The impact of shared competencies and scopes of practice on regulation and quality of care

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Outline

1. Competence and Scope of Practice
2. Shared Competencies across Professions
3. Interprofessional Education and Collaboration: Drivers and Outcomes
4. Take-Aways
Definition of Competency

• Competence
• Competency
• Competency statement

• Competence: the potential ability to function in a given situation

• Competency: actual performance in a given situation

• Competency statement: description of an expected level of performance that results from an integration of knowledge, skills, abilities, and judgment; the description is objective and measurable
Continuing Competence

Definition:

“Continuing competence is the ongoing commitment of a registered nurse to integrate and apply the knowledge, skills, and judgment with the attitudes, values, and beliefs required to practice safely, effectively, and ethically in a designated role and setting.”

Case di Leonardi & Biel, 2012
Journal of Continuing Education in Nursing
American Nurses Association

The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession’s responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders.

Key Message #1:

Nurses Should Practice to the Full Extent of Their Education and Training

Key Message #3:

Nurses Should be Full Partners, with Physicians and Other Health Professionals, in Redesigning Health Care in the United States

Shared Competencies
Shared Competencies across Professions

- Professionalism/Ethical Practice
- Patient-Centered Care
- Interprofessional Teams
- Evidence-based Practice
- Quality Improvement
- Safety
- Informatics
- Systems-based Practice

- Values/Ethics
- Roles/Responsibilities
- Interprofessional Communication
- Teams and Teamwork
Academia to Practice: The Continuum

- Pre-qualification Program (2-4 years)
- Transition Program (3-12 months)
- Practice (1-40 years)

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert
“It is ironic, indeed, to realise that a football team spends 40 hours per week practicing teamwork for those 2 hours on a Sunday afternoon when their teamwork really counts. Teams in [healthcare] organizations seldom spend 2 hours per year practicing, when their ability to function as a team counts 40 hours per week.”

The Question of Competence: Reconsidering Medical Education in the Twenty-First Century
Edited by Brian D. Hodges and Lorelei Lingard
2012
Interprofessional Education and Collaborative Practice

Interprofessional Education (IPE): When students from two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes (World Health Organization, 2010)

Interprofessional Continuing Education (IPCE): When members from two or more professions learn with, from and about each other to enable effective collaboration and improve health outcomes (ACCME, ACPE, ANCC, 2014)

Interprofessional Collaborative Practice (IPCP): When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care (WHO, 2010)
Drivers for IPE/IPCP

Recommendations from the Institute of Medicine (IOM) – now the National Academies of Sciences, Engineering and Medicine

- Need to use our existing workforce optimally to deliver the most cost-effective care
- Need to produce a health care workforce that is responsive to the needs of both the patient and the health care system
- Need to ensure that health care providers can practice to their full scope of practice
- Will require a cooperative effort to form teams of providers able to bring unique skills together to meet the needs of patients

1972
Drivers for IPE/IPCP

- 1972 – Institute of Medicine: “Educating for the Health Team”
- 1999 – Institute of Medicine: “To Err Is Human: Building a Safer Health System”
- 2001 – Institute of Medicine: “Crossing the Quality Chasm”
- 2003 – Institute of Medicine: “Health Professional Education – A Bridge to Quality”
- 2009 – Institute of Medicine: “Redesigning Continuing Education in the Health Professions”
- 2010 – Institute of Medicine: “The Future of Nursing”

“Do none of you talk to each other?:
the challenges facing the implementation of interprofessional education”

CAROLINE CARLISLE, HELEN COOPER & CAROLINE WATKINS

1 University of Manchester; 2 University of Liverpool; 3 University of Central Lancashire, UK
## Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes. (Please refer to subcategories listed on slides 5-7)

<table>
<thead>
<tr>
<th></th>
<th>2013 (N=887)</th>
<th>2014 (N=764)</th>
<th>2Q 2015 (N=474)</th>
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<tbody>
<tr>
<td>Human Factors</td>
<td>635</td>
<td>547</td>
<td>464</td>
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<tr>
<td>Communication</td>
<td>563</td>
<td>517</td>
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<td>Leadership</td>
<td>547</td>
<td>489</td>
<td>343</td>
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<td>Assessment</td>
<td>505</td>
<td>392</td>
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<td>Information Management</td>
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<td>115</td>
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<td>Physical Environment</td>
<td>138</td>
<td>72</td>
<td>Health Information Technology-related 74</td>
</tr>
<tr>
<td>Care Planning</td>
<td>103</td>
<td>72</td>
<td>Care Planning 64</td>
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<tr>
<td>Continuum of Care</td>
<td>97</td>
<td>Health Information Technology-related 59</td>
<td>Information Management 29</td>
</tr>
<tr>
<td>Medication Use</td>
<td>77</td>
<td>Operative Care 58</td>
<td>Medication Use 29</td>
</tr>
<tr>
<td>Operative Care</td>
<td>76</td>
<td>Continuum of Care 57</td>
<td>Performance Improvement 26</td>
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</table>

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.
## Evidence/Outcomes

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Positive</th>
<th>Neutral</th>
<th>Mixed</th>
<th>Not Reported</th>
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<tbody>
<tr>
<td>Level 1: Reaction</td>
<td>25</td>
<td>0</td>
<td>7</td>
<td>14</td>
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<tr>
<td>Level 2a: Perceptions and Attitudes</td>
<td>14</td>
<td>1</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Level 2b: Knowledge and Skills</td>
<td>19</td>
<td>1</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Level 3: Behavioral Change</td>
<td>15</td>
<td>0</td>
<td>5</td>
<td>26</td>
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<tr>
<td>Level 4a: Organizational Practice</td>
<td>11</td>
<td>1</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>Level 4b: Patient/Client Care</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>35</td>
</tr>
</tbody>
</table>

Evidence/Outcomes

- Level 1: Reaction – value/support IPE; satisfaction with involvement; enjoyable/rewarding
- Level 2a: Modification of attitudes/perceptions – positive attitude over time; some mixed (positive then negative)
- Level 2b: Acquisition of knowledge/skills – self-reported improvements in knowledge and skills; 2 studies validated change
- Level 3: Behavioral change – self-reported change in behavior; 2 studies validated (ED teamwork and breaking bad news)
- Level 4a: Change in organizational practice – improvements in service delivery (illness prevention, patient screening, safety practices)
- Level 4b: Benefit to patients/clients - improvements in mortality rates, reduced clinical errors and patient LOS; clinical status (BP and cholesterol levels)
ANCC Credentialing Programs

Interprofessional competencies, expectations embedded in all credentialing programs within ANCC
• Criterion requires evidence of interprofessional collaboration and outcomes achieved
• MD – RN communication and collaboration strong in Magnet-designated organizations
• Patient outcomes:
  • Increased breast-feeding rates in NICU
  • Decreased LOS
  • Reduced complication rates for CV patients
  • Reduced asthma readmission rates
  • Decreased average BMI

• All criteria are interprofessional
• Demonstrates positive practice environment
• Healthcare team communication is enhanced
• Patient safety is a collaborative effort
• Patient outcomes improve:
  • Pressure ulcer rates fell significantly
• Credentials organizations for IPCE with medicine and pharmacy

• Outcomes:
  • Patient outcomes:
    • Average length of stay
    • Number of infants on ventilators
    • Maternal complication rates
    • Overall maternal health
  • Team performance:
    • Applications of guidelines and evidence in to practice
    • Identifying appropriate treatment

• National Healthcare Disaster Interprofessional Certification (in dev)
  • Target outcomes:
    • Reduce responder injuries and fatalities
    • Enhance population outcomes

• Nursing Case Management Certification
  • Interprofessional collaborative care coordination for discharge planning
  • Patient outcomes:
    • Reduce ER visits within 72 hours of discharge
    • Readmission within 7 days of discharge
Take-Away Messages

- All nurses should practice to the full extent of their education and training.
- Nurses work collaboratively and interdependently in teams that include other health care professionals, patients, and families.
- Nurses may lead teams, or be good followers on teams.
- Team skills can be taught.
- Patient outcomes are better when team collaboration is strong.
- There are evidence-based strategies that improve team functioning.
Thank You!

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