

Meeting the Ongoing Challenge of Continued Competence

Properly conceived and executed, regulation can both protect the public's interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients.

– *Crossing the Quality Chasm, 2001*

I. Introduction and Purpose

Nursing is a profession that requires the application of substantial knowledge, skills and abilities. The unsafe or unethical practice of nursing could cause harm to the public unless there is a high level of accountability. (Sheets, 1999) Thus, it is the responsibility of boards of nursing to hold nurses professionally accountable. The regulation of nursing is all about public protection and patient safety. As the pace of technological and scientific development accelerates, one of the greatest challenges to all health care practitioners is the attainment, maintenance and advancement of professional competence. In 1995, the Citizen Advocacy Center (CAC) asked the question, "Can the public be confident that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent years and decades after they have been in practice?" CAC's response in 1995 was: "No." (Swankin, 1995). Ten years later, nursing is still seeking an answer.

The National Council of State Boards of Nursing has long acknowledged continued competence as a critical regulatory issue for Boards of Nursing. In an effort to have language applicable to all practitioners at every level of practice, NCSBN defined competence as... *the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health.* (NCSBN, 1996) (See Attachment A for a chronological listing of NCSBN activities, beginning in 1985.)

Continued competence has been studied and talked about. There have been proposed regulatory approaches but there has not been agreement on what to do about it. The nursing profession "...has clearly seen the need for continuing competence but has grapple with how this can be universally accepted by all nurses." (Bryant, 2005, p. 25) But increasingly licensing boards are being challenged to provide assurance to the public that licensees meet minimum levels of competence throughout their careers, not only at the time of entry and initial licensure. Continued competence is a critical challenge for regulatory boards in the 21st century. It is time to address that challenge.

II. Background

While some boards of nursing have addressed the challenge with state initiatives, there has not been an elegant national regulatory solution for evaluating continued competence. Why is this so?

- Competence is multifaceted and may be difficult to measure.
- The sheer volume of nurses in practice makes it difficult to identify feasible and meaningful yet cost-effective regulatory approaches.
- There is no agreement on who should be responsible for continued competence.
- Nursing careers take widely divergent paths, varying by professional role, settings, clients, therapeutic modalities and other professional criteria as well as level of health care delivery.
- In addition, there is the inherent evolution of practice from the new graduate-entry-level to the experienced-focused practice level of competence.

- Thus, it is not clear what standard should be used to evaluate continued competence. Should the standard be based upon:
 - Current entry-level competency for the profession (i.e., NCLEX)?
 - Generalist core competency each licensure level (RN, LPN/VN, APRN)?¹
 - Focused areas of practice for?
 - Essential emerging knowledge?
 - Some combination of the above?
 - None of the above (something not yet identified and/or articulated)?
- It is not clear how to evaluate whether a standard has been met.
- It is not clear what to do if a licensee cannot demonstrate continued competence. (NCSBN, 1996).

These are challenging issues that NCSBN has been struggling to address (See Attachment B for a more detailed discussion of these background questions.) But after many years, there are still insufficient answers. Rouse observes that a "...perfect solution – simple, effective, inexpensive and acceptable to all – does not exist and is unlikely to ever be realized." (Rouse, 2004) A better approach may be to work around these issues and ask some new questions.

III. New Questions

What are some new questions that may help us look out of, around and under the box?

A. How can boards of nursing be more effective in protecting the public?

Boards could be more proactive in providing the public assurance that practitioners continue to be safe years after completing education and first becoming licensed. When legal authority for nursing practice was granted to registered nurses at the beginning of the 20th century and to licensed practical/vocational nurses mid-century, it brought nursing a new level of professionalism. Now, at the beginning of the 21st century, in a time of unprecedented challenges and coping with new knowledge and advancements in technology knowing that at one point in time a nurse was qualified is not enough. Boards have a role in assuring the public that licensed nurses meet minimum standards of competence throughout their professional lives.

B. Assuming there is not a perfect regulatory solution that would guarantee the continued competence of all nurses, what could the boards require that would be creditable with the public and acceptable to the profession?

In the interest of public protection, jurisdictions have strict requirements for obtaining initial licensure. However, requirements for licensure renewal are generally less stringent. One approach is to replace current periodic renewal processes with more substantive requirements for "licensure maintenance."

C. Why should nurses have to do more to maintain licensure?

Licensure is a privilege and each licensed nurse has responsibility to the licensing entity granting the authority to practice and to the public who receives nursing services. This responsibility includes the duty to attain and maintain licensure. Just as the board identifies the requirements for initial licensure, the board identifies the requirements to renew licensure. Currently, for most boards, that means paying a fee and avoiding serious disciplinary action. Requiring a licensee to maintain licensure means the board would need to articulate credible and meaningful requirements for ongoing licensure.

¹ Generalist core competence could consist of those content areas that course all nursing roles and all nursing settings for each level of licensure.

D. What could demonstrate licensure maintenance?

Licensure maintenance could include multiple elements, but should start with an assessment of the nurse's practice to direct professional development activities. In 1991, the NCSBN first articulated that learning strategies, such as continuing education, should be selected on the basis of assessment to identify learning needs.

E. What are activities that have credibility with the public and are meaningful to nurses?

The public needs assurance that nurses have current knowledge and are safe practitioners. The nurse needs the incentive of value added to one's career and practice. Accordingly, the public looks for requirements that demonstrate currency and ability to practice safely. Nurses would benefit from requirements that are relevant to the nurse's practice, promote professional development and can be used to meet the multiple demands of employers, boards and others.

F. Licensure maintenance rather than continued competence – isn't this just semantics?

How language is used is important for how a proposal is perceived. For example, if a nurse does not obtain continuing education hours, does that really mean that he or she is incompetent? Or does it mean the nurse didn't take CE courses? If a nurse takes the requisite continuing education course, does that show that the nurse is really competent? Or does it mean that the nurse signed an attendance sheet at a class?

Talking about continued competence makes professionals feel singled out and vulnerable. The concept of continued competence is intended to encourage practitioners to maintain their practice. But it is threatening to many. There is fear of the licensing board. There is fear of losing one's livelihood. There is fear of failure.

Licensure maintenance implies universality, something required of everyone. It may allow people to get past the rhetoric and focus on the real challenge – the identification of substantive content for re-qualification requirements.

IV. Who is Asking?

Ben Shimberg, who was a nationally recognized expert in testing, credentialing and professional regulation, first became interested in continued competence in 1967 because of the work of a governmental commission created to address the question of "medical obsolescence." That commission stated that simply making educational opportunities available was not enough – there had to be incentives to insure that physicians and other health professionals kept up-to-date and maintained the skills to deliver high quality care. (CAC, 1996.) In 1970, the US Public Health Service called for the development of more sophisticated approaches tied to re-licensure or recertification (suggesting the consideration of peer review, re-examination, self assessment and supervisory assessment as well as continuing education). (CAC, 1996)

The NCSBN Nursing Practice & Education (NP&E) Committee considered the measurement of competence from an empirical and standard-setting perspective in the 1991 paper *The NCSBN Conceptual Framework for Continued Competence*. This paper stressed the importance of both assessment (to determine learning needs) as well as strategies to promote continued competence. (NCSBN, 1996)

In *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, the Pew Taskforce on Health Care workforce Regulation recommended, “(3) States should base their practice acts on demonstrated initial and continued competence...[and] (7) States should require each regulatory board to develop, implement and evaluate continuing competence requirements to assure the continuing competence of regulated health care professionals...” (Pew, 1995).

In 1996, the Essential and Continued Competence Subcommittee completed a new position paper entitled *Assuring Competence: A Regulatory Responsibility* that incorporated the definition of competence referenced above, standards for competence (see Attachment C) and a Model for Individual Competence Evaluation. (NCSBN, 1996)

In 1998, the NP&E Committee, building upon previous NCSBN Work, developed the Continued Competence Accountability Profile (CCAP). CCAP was a portfolio approach where the nurse applied the steps of the nursing process – assessment, planning, implementation and evaluation – to the nurse’s own professional development. (NCSBN, 1998) CCAP was presented at the 1998 Area Meetings as an alternative to continuing education. The response of the membership at that time was that the concept was interesting, with many excellent elements. However, CCAP was viewed as too complex and not administratively feasible as a regulatory approach to continued competence.

The Institute of Medicine (IOM) stunned the nation in 1999 with, *To Err is Human: Building a Safer Health System*. That reported that between 44,000 and 98,000 people die each year from preventable medical errors. (IOM, 1999) This report addressed a whole range of errors from omissions to commissions to inappropriate therapies. A major concern identified is the length of time between the discovery of more effective treatments and their incorporation into routine patient care. This has direct implications for practitioners to stay current in their knowledge and skills. The IOM recommended the implementation of periodic reexamination and relicensing of physicians, nurses and other providers based on competence and knowledge of safety practices, and to work with certifying and credentialing organizations to develop more effective methods to identify and take action when providers are unsafe. (IOM, 1999)

In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine observed that “There are no consistent methods for ensuring the continued competence of health professionals within the current state licensing functions or other processes”. (IOM, 2001)

In April 2003, the IOM issued another report entitled *Health Professions Education – A Bridge to Quality*, which viewed professional competency assurance as the shared responsibility of public and private sectors. The IOM recommended that:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care – as defined by the five competencies defined by the committee² – through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods. (IOM, 2003)

Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies, among other requirements. (IOM, Bridge, 2003, p__)

Keeping Patients Safe: Transforming the Work Environment of Nurses acknowledged that “prelicensure or pre-employment education cannot provide sufficient frequency and diversity of

² The authors of the IOM report believe that all health care professionals *should be educated to deliver patient centered care, as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics.* (IOM, 2003)

experiences...in the performance of every clinical nursing intervention needed for every clinical nursing intervention needed for patients.” (IOM, *Nurses’ Work Environment*, 2003, p.203). This is amplified in the face of the growth of new knowledge and technology.

The NCSBN research project, *Evaluating the Efficacy of Continuing Education Mandates* (Smith, 2003) revealed how professionals perceive they have attained professional development. That study showed that work experience is a stronger contributor to the growth of abilities than continuing education, working with mentors or self-study. This research was used to support the continued competence approach used in the current NCSBN *Model Nursing Practice Act and Model Nursing Administrative Rules*, adopted by the 2004 NCSBN Delegate Assembly, requires 900 practice hours rather than continuing education. (NCSBN, 2004)

In 2004, the Citizen Advocacy Center (CAC) presented the *CAC Road Map to Continued Competence*, built upon ten principles:

1. Using **collaboration** among a broad base of stakeholders
2. For the purpose of **quality**
3. Using **evidence-based** approaches
4. That **build upon what works**
5. With a **uniform definition of competence** across all health field professions.
6. It must be **mandated** to be successful.
7. It must be a **clinician responsibility** that positively develops careers.
8. The cost should be borne by health professionals, **using licensing fees to pay for competency assurance.**
9. **Due process** must be respected and balanced with the public’s **right to know**,
10. **Licensing boards should have ultimate authority.** (CAC, 2004)

The CAC Road Map consists of a two phased plan built upon the action areas of conducting research, seeking legislative and regulatory mandates, using evidence-based methods to demonstrate continuing competence, changing education programs, financing, continued competence programs and reforming continuing education programs. (CAC, 2004) The plan includes national meetings to build consensus and identify priorities as well as pilot projects to study the reliability, validity and accuracy of various assessment and assurance methods. (CAC, 2004) The targeted destination to be reached via the road map is “a destination where all health care professionals periodically demonstrate their competence through one of a variety of acceptable methodologies.” (CAC, 2004). A final resource put forward by CAC is a five step model for the individual practitioner, that includes routine periodic assessment, the development of a personal plan, the implementation of a personal plan, documentation of all steps and demonstration/evaluation of competence. (CAC, 2004).

V. Review of Approaches Already in Use

Nursing Regulation

Currently, the most common continued competence requirement for nursing licensing boards is continuing education, which is required of RNs by 25 boards and of LPN/VNs by 24 boards. Of these, 12 boards require specific subject matter as part of licensure maintenance (NCSBN, 2002). Other nursing board approaches to continued competence include requiring a specified number of practice hours (21 boards for RNs, 22 board for LPN/VNs; also see NCSBN Models) or a nursing refresher course if a nurse who has had an inactive license seeks to return to practice (24 boards for both RNs and LPN/VNs). Three states require a competency examination under specific circumstances (e.g., an extended number of years out of practice). (NCSBN, 2002) Several states have completed continued competence initiatives or have an initiative under way.

Although the Colorado Board of Nursing discontinued its continuing education requirement in 1994 because it found no evidence that it was effective in assuring continued competence, as noted above (Karen Brumley, personal communication February 1994) other states to have CE requirements. For example, the Arkansas Board of Nursing also worked on the challenge of continued competence, and

implemented continuing education requirements for nurses holding active licensure. The Board must recognize the approval bodies that approve the continuing education programs that are used to meet this requirement. More information regarding the Arkansas CE requirements can be found at www.arsbn.org (personal communication Faith Fields).

The Kentucky Board of Nursing held a number of open forums in 1997 to examine competency issues. A professional portfolio including skills assessment inventories, peer review, formal nursing courses and continuing education was developed. Currently, the continued competence requirements for Kentucky, which is moving to an annual renewal process, offers a number of alternative activities that nurses can select (ranging from continued education hours to research to publication to a combination of CE and work evaluation). (Spur, 2004) The Texas Board of Nurse Examiners was authorized by the Texas Legislature to offer grants for conducting pilot programs to study the questions 1) What constitutes basic competency and 2) Can valid and reliable methods of measurement be developed? (Green, 1999) The eight funded projects considered tests, skill demonstration, peer evaluation, critical thinking skills tests and portfolios. Currently, the Texas Board of Nurse Examiners is authorized to recognize, prepare or implement continuing competency programs for license holders and may require participation in continuing competency programs as a condition of renewal of a license. Such programs may allow a license holder to demonstrate competency through various methods, including targeted continuing education programs, consideration of the license holder's professional portfolio (including certifications). The board may not require more than a total of 20 hours of continuing education in a two-year period, and may not require more than 10 hours consisting of classroom instruction in approved programs. (Texas Administrative Code, Title 22 Part II, Chapter 216.

The North Carolina Board of Nursing has a project underway, based on a determination that continued competence is both an evaluative process carried by the nurse, employer and Board of Nursing and a self-directed and ongoing process by the nurse for purposes of licensure renewal. Their pilot project includes a broad-spectrum sample of nurses from a variety of settings who are expected to complete a self-assessment and action plan. The board has developed a number of tools to support nurses in *reflective practice* – defined as “a process for the assessment of one’s own practice to identify and seek learning opportunities to promote continued competence.” After six months, the nurses will be assessed as to how they have implemented their work plans. The North Carolina Board of Nursing plans to seek legislation in 2005 with implementation in 2006. (NCBN, 2005)

In Ontario, the College of Nurses and other health colleges were mandated to develop and implement continued competence programs in the 1990s. The Ontario College of Nursing developed a reflective practice and portfolio model that began as a voluntary program and is now mandatory as part of the licensure renewal process.

Other Health Professions

Many health professions continue to require continuing education as the primary continued competence activity. According to the Federation of Chiropractic Licensing Boards (FCLB), doctors of chiropractic are required to have a certain number of hours of continuing education in order to qualify for licensure renewal in most US jurisdictions. (FCLB, 2005) Optometric licensing boards use continuing education to certify the continuing competence of licensed optometrists. The American Association of Regulatory Boards of Optometry (ARBO) found that state boards were duplicating work when many boards approved the same CE courses every year. In response, ARBO created the Council on Optometric Practitioner Education (COPE), a national clearinghouse for all CE courses of a statewide, regional or national scope, to prevent duplicative efforts by state boards. (ARBO, 2001) Similarly, the Association of Social Work Boards (ASWB) created its Approved Continuing Education (ACE) Program to provide a national system to review and approve the providers of continuing education programs for social workers. Approved providers include universities, professional associations and both profit and non-profit organizations. ASWB does not approve individual courses. Most social work boards require social work continuing education. (ASWB, 2002).

One of the first health professions to look for new approaches to continued competence was the Commission on Dietetic Registration who first developed self-assessment modules in 1989. Their first

step was to identify the scope of practice of an experienced dietician and then developed a self-assessment module, using case studies, to evaluate the dietician's performance. An important aspect was establishing a feedback system allowing the dietician to receive an individualized commentary on their performance. The Commission has gone on to develop a variety of modules focusing on key areas of dietary practice. (CDR, 2005).

Continuing competence requirements for physical therapists is most often through continuing education and practice hours. The Federation of State Boards of Physical Therapy passed a motion at its 2004 Annual Meeting to support regulatory boards in the development of standards for measuring continuing competence. FSBPT has also developed standards for competence and some tools to support ongoing competence, including a jurisprudence examination and a self-assessment examination that is being currently being tested in pilot states. (FSBPT, 2002)

Continuing Professional Development (CPD) for pharmacists is an approach to lifelong learning that is being discussed as a possible model for use in the United States. CPD does not replace continuing education, but quality-assured CE is an essential component of CPD. Rouse believes that a quality improvement of the existing system for pharmacist CE can be achieved. (Rouse, 2004)³ In addition, the National Association of Boards of Pharmacy is developing a self-assessment examination for pharmacists.

The National Certification Board of Occupational Therapists (NCBOT) developed a portfolio approach that requires occupational therapists (OT) to accumulate a set number of professional development activities for each renewal cycle. Half of the activities must be directly related to the delivery of occupational therapy services. NCBOT provides a number of tools and case studies on their web site to assist practitioners in the development of their professional portfolios. (NCBOT, 2005)

The Federation of State Medical Boards established a Special Committee on the Evaluation of Quality of Care and Maintenance of Competence in 1998. This group defined competence as, "Possessing the requisite abilities and qualities (cognitive, non-cognitive and communicative). They also considered the concept of *dyscompetence*, which they defined as "failing to maintain acceptable standards in one or more areas of professional physician practice," and incompetence, defined as "lacking the requisite abilities and qualities ...to perform effectively in the scope of professional physician practice." The committee's recommendations included to develop and implement methods to identify physicians who fail to provide quality care and to identify the dyscompetent physician. In addition to providing opportunities for improving physician practice in problem areas, they recommended that state medical boards develop programs to enhance overall physician practice. (FSMB, 2005)

The members of the American Boards of Medical Specialties (ABMS) have, until recently, concentrated on initial certification. Since 1998, the physician specialty boards have been moving toward periodic recertification to maintain board certification. In 2000, ABMS Member Boards approved the establishment and basic elements of a system for "Maintenance of Certification." This system would eventually replace periodic re-certification. (Brennan, 2004) Member Boards are working on establishing specialty-specific requirements and processes for "Maintenance of Certification" or MOC. There are four components to the MOC: 1) evidence of professional standing (e.g., unrestricted license); 2) Evidence of a commitment to lifelong learning and involvement in periodic self-assessment to guide learning; 3) evidence of cognitive expertise based on an examination; and 4) evidence of evaluation of performance in practice. (ABMS, 2005)

III. New Directions

³ Pharmacy continuing education is approved by the Accreditation Council for Pharmacy Education, which also offers a service to link pharmacist to appropriate CE courses.

NCSBN 2005 Midyear Meeting

Continued competence was a major discussion at the 2005 Midyear Meeting. Participants were asked to discuss in small groups three questions. The first question was: *Is it the duty of the board of nursing to assure consumers that competence is maintained throughout the lifetime of the license?* Each table of participants talked about this question, and each table reported out on their discussions. The majority of participants said yes, boards do have a duty or indicated that it was a shared responsibility. There were some attendees who perceived continued competence as an employer responsibility. One person asked, in the face of the nursing shortage, how vigorous the process should be?

The second question for discussion was: *Describe how your Practice Act & Rules address the maintenance of competence.* The identified approaches were: minimum practice hours, mandatory reporting of unsafe practice, standards on the expected knowledge, skills and abilities, continuing education requirements and “pay your fees and stay out of trouble.” The most common approaches in current use were continuing education requirements and minimum practice hours.

The third discussion question was: *What are the essential components of an effective regulatory model for the maintenance of competence?* The most common element reported was some form of assessment (examples included: self assessment, core competency test for practicing nurse, Dorothy Del Bueno’s model, measurement process, measurement tool, core competency measurement by an affective-cognitive-sensory monitor, and regional assessment centers). Other suggested elements were portfolios, demonstration and observation, general guidelines provided by Member Boards, tracking systems, manage or remove the non-competent nurse, evidence based discipline, remediation courses, web based resources, and continuing education.

Fiscal Year 2005 Strategic Initiative

The 2004 Delegate Assembly adopted a strategic plan to guide the organization for the next three years. Part of that plan is “*Strategic Initiative #4: Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related healthcare providers.*” Utilizing the Balanced Scorecard strategic management model, a strategic objective was developed by the Board of Directors to accomplish this initiative. The following Strategic Objective was assigned to the Testing Services Department: “*Strategic Objective #2: Develop an assessment instrument to measure continued competence of RNs and LPN/VNs.*”

Based on this directive, the NCSBN Testing Department is developing a practice analysis of post entry-level nurses. In addition, a public opinion survey regarding public perceptions of continued competence for nurses is in the process of being conducted. As part of the usual development process for a job analysis, at least two subject matter expert meetings are expected to occur this summer: One meeting is to develop a comprehensive list of LPN/VN nursing activity statements to assess LPN/VN practice and one meeting to develop a comprehensive list of RN nursing activity statements to assess RN practice. After comprehensive lists of RN and LPN/VN nursing activity statements have been developed, post entry-level RNs and LPN/VNs will be surveyed regarding the frequency and importance of nursing activities. Data collection is scheduled for FY06 with initial reports expected in late Spring/early Summer of 2006. The purpose of the job analysis is to describe the practice of experienced nurses with the idea of developing an assessment instrument for experienced nurses. What is learned from this study may be very useful for devising a continued competence regulatory model.

VII. Discussion

Unlike other health professions who number in the thousands, there are over two million nurses in the United States. Such huge numbers have tremendous impact on the resources needed, and thus the approach used, to assure continued competence of nurses. It is estimated that less than 20% of nurses are professionally certified. Thus, the medical model is not a good fit for nursing.

The NCSBN strategy of analyzing the practice of experienced nurses is a crucial first step toward the development of a regulatory model. It will help us describe the practice of an experienced nurse. That will inform whatever model is eventually developed.

The NCSBN has been looking at continued competence since 1985. The physicians first began to focus on continued competence in 1998. Since then, several member boards of the American Boards of Medical Specialties began to require periodic reexaminations to maintain board certification. Other medical specialties are also moving in this direction. Most physicians are board certified, so that 85-90% of physicians could be assessed by mandatory periodic recertification examinations allowing this approach can be used as the primary continued competence mechanism for doctors. Boards of medicine have to develop continued competence mechanisms for the much smaller number of practitioners who are not board certified.

The CAC Road Map put forward in 2004 is very similar to the steps of the CCAP portfolio approach developed by the NCSBN in the late 1990s.⁴ So, one possibility for nursing is for the NCSBN to revisit the CCAP and the portfolio approach. However, the criticisms that were raised in 1998 would still be concerns today: it is a paper trail, it is difficult to quantify and it raises questions of reliability and validity. While developing a portfolio can be an enriching experience, it can also be busy work with little relation to actual practice.

What the Pew Taskforce and the Institute of Medicine and the Citizens Advocacy Center advocated is the periodic demonstration of competence. But there is more than one way to demonstrate competence. There are formal examinations. But there is also self-assessment tests and reflection on one's practice. There are open book tests that look less at what you can recall and more at how you think and synthesize and apply knowledge. In the current healthcare environment, isn't how a nurse problem solves and where she or he goes to find answers more important than just retained facts?

Assessment results do not have to determine "in or out." Results could be used to provide feedback and direction to the nurse. Boards could provide licensees time to study and work on improvement, and then reassess. Boards would have to make challenging policy decisions about how long, number of tries and how to deal with nurses who cannot meet requirements. If the re-qualification requirements are reasonable, substantive and rationally related toward meeting the goal of assuring the currency of nurses, it is the role of the board of nursing to enforce those requirements.

Periodic assessment is not an unrealistic expectation – it is opportunity for quality improvement. Continuous quality improvement is a logical requirement for licensure maintenance.

VIII. Conclusions

We are living in a complex, complicated world. Given a constant onslaught of new knowledge and technology, that an individual was successful in completing nursing education, passing an examination and meeting other requirements at a point in time is not enough. Licensure renewal and staying out of trouble is not enough. Licensees need to demonstrate that they are taking substantive steps to maintain licensure.

Some nurses will ask, "Where is the evidence we aren't competent?" It is true that research is needed to study the practice of experienced nurses. Research is needed to assure that there is evidence to support that a continued competence strategy is effective. But it is disingenuous to suggest that in the current environment and in the face of startling, frightening statistics involving error that assuring the maintenance of continued competence of health professionals, including nurses, is not needed. Patient safety initiatives must address individual competency as well as system redesign and

⁴ The CAC is taking on even more daunting a challenge than NCSBN, because it is trying to move multiple health professions to implement continued competence requirements.

improvement. IOM has identified five competencies for all health care professionals (*patient centered care, interdisciplinary team, evidence-based practice, quality improvement and informatics*). This may provide a starting place for determining substantive requirements for licensure maintenance.

Boards of nursing cannot go it alone. This has to be a collaborative effort. Nurses, employers, educators, nursing organizations, CE providers, consumers and boards of nursing are all stakeholders and have perspectives to share and expertise to offer. Stakeholder buy-in to any regulatory model is important. But the bottom line is that only governmental licensing boards have the authority to enforce change.

Appendices

Appendix A – NCSBN Timeline – Continued Competence Activities

Appendix B – Discussion of Continued Competence Challenges

Appendix C - Principles and Premises Identified in Previous NCSBN Documents

Works Cited

American Board of Medical Specialties. (2005). Maintenance of Certification (MOC). Retrieved May 18, 2005, from <http://www.abms.org/MOC.asp>

Association of Social Work Boards. (2001). *ACE application guidelines for continuing education providers*. Culpeper, VA: Author.

Association of Regulatory Boards of Optometry. (2001). *Response of the Association of Regulatory Boards of Optometry to the request for comments for the summit on board certification & continued competence*. Bethesda, MD: Author.

Brennan, T.A., Horwitz, R. I., Duffy, R.D., Cassel, C.K., Goode, L.D. & Lipner, R.S. (2004). The role of the physician specialty board certification in the quality movement. *Journal of the American Medical Association*, 292(9), 1038-1043.

Bryant, R. (2005). *Regulation, roles and competency development*. Geneva, Switzerland: International Council of Nurses.

Citizen Advocacy Center.(1996). *Continuing professional competence: Can we assure it?* Washington, DC: Author.

Citizen Advocacy Center. (2004). *Maintaining and improving health professional competence: The Citizen Advocacy Center road map to continuing competency assurance*. Washington, DC: Author.

Commission on Dietary Registration. Professional development resource center. Retrieved May 19, 2005, from <http://www.cdrnet.org/pdrcenter/index.htm>

Faith Fields (personal communication April 15, 2005).

Federation of Chiropractic Licensing Boards. (2005). Continuing Education for CDs. Retrieved May 19, 2005, from <http://www.fclb.org/>

Federation of State Boards of Physical Therapy. (2002). *Standards of competence*. Alexandria, VA: Author.

Federation of State Medical Boards. (1998). *Report of the Special Committee on the Evaluation of Quality of Care and Maintenance of Competence*. Retrieved April 18, 2005, from http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/quality_of_care

- Green, A. & Ogden, B.S. Three state nursing boards examine continued competency. *Nursing World*. Retrieved March 18, 2005, from <http://www.nursingworld.org/tan/99marapr/competen.htm>
- Institute of Medicine. (2001). *Crossing the Quality Chasm*. Washington, DC: National Academies Press.
- Institute of Medicine., (2003). *Keeping patients safe: transforming the work environment of nurses*. Washington, DC: National Academies Press.
- Institute of Medicine. (2003). *The Education of Healthcare Professionals: A Bridge to Quality*. Washington, DC: National Academies Press.
- Institute of Medicine. (1999). *To Err is Human*. Washington, DC: National Academies Press.
- Institute of Medicine. (2002). *Who will keep the public healthy: Educating health professionals for the 21st century*. Washington, DC: National Academies Press.
- Karen Brumley (personal communication February 1994).
- North Carolina Board of Nursing. *Continued competence pilot program*. Retrieved March 18, 2005, from <http://www.ncbon.com/ContinuedCompetence/>
- National Council of State Boards of Nursing. (1996). *Assuring competence: A regulatory responsibility*. Chicago: Author.
- National Council of State Boards of Nursing. (1991). *Conceptual framework for continued competence*. Chicago: Author.
- National Council of State Boards of Nursing. (1998). *Continued competence accountability profile*. Chicago: Author.
- National Council of State Boards of Nursing. (2004). *Model nursing practice act and nursing administrative rules*. Chicago: Author.
- National Council of State Boards of Nursing. (2002). *Profiles of Member Boards 2002*. Chicago: Author.
- National Certification Board of Occupational Therapy, (2005). Professional Development Provider Registry accessed May 19, 2005, from <http://www.nbcot.org/registry/index.html>
- Rouse, M.J. (July/August 2004). Continuing professional development in pharmacy (2004). *Journal of the American Pharmacy Association*. 2004;44:517-520.
- Sheets, V. (1999, March). Supporting careers of competence: A regulatory challenge. Paper presented at the American Board of Medical Specialties Competence Conference.
- Smith, J. (2003). *Evaluating the efficacy of continuing education*. Chicago: National Council of State Boards of Nursing.
- Spur, P. (2004). Continuing education/competency – are you exercising all of your options? *Kentucky Nurse*, retrieved March 8, 2005, from http://www.findarticles.com/p/articles/mi_qa4084/is_200410/ai_n9461021
- Swankin, D. (1995). The role of licensing in assuring the continuing competence of health care professionals. Washington, DC: Citizen Advocacy Center.

Taskforce on Health Care Workforce Regulation, (1995). *Reforming healthcare workforce regulation: Policy consideration for the 21st century*. San Francisco: Pew Health Professions Commission.

Texas Administrative Code, Title 22 Part II, Chapter 216.