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An Organizational Competency Validation Strategy for Registered Nurses

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June Levine, BSN, MSN, RN ❍ Joyce Johnson, PhD, RN-BC

Nursing competency validation must be effective to ensure safe and quality patient care. In this article, the authors discuss the components of an organizational validation strategy that includes clear definitions, selection of competencies, and responsibilities for initial and continuing competency assessment. Recommendations are made to assist nursing professional development specialists in implementing strategies to improve the assessment and validation of nursing competency.

Current methods of defining and measuring clinical competency are not optimal or consistent. There is no common definition of competence and no evidence for one best method to assess competence. Each organization defines its processes to ensure staff competence. Many of these efforts focus on measuring the nurse's capability to perform a particular skill, not on the nurse's overall ability to perform in a practice setting (Koncaba, 2007). This approach reinforces an archaic belief that professional nursing practice is about doing and not about thinking. The knowledge required for a nurse to ensure patient safety and quality is not traditionally reinforced during competency validation.

In traditional competency programs, competency is validated on hire and annually thereafter using skill stations. The validation process has been focused on moving large numbers of nurses through the program with little connection to performance improvement, scope of practice, nursing expertise, performance appraisal, and, most importantly, patient safety. Most often, only psychomotor skills are validated with little attention given to the clinical reasoning that contributes to quality patient-focused care. Educators often lead this process without active management involvement. In fact, depending on the organization, competency validation may be completed only in the classroom with no formalized follow-up in the clinical setting. The staff member is usually coached through the assessment process using validation processes that are not standardized, resulting in each nurse being validated as competent through a variety of methods without attention to his or her need for remediation. Competency assessment must involve more than a checklist and a test (Whelam, 2006).

Not only is there is a lack of consensus about the definition of competence and how to validate it appropriately; there is ambiguity about how a registered nurse (RN) becomes competent and maintains competence. Effective competency validation requires a dynamic process dependent on the skill or behavior to be assessed, the practice setting, and the expertise of the staff member. Too often, one validation method is used for all staff every time the skill or behavior is validated. Competence assessment is a dynamic review of the practice of an individual nurse. It is critical to recognize that competence at one point in time does not ensure competence at a later date. Thus, there is a need for a process that encourages ongoing assessment of critical areas such as emergency management skills that incorporate elements of nursing practice that transcend procedural competence.

DEFINITIONS FROM THE LITERATURE

Stobinski (2008) stated "that the single greatest problem in competency assessment is the lack of a definition for the term competency" (p. 421). Stobinski maintained that the assessment of competency depends on a definition of the term, which drives the assessment process. If the capacity for learning were the basis for competency, then basic knowledge testing would be a good measure; however, if the ability to apply those skills is included in the definition of competency, then there must be a means to test those skills. For nursing, the definition of competency has proven elusive and inconsistent (Stobinski, 2008). Lundgren and Houseman (2002) aligned having a clear definition of competency with the concept of continuing competency and found that continuing competence depends on a clear definition for nursing competency. "The issue of continuing

June Levine, BSN, MSN, RN, is Healthcare Consultant, Chatsworth, California.

Joyce Johnson, PhD, RN-BC, is Regional Director of Education and Research, Kaiser Permanente, Pasadena, California.

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ADDRESS FOR CORRESPONDENCE: June Levine, BSN, MSN, RN, 100 S. Los Robles Ave. Suite 501, Pasadena, CA 91188 (e-mail: Jalevine18@aol.com).

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competence is intimately bound to the issue of competence itself—how it is defined and measured" (Lundgren & Houseman, 2002, p. 235).

In the review of more than 20 articles with definitions for competence, competent, and competency, the following terms were noted: level of performance, behaviors, safety, integration and application of knowledge and skills in a context, measurable actions, desirable outcomes, and quality patient care (Alspach, 1990; American Nurses Association [ANA], 2008; Brosky & Scott, 2007; Brunt, 2008; Burns, 2009; Gillespie & Hamlin, 2009; Klein, 2009; Koncaba, 2007; Kupsick, 2005; Stobinski, 2008). Some authors used "competence," "competent," or "competency" synonymously, whereas other authors argued that the words were subtly but essentially different (Koncaba, 2007). The American Academy of Ambulatory Nursing defined competence as "having the ability to demonstrate the technical, critical thinking, and interpersonal skills necessary to perform one's job" (Laughlin, 2013, p. 513). Schroeter (2008) stated that "competence" and "competency" are not interchangeable. "Competence refers to a potential ability and/or a capability to function in a given situation. Competency focuses on one's actual performance in a situation. This means that competence is required before one can expect to achieve competency" (Schroeter, 2008, p. 12). For any skill or behavior, the demonstration of competency requires an ability to demonstrate both physical and cognitive skills.

COMPETENCY ASSESSMENT

Competency is usually assessed for the following reasons:

- To ensure staff has the skills and abilities they need to perform to the expectations of their job description and organizational policies and procedures.
- To determine gaps in employee performance that need to be closed to ensure safe and competent care.
- To evaluate job performance.
- To provide aggregate data on competency patterns and trends as a basis for staff education and practice changes.
- To use competency data in organizational quality improvement efforts.

In performing competency assessment, Howanitz, Valenstein, and Fine (2000) outlined four levels of competence that should be addressed in the assessment process:

Level 1 = What an individual "knows" measured by his or her general knowledge

Level 2 = An individual "knows how" to act measured by his or her competence

Level 3 = An individual "shows how" to act as measured by his or her performance

Level 4 = What an individual "does" as measured by his or her action

The significance of these levels lies in the ability of an organization to describe competence only when Level 4 is achieved. The professional nurse must not only know what to do, how to do something, and demonstrate how it is done but also perform it in practice when no one is looking. Organizations must identify who within the organization bears accountability for each of these levels and tie this responsibility into performance. Critical to this analysis is the requirement that any process of competency assurance must be shaped and guided by the profession of nursing (ANA, 2000).

There is sufficient evidence in the literature to demonstrate that competency assessment is a very productive and viable approach in quality management and performance improvement (Alspach, 1990; Stanton, Swanson, & Baker, 2005). "Tying competency assessment to quality improvement is the key to creating meaningful, cost-effective, ongoing competency assessment" (Wright, 2005, p. 20). Stanton et al. (2005) emphasized that the selected competencies should be defined as measures and should be able to be collected in a standardized way across multiple staff and sites of care. By connecting competency assessment to measurable performance improvement data, the organization has ensured that competent practice is more than validating a set of steps only when someone is watching.

Promoting a competency-based practice model consistently facilitates the application of what a nurse knows into his or her practice. This model guides the development of programmatic objectives to assist in defining the competencies needed to ensure quality. Pforr, Leeseberg, and Brixey (2010) defined competency-based practice as "a patient care delivery system that emphasizes the nurse's ability to demonstrate competence in the high-risk, problem-prone aspects of care related to a specific role and clinical setting" (p. 121).

CONTINUING COMPETENCE

A review of the literature finds that most definitions reflect the context from which they were developed (Whittaker, Carson, & Smolenski, 2000). Terms found in the literature for describing continuing competence include periodic assessment, integration, and application of knowledge and skills in a designated role and setting (ANA, 2010; Association of Registered Nurses of Newfoundland and Labrador, 2008; Brunt, 2008; Whittaker et al., 2000).

Vernon (2012) reviewed the criteria for continuing competence from five countries: Australia, Canada, Ireland, New Zealand, and the United States. Vernon's work was part of an effort to agree on international criteria to affirm continuing RN competence. The top four identified criteria were self-declaration of competency through practice, recent and current practice, continuing professional development, and peer review. Two findings are of particular interest: There was agreement that RNs should be responsible for assessing their own practice and that an individual nurse's competence should be contextualized to his or her practice specialty.

The concept of recent and continued practice is another definition that requires professional and organizational agreement that should include reference to an individual nurse's specific specialty as a basis for ensuring competency. The continuing competence of RNs simultaneously protects the public and the advancement of the profession. The public has a right to expect competence throughout nurses' careers. Critical to any competency-based practice model is an identified cohesive mechanism for ensuring continuing competence for nurses (Burns, 2009). According to the ANA (2000), continuing competence is definable and measurable and is the shared responsibility of the profession, regulatory bodies, organizations/workplaces, and individual nurses. The current *Code of Ethics for Nurses* (ANA, 2001) supports the concept of continued competency in nursing, emphasizing individual nurse responsibility for the quality of his or her practice.

The National Council of State Boards of Nursing believes continued competence is a critical regulatory issue for boards of nursing that has not been sufficiently addressed. Nursing professional organizations, through their certification boards, promote continuing competence as more than maintenance but as a deliberate endeavor by an individual RN to advance his or her knowledge based on changing consumer needs, technological advancement, and changes in professional practice.

When a clinical practitioner is initially licensed, he or she is deemed by the state to have met minimal competency standards. The challenge of licensure boards is to ensure practitioners are competent throughout their practice career not just at the time of initial licensure (Whittaker et al., 2000). "Clinically relevant competency is not present at the completion of prelicensure education; however, the licensing examination is the only widely used measurement and it has assumed the role of proxy measurement for competency" (Stobinski, 2008, p. 417).

Using the del Bueno Performance-Based Development System, data showed that only 30% of 760 new RN graduates were consistently able to recognize and safely manage hospitalized patients' commonly occurring problems or complications.

Assumptions about increased years of experience leading to a higher competence level also were not consistently supported (del Bueno, 2001).

In addition, there is not universal understanding within the nursing profession that nurses regress to a lower level of clinical competency when beginning work in a new subspecialty or work area (Stobinski, 2008). When nurses are floated and transferred to multiple clinical settings without appropriate education, they are unable to perform safe, competent patient care at the level of the RN assigned to the specialty area. Thus, the float nurse's duties must be defined in a narrower context. The Institute of Medicine (2010) emphasized the importance of residency programs and recommended three groups of nurses who should participate in a residency program: RNs new to the profession, newly licensed nurse practitioners, and RNs new to a nursing specialty. The significance of this recommendation lies in its recognition of a need for a formalized structure to assess and ensure competency when entering the profession and when making the transition to a new specialty.

CRITERIA FOR COMPETENCY SELECTION, INITIALLY AND ONGOING

For most clinical organizations, the selection of procedural competencies to be validated occurs at initial employee hire and annually thereafter. According to Wright (2005), the competency assessment process includes hire assessment, initial competency assessment, and ongoing competency. Ongoing competency assessment should not be a repeat of competencies' reviewed on hire and should reflect "the new, changing, high-risk and problematic aspects of the job" (Wright, 2005, p. 18). Stanton et al. (2005) suggested specific criteria for competency selection that encourages the usual choices of high-risk, low-volume, problem-prone procedures or situations; unusual incidents and regulatory requirements reflect a clear connection with quality improvement efforts. All competency selections should be evidence based with broad professional consensus (Stanton et al., 2005). Rusche, Besuner, Partusch, and Berning (2001) outlined five opportunities for competency validation: corporate orientation, core nursing orientation, unit-specific nursing orientation, ongoing evaluation, and specialized evaluation. Rusche et al. also indicated that selected competencies should be based on the criteria of high-risk, high-frequency, and/or problem-prone procedures, equipment, and common tasks.

FREQUENCY OF ONGOING COMPETENCY ASSESSMENT

There is no basis for determining how frequently healthcare practitioners should be required to demonstrate their continued competence (Swankin, 2006). It is important to acknowledge that competency assessment should not be unique to the profession of nursing. Organizations are obligated, as well as their staff, to maintain and advance job knowledge and skills. Research across the health professions has shown that the length of time a professional has been practicing is not a good indicator of competency (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Austin, Marini, Crouteau, & Violato, 2004; Choudry, Fletcher, & Soumerai, 2005). Thus, assessment should be tied to actual practice, not to the assumption of competence based on years of experience.

According to Kobs (1997, as cited in Rusche et al., 2001, p. 238) "in the absence of error, competence can be assumed." If a caregiver has been performing successfully and there have been no adverse outcomes,

there can be an assumption of competence. However, this assumption presupposes that there are sufficient opportunities to sample skill performance by observing practice in the clinical area and in the skill laboratory that are performed frequently and have potential or actual risk. Therefore, one could argue that only high-risk, infrequent procedures or risk situations need to be reviewed on a periodic basis to maintain ability (Rusche et al., 2001).

TABLE 1 Validation Methods

External methods	• Academic nursing education.
	• Certification, recognized by various nursing professional organizations.
Examination of internal documents	• Documentation review.
	• Quality improvement outcomes.
Observation	• Observation of clinical performance within the practice setting.
	• Patient education, observed.
Professional activities completed by the nurse	• Presenting at local, state, and national meetings.
	• Publishing in a scholarly journal.
	• Teaching registered nurses and other healthcare professionals.
	• Conducting nursing research.
	• Self-directed learning activities.
	• Portfolio development.
	• Continuing education courses related to the nurse's individual practice.
	• Clinical practice that is continuous.
System enhancements	• Competency validation tools usually used for procedural competency assessment should contain both the procedural steps and relevant clinical questions related to safety and quality before, during, and after the procedure.
	• Performance appraisals should include competency validation.
	• Cognitive appraisal of role expectations and individual abilities via self, peers, supervisors, and patients (reflective practice).
	• Evaluation of self-confidence and competence should be aligned with selected procedures and/or behaviors.
	• Validation methods should vary based on specialty, reason for validation, and individual nursing needs.
	• Examinations for skill assessment and/or clinical reasoning ought to be considered.
	• Case presentations with group discussion.
Internal strategies	• Exemplars, self-reflection.
	• Reflective discussions about nursing practice.
	• Simulations in the clinical setting and/or computer based.
	• Patient care rounds as an example of concurrent review of patient management.
	• Continuing education courses related to the nurse's individual practice with defined outcomes based on competencies.

However, new equipment, new procedures, changes in regulations, and changes in the evidence provide a critical opportunity to assure continuing competence.

Yet, being competent does not guarantee good performance (Lake & Hamdorf, 2011). Competency is one determinant of performance, but the relationship is not direct, and the exact contribution is unknown. Other factors—such as work setting, time, and motivation—also play a major role in determining performance (Stobinski, 2008). If competency is closely related to performance, then assessment of competency has value from a management perspective. It may be used to identify gaps in knowledge that need development, and it enables managers to match competencies to patient care needs (Edwards, 1999).

METHODS OF MEASURING COMPETENCY

According to the literature, there is no one method to ensure overall competency in nursing. However, the professional

TABLE 2 Conclusions

1. Responsibility
1a. Competence for licensure is the purview of the board of registered nursing.
1b. The individual registered nurse (RN) is accountable for his or her professional competence and must assume responsibility for ensuring and documenting continued competence.
1c. RNs progress in their competence from novice to expert. Changes in their practice specialty require both individual and organizational commitment to ensure competent practice.
1d. Ensuring continued competence is a shared responsibility between the profession, regulatory bodies, the organization, and the RN. That shared responsibility must be clearly defined.
1e. Orientation is an organizational strategy that should define the roles of the educator, the manager, and the RN relative to competency. Organizations should build in mechanisms for RNs to demonstrate this accountability.
2. Competency Assessment
2a. Competency assessment is a blending of knowledge, skills, attitudes, and judgment.
2b. Assessing competence for an individual RN should include effective communication skills with patients, physicians, and other staff, critical thinking ability as well as psychomotor skills through a variety of validation methods.
2c. The assessment of an RN as competent for an individual skill or knowledge base is not a guarantee of overall competent performance and is only one determinant of performance.
3. Competency Selection
3a. Continuing competency assessment should reflect selecting high-risk procedures done infrequently, problem-prone procedures, practice changes based on evidence, infrequent performance of various skills, new equipment, and internal organizational needs.
3b. Competency selection should include evidence-based measures that can provide data for organizational quality goals.
3c. Competency selection should occur at least annually with attention given to choosing a few important ones critical to patient care needs.
3d. Selection of competencies and the validation method should change annually.
4. Validation
4a. Changes in clinical practice require a systematic validation process for all affected staff to word is ensure standardization, safety, and quality.
4b. Individuals who have been assessed as competent to validate the psychomotor and critical thinking aspects of the competency must perform competency validation.
5. Organization
5a. Performance evaluations must be competency based and aligned with the outcomes of competency assessment.
5b. Organizations should develop a competency-based performance model that includes the concepts of assessment, validation method, clarification of definitions, organizational roles (for nurses in professional development roles, manager, clinical expert, and individual employee), and the use of performance evaluation.

TABLE 3 Recommendations for Implementation

1. Responsibility
1a. The role responsibilities for implementing competency selection and validation method should be a joint effort of the clinical management team and the department of education.
1b. Clinical managers and professional development staff should assume joint responsibility in assuring registered nurse (RN) competence before he or she can work independently.
1c. Managers ought to be ultimately responsible for the competence of the staff with assistance from professional development.
2. Selection
2a. Define initial competencies and those validated annually for all RNs and ones specific to the different nursing specialties.
2b. Choose competencies based on considerations of high-risk and/or low-volume procedures, new equipment, patient care incidents, and Stanton et al.'s criteria for competency selection.
2c. Annually review all selected competencies to assess the continuing need for validation and/or a change in skill validation method.
3. Validation
3a. Provide an educational program for staff who will validate others. The program should consist of educating the validators on the validation process, methods and tools, adult learning principles, and effective communication. Information should be updated as tools change.
3b. Ensure that RNs conduct validation for nursing competencies unless such competencies are validated by another healthcare professional who is a content expert in the skills, critical thinking, and interpersonal elements of the Competency Validation Tool. Unlicensed assistive personnel and licensed vocational nurses/licensed practical nurses, knowledgeable in a particular procedure can contribute, as appropriate, to the competency validation process for an RN.
3c. The outcomes of the coaching process should be focused on the validator's ability to perform selected competencies without coaching and a demonstration of proficiency in teaching others.
3d. Select validation methods that best reflect the competency, the reasons for the validation, and the specialty in which the nurse is working. For select competencies, staff could be offered a choice of methods to validate the selected competency.
3e. Validation methodologies should be changed to enable enhanced learning.
3f. Use a consistent competency validation tool for procedural competencies that includes psychomotor skills, critical thinking, and interpersonal skills necessary for competent practice. It also should identify the scope of practice differences between RNs, licensed vocational nurses/licensed practical nurses, and unlicensed assistive personnel.
4. Organizations should
4a. Implement a competency-based organizational model for initial competency and continuing competency assessment that ensures the nursing staff can meet the needs of the patients served by the organization. RNs in professional development roles should lead the implementation team.
4b. Adopt definitions for competent, continuing competence, and competency validation and integrate them into policies and procedures and discuss them in orientation.
4c. Assist RNs in developing a professional portfolio that reflects their contributions to the profession and patient care as well as their educational and work history.
4d. Provide an environment where nurses are empowered and expected to take responsibility for their own competence through self-reflection, seeking out and participating in education offerings and experiences that will demonstrate continuing competence in all areas of their professional practice.
4e. Implement an organizational method to track competency progress for individual staff that includes at least competency validation date, method of validation, and number of RNs completing validation.
4f. Use competencies in quality improvement activities and trend data to assist in improving patient care.

Continued

TABLE 3 Recommendations for Implementation, Continued
4g. Develop competencies that align with such professional behaviors as effective communication, emotional intelligence, reflective thinking, and professional standards.
4h. Select a method to provide updates on practice changes that are based on the critical nature of the change and the amount of information to be conveyed.
4i. Develop a competency-based performance evaluation that aligns with professional nursing practice and the defined competency outcomes.
4j. Recognize the need for different competency requirements for new graduates, RNs new to a specialty, and RNs not new to the specialty but new to the organization.

portfolio is cited as a method of illustrating an RN's competency (Burns, 2009; Byrne et al., 2007; Stobinski, 2008).

The portfolio may also be used in performance evaluation. However, most would agree that the theory behind the competency should be part of the validation process, which helps to select the correct assessment methodology. Thus, when using a professional portfolio as a measure of competency, it is critical to develop a content validation strategy.

Each competency, whether procedural (dressing changes, injections) or nonprocedural (patient triage, patient education), requires a unique learning strategy that ought to vary over time to build knowledge, capture changes in evidence, and facilitate a broader validation method. Suggested validation methods from the literature are listed in Table 1 and are grouped into specific categories (Association of Registered Nurses of Newfoundland and Labrador, 2008; Brosky & Scott, 2007; Budzinski-Braunscheidel & Whalen-Espin, 2010; Burns, 2009; Carney & Bistline, 2008; Koncaba, 2007; Lake & Hamdorf, 2011; Lenburg, 2010; McGuire, 2001; Stobinski, 2008; Valloze, 2009; Whelam, 2006; Wright, 2005).

RESPONSIBILITY FOR COMPETENCY ASSESSMENT AND MAINTENANCE

The literature offers a broad perspective on who is responsible for competency assessment and maintenance. Consistent with many other professions, assurance of competence is the shared responsibility of the profession, individual practitioners, professional organizations, credentialing and certification entities, regulatory agencies, and employers. In addition to having the responsibility for initial licensure and initial competency, many authors believe that the state boards of nursing should also be responsible for continuing competence. They support this position by suggesting that the hallmark of a self-regulating profession is the expectation that the profession be responsible for shaping and guiding any process for ensuring nurse competence. The profession and professional organizations play a part in competence through credentialing and certification. Regulatory agencies define minimal standards of competency to protect the public. The ANA (2008) reinforced individual RN responsibility for maintaining continuing competence. Most educators and organizational leaders agree that the RN is responsible and accountable for maintaining his or her professional competence. Organizations through their management staff are responsible for the competent performance of the staff as documented in the performance evaluation. To provide a complete performance review, the manager may need to consult with other qualified staff to ensure an individual staff member has competency-based performance and practices at the professional nursing level. The employer is responsible and accountable to provide a practice environment conducive to competent practice. Within this accountability is the critical importance of providing competent individuals to perform the validation of both psychomotor and behavioral processes through a structured consistent approach.

Yet, no single evaluation method or tool can guarantee competence. Competence is situational and dynamic; it is both an outcome and an ongoing process. Context determines what competencies are necessary. Tying competency validation outcomes to performance evaluation helps ensure the individual accountability needed to perform patient care.

The following conclusions guided the implementation recommendations. Both the conclusions and recommendations are grouped into five similar categories: responsibility, assessment, selection, validation, and organization (see Tables 2 and 3).

SUMMARY

One of the greatest professional challenges is ensuring that a competent nursing staff expertly cares for patients within an ever-changing healthcare environment. The profession of nursing must require sufficient academic knowledge and experience that enables the new graduate and the RN new to a specialty to understand the complexities of patient care. Healthcare organizations must recognize that the complexity of caring for individuals in today's environment brings with it multiple challenges. RNs must recognize their responsibility to ensure their on-going competence, understanding how to critically assess and intervene to ensure patient safety and quality.

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