkit:													
24. The tasks required within the toolkit are clearly outlined	1	2	3	4	5	6	25. The case studies are helpful	1	2	3	4	5	6
26. The toolkit is appropriate to my role/grade	1	2	3	4	5	6	27. The templates provided are useful	1	2	3	4	5	6
28. The clinical examples provided are useful	1	2	3	4	5	6	29. The content is up to date	1	2	3	4	5	6

Please indicate whether you Strongly Agree (1), Agree (2), are Unsure (3), Disagree (4) or Strongly Disagree (5) with each statement below, by circling the appropriate number. Please indicate (6) if not applicable.

With regard to outcome:													
30. The toolkit increased my knowledge of the concept of <i>competence</i>	1	2	3	4	5	6	31. The toolkit increased my knowledge of <i>competence frameworks</i>	1	2	3	4	5	6
32. The toolkit increased my knowledge of <i>competence determination</i>	1	2	3	4	5	6	33. The toolkit increased my knowledge of <i>competence assessment</i>	1	2	3	4	5	6
34. The toolkit increased my knowledge of <i>personal development planning</i>	1	2	3	4	5	6	35. I believe that this toolkit is emerging at the right time	1	2	3	4	5	6
36. My motivation towards competence assessment and development has improved since reading this toolkit	1	2	3	4	5	6	37. I believe that using this toolkit will be useful to assess my own competence and identify my learning needs	1	2	3	4	5	6
38. I would recommend the toolkit to other nurses/ midwives	1	2	3	4	5	6	39. My discipline/ profession was adequately represented in the toolkit	1	2	3	4	5	6

With regard to the <i>information</i> received on using the competency toolkit:													
40. I received sufficient written instruction , within the pack on the use of the toolkit	1	2	3	4	5	6	41. I believe that more written instruction within the pack on the use of the toolkit is required	1	2	3	4	5	6
42. I believe that additional one-to-one instruction on the use of the toolkit is required	1	2	3	4	5	6	43. I believe that additional group instruction (in the form of a study day) on the use of the toolkit is required	1	2	3	4	5	6
44. I believe that more support within the organisation is required when using the toolkit	1	2	3	4	5	6	45. I believe that more support from colleagues is needed when using the toolkit	1	2	3	4	5	6

Section 3 - Comments

This section concerns any other information that you may view as pertinent to the study. Please write your views on using the toolkit in the boxes provided.

46. Please list, in rank order, three things that you think would improve the toolkit.

1.

2.

3.

47. What do you see as the main challenges to the use of the toolkit in its current form?

48. What professional benefits do you feel you will have from using the toolkit?

49. Please provide any other comments you would like to make or examples from practice that you think we should include in the next edition.

Section 4 Demographics

Please tick the appropriate box below (tick ONE box per question only)

1 – Age

20-29 yrs	☐
30-39 yrs	☐
40-49 yrs	☐
50+ yrs	☐

2 – Profession

Nurse	☐
Midwife	☐
Other (please specify)	☐

3 – Registration

Children's	☐
Intellectual disability	☐
General	☐
Midwifery	☐
Psychiatric	☐
Tutors register	☐

4 – Years since FIRST registration as a nurse/midwife

1-5	☐
6-10	☐
11-15	☐
16-20	☐
20+	☐

5 – Years working in your CURRENT area as a nurse or midwife

1-5	☐
6-10	☐
11-15	☐
16-20	☐
20+	☐

6 – What is your HIGHEST qualification?

Certificate in Nursing or Midwifery	☐
Nursing or Midwifery Diploma	☐
Nursing or Midwifery Degree	☐
Masters in Nursing or Midwifery	☐
Other Certificate	☐
Other Diploma	☐
Other Primary Degree	☐
Other Master	☐

7 – In which country have you done most of your nursing or midwifery studies?

Republic of Ireland	☐
UK	☐
USA	☐
The Philippines	☐
India	☐
China	☐
Australia	☐
Poland	☐
Nigeria	☐
South Africa	☐
Other (please specify)	☐

8 – Please indicate your current grade

Staff Nurse or Midwife	☐
CNM/CMM 1	☐
CNM/CMM 2	☐
CNM/CMM 3	☐
CNS/CMS	☐
ANP/AMP	☐
ADoN/ADoM	☐
DoN/DoM	☐
Clinical Facilitator / Clinical Placement Coordinator	☐
Nurse or Midwife Practice Development Coordinator	☐
Public Health Nurse	☐
Other (please specify)	☐

9-Please indicate your main area of practice and tick the title that best represents your current work location.

A – General nursing

Medical	☐
Surgical	☐
Community	☐
Oncology	☐
Critical care (CCU/ ITU/ A&E)	☐
Sexual Health	☐
Older person	☐
Outpatients	☐
Theatre	☐
Prison service	☐
Case load holder with responsibility for older persons	☐
Other (please specify)	☐

B – Midwifery

Antenatal	☐
Postnatal	☐
Delivery	☐
Community	☐
Theatre	☐
All areas	☐
Other (please specify)	☐

C – Children's nursing

Medical	☐
Surgical	☐
Community	☐
Oncology	☐
Critical care (CCU/ ITU/ A&E)	☐
Outpatients	☐
Theatre	☐
Prison service	☐
Other (please specify)	☐

D – Mental health nursing

Community based Day Services	☐
Residential Facilities	☐
Community Mental Health Team	☐
Primary care	☐
Other (please specify)	☐

E – Intellectual disability nursing

Residential Services	☐
Daycare service	☐
Community residence	☐
Community nursing	☐
Other (please specify)	☐

Thank you for taking the time to complete this questionnaire. Your participation in this study is valued highly.

Appendix 4

Interview guide

Development, testing and evaluation of a toolkit to support nurse and midwife clinical competency development

SCHEDULE OF TOPICS

Preamble to the interview

- Welcome and review the research purpose.
- Discuss the research interview, timing (40 minutes) and outcome and answer any participant questions.
- Complete participant consent form.
- Seek permission to record the interview and demonstrate how to turn off the recording device.

Opening Question

What are your views on the toolkit?

- The purpose of this interview is to explore your views of the toolkit that you have completed, to see if we could improve it in any way.
- I am interested in your views and what you think is important, so there are no set questions. I have a number of areas that I am interested in, but anything else you would like to say is even more important, so please do add it in. Shall we start with:
- The relevance of the toolkit (how applicable it was to your role/grade)?
- The readability of the toolkit (ease of reading, accessibility of information, conciseness and clarity of content)
- The content quality (depth and breadth of content, ordering, sequencing and grouping of content)
- The user-friendliness of the tool (ease of navigation, clarity of pathway direction, ease of use of prompts, tasks, reminders, visual appeal)
- The credibility of the toolkit (did you believe it, trust the content, or did it seem strange to you? Was it up to-date?)
- Its helpfulness and novelty (tasks included, case studies, tips and pointers, websites etc)
- Was your discipline adequately represented?
- Ways the toolkit could be improved?
- Any other comments on the tool?
- Any comments on the whole initiative (welcome, unwelcome?)

Examples of probes

- Can you tell me more about that.
- That's interesting, can you say more.

Conclusion to the interview

- Explain how/when/where interview data will be stored and disposed of.
- Answer any questions the participant raises.
- Check participant well-being.
- Thank participants for their involvement.



*National Council for the
Professional Development
of Nursing and Midwifery*

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