The competency movement appeared in nursing in the late 1980s at a time when nursing education was moving from hospitals towards the university sector. In Australia, the shift of nursing education into universities and a focus on the development of generic knowledge and broad reaching skills created a disparity between what the clinical environment perceived was needed in terms of skills and what the university environment was prepared to deliver. A convergence of change in educational direction and the introduction of competencies in nursing appeared to fit with the concept of ongoing assessment of a wide range of nursing activities in the clinical setting. Competencies provided a way for nurses to demonstrate skills to applied across nursing clinical areas. Thus, creating a more adaptable nursing workforce.

The research aimed to explore the function of competencies in shaping the organisation of nursing work. The aim was to generate an understanding of how competencies have constructed knowledge development and subsequently influenced practice. Through this process the research sought a better understanding of how, where and why competencies are positioned in nursing.

The theoretical framework underpinning the research was grounded in the broad tradition of critical theory and more specifically the work of Jürgen Habermas. Critical theory is perceived as liberating in nature and a tool for explaining and transforming all the circumstances that have constrained human beings. Critical theory also seeks to combine philosophy and social science in developing explanations of broad social structures and human actions in the construction of our social worlds. The focus is emancipatory which cannot be achieved without the interplay these factors.

Habermas (1981) argued that language was critical to the pursuit of democracy and a rational world. Habermas identified three forms of knowledge each associated with certain interests which he termed technical, practical and critical knowledge forms. Technical knowledge reflects positivist interests, practical knowledge interpretive interests and critical knowledge emancipatory interests. Each form is considered legitimate except where one dominates and suppresses other knowledge forms. Thus, these interests function together to provide a way of interpreting a social context and were applied as the theoretical lens in this research.

The site of data generation was a large metropolitan hospital in Queensland with 500+ beds. The hospital had developed a competency framework that allowed registered nurses (RNs) and enrolled nurses (ENs) to demonstrate skills (competencies) and to build a more adaptable and flexible workforce. The research sample included both ENs and RNs to allow for a full exploration of the function of competencies within the clinical environment. Inclusion criteria was that nurses were permanent or part-time staff and had completed mandatory hospital competencies.

A total of 16 individual interviews were undertaken with eight RNs and eight ENs. There were also three RN focus group interviews with a total of 14 participants and two EN focus group interviews with a total of 11 participants.
To ensure a depth of data within the research there were three key data sources:

1. A contextual review of literature
2. Individual interviews were conducted.
3. Focus group interviews

The process of analysis explored the functions of competencies within the nursing workplace. This exploration allowed the research to develop an understanding of how and why competencies had shaped scopes of practice and the role identification of both EN and RN participants.

The review of literature identified educational institutions, employers, governments and regulatory authorities that separately and combined defined standards of practice for nurses. The generic nature of competencies and the drive to ensure consistency in the delivery of care had created an environment where what was considered competent was defined through the efficiency lens of the organisation.

Data analysis sought to explore how the use of competencies reshaped the practices of ENs and RNs within an organisation. Nursing competencies as technologies were grounded in the assumption that the standardization of nursing work would mean less variation in practice and therefore better outcomes for patients. The standardization of knowledge, or the creation of uniformity and consistency, restricted the space within which nurses could practice autonomously and eroded the potential for reflection and for practice based on critical thought.

A second level of analysis explored the concept of communicative action and associated mutual understanding through a shared and undistorted language. The underlying assumption in establishing the competency framework was that ENs and RNs would have a shared understanding of the two roles and that this understanding would be developed through interaction. Nonetheless, of competencies, as techniques, had displaced the space within which nurses interpreted their work and the context in which nurses' work. The result was constraints on the development of a shared understanding through critical thinking considered to be an essential part of the role of the RN.

Thus, competencies further shaped the everyday practice of nurses in limiting differences in the performance of skills. The coincidence of arguments about a theory-practice gap in nursing and the appearance of competencies gave support to the new emphasis on practical skills as a consistent and measurable standard of practice that was transferable between different roles and across clinical areas.

The third analytical dimension turned to emancipation in nursing. The underlying subculture within nursing of role delineation, as defined by educational standards and skill acquisition, was eroding as a result of competencies. Hence, competencies served particular political interests and in the context of this research, neither the interests of RNs nor ENs.

Relationships between RNs and ENs and between these practitioners and the organisation were subject to the norms of rewards and responsibilities dictated by the organisation. These rewards and responsibilities were associated with the redistribution of workload between nurses creating a changed in the dynamics between EN and RN. For ENs, the competency framework was a strategy that gave legitimacy to expanded practice. Yet, the RN was at risk of being deskillled through practice standardization and the manipulation of skill-mix. Furthermore, and although the scope of practice of ENs had been expanded, this latter group was not financially remunerated for taking on the increased levels of responsibility.

Since the 1980s there has been a pedagogical shift in nursing education that has emphasized the importance of critical thinking and autonomy for nurses. Yet the domain of governmentality endures where language and other strategies are used to ensure a disciplined standardization of nursing practice. These governmental practices or technologies become normalized and taken for granted, which obscures the space needed for critical reflection. Competencies have thus become neutral technologies that are
not viewed as instruments of power but as individual assets. The competency framework had created a process of production where the focus had become, not the acquisition of knowledge, but greater control over the nursing workforce. The move to greater workforce flexibility saw the rise of a set of generic measures of skills that obscured the complexities of nursing practice and allowed for RNs and ENs to be perceived as equal participants in patient care.

Title:
The Function of Competencies in Nursing: A Critical Exploration

Keywords:
competency framework, professional functions, scope of practice, educational standards, on-the-job training and organisational control, regulatory standards

References:


Abstract Summary:
Within the clinical environment competency frameworks have been structured around a minimum standard of practice. A system of generic competencies has the potential to obscure the knowledge and skill of the RN and to blur the boundaries between the scopes of practice between the RN and EN (LPN).

Content Outline:
Introduction:
The demand for more nurses, flexibility within the workforce and a desire to provide for wider opportunities for both nurses and the public has created a push towards assessments that are relevant to the clinical environment. These assessments have the potential to create little difference between the scopes of practice of the enrolled nurse (EN) [LPN] and registered nurse (RN). Clinical competence is associated with what the student is able to achieve in practice and university education is seen as the attainment of scientific knowledge. The disparity between these two areas has created a perception of skill gap which has lead to a widening between the demands from university training and clinical expectations.

ENs are viewed as taking the middle ground within healthcare functioning with the necessary skills to allow for safe patient handling. The RN functions on the higher ground incorporating complex skills, critical thinking and decision-making capabilities. While the very nature of the EN has been to function as part of a team with the RN, this function has been difficulty to define due to the lack of clear parameters around scope of practice and the role of delegation in the clinical environment. Therefore the distinction between the RN and EN can therefore only be witnessed in the theoretical world.

Competencies have been accepted as a positive development within nursing however issues in developing consistency within the framework has raised numerous issues. These issues include difficulty in identifying minimum standards of performance, being able to reflect the complexity associated with patient care and the variety of definitions associated with standards of care. While competencies are seen as the minimum standard of required knowledge or required skill, there has been little room to witness the improvement or transition of skill as practitioners develop the application of their critical knowledge and thinking.

Major point 1: The application of the competency framework can be perceived as a way to standardize practices based on the rationale of quality and safety thereby creating equality within the clinical environment.

- Supporting point 1: Historically nursing training followed an apprenticeship style of training, learning from the master who transferred skill and knowledge through direct supervision. As nursing moved towards theoretical frameworks and a scientific foundation, organisations sought to provide a middle ground. This middle ground has attempted to ensure a consistency in care delivery through the development of pre-defined skills that reflect the proficiency of a nurse.
- Supporting point 2: Competencies give the appearance between organisational demands and the working environment. The function of the competency framework, in seeking to produce uniformity, has allowed the practitioner to enter the organisation, identify the organisation's standards and begin to practice in a way that ensured that they were consistent with these standards. Competencies have become a structure within which theoretical knowledge was devalued and the focus become one in which education was seen as more flexible.

Major point 2: The underlying assumption of the competency framework approach appears to be that the EN and the RN will have a shared understanding of the roles each member plays within the team while creating equality in workload allocation.

- Supporting point 1: The traditional training of nurses, following the apprenticeship framework of passing knowledge from the master to the apprentice through direct supervision, were seen as out of place with the modern function of nursing. RN training, at a university level, provides for more theoretical foundation, relying on the development of critical thinking, research and clinical judgement. EN training is seen as the more practical focused training, placing more emphasis on the developmental skill acquisition. As a result of these differences new RNs, in particular, appear to struggle with the transition from student to practitioner. To combat this gap and to achieve consistency in the delivery of care, organisations have to sought to create a way to use the competency framework to provide a consistent and measurable standard of practice across areas.
• Supporting point 2: As governments and working environments demand a more flexible workforce, the development of the competency framework has increased the perception that the RN and EN are equal within the clinical environment. Nurses that have struggled within the academic environment have found success within the competency based environments. The use of multiple competency assessments, established with both the RN and EN as equal, creates tools and frameworks that regulate the areas in which nurses can work, creating a commonplace approach satisfying an approach to practice that doesn't identify the individuals knowledge about provision of safe and effective care.

Major point 3: The underlying subculture of role delineation as identified by educational standards and skill acquisition has the potential to be eroded within the competency framework. The organisation and regulatory authorities have the capacity to wear away the identified roles of the RN and EN through the manipulation of the competency framework.

• Supporting point 1: Specific competencies, as developed by organisations, have been created to demonstrate set skills or role performances that produce actions that will meet the needs of the organisation. The focus of these is to create conformity, producing uniformity and consistency within nursing care. The need for conformity has created a setting from which mechanical skill development, specifically on-the-job training, focuses the framework on the psychomotor skills associated with tasks rather than the behaviors and attitudes that are ideally associated with nursing.

• Supporting point 2: Using the competency framework to ensure that nurses are performing skills safely, following specific guidelines, has the potential to create a sense of control for management and regulatory authorities. The RN sees the competency framework as a means to justify staffing levels and skill mix while the EN view the framework as tool that enables them to be validated within their working environment.

Conclusion: The competency framework has created emancipation for one group of nurses, providing flexibility while providing limitations for the other group limiting their control. The EN has seen the competency framework as a means through which they can function at their full scope of practice. The RN, however, finds the framework as a method by which the organisation is able to manipulate skill-mix as it relates to the acuity of patients. This has the potential to limit the RNs application of knowledge and see the competency framework as political and economic.

Breaking down nursing into activities designed to allow for observations limits the functionality of the nurse's role. This limitation makes assumptions on prior knowledge and skills, transforming the competency to a skill statement instead of assessments that demonstrate critical thinking and complex knowledge. The generic nature of the competency framework and the drive to ensure consistency in the delivery of care has created an atmosphere where what is considered competent is seen through the lens of the organisation. This further limits the ability to be able to differentiate between the theoretical training of the RN and EN creating an environment where on-the-job training is given higher weighting to theoretical foundation.

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