Competency Assessment Tools for Registered Nurses: An Integrative Review
Crystal A. Wilkinson, RN, MN

abstract

Background: The clinical nurse educator in practice settings assists registered nurses through education and works with nurse managers to evaluate the continuing competency of registered nurses. The availability of self-reporting tools with acceptable psychometric properties may contribute to an understanding of staff expertise and continued competence to perform their required duties.

Methods: An integrative review of the literature was conducted using keyword searches in CINAHL, ERIC, and PsycINFO. The search for tools published in the past decade focused on self-assessment of continuing competence in practicing nurses.

Results: Four research reports were found with multidimensional self-reporting tools designed for use with nurses in ongoing practice. Each tool specifies a unique set of dimensions of continuing competency (e.g., clinical care, leadership, interpersonal relationships) and has had its validity or reliability tested with practicing nurses.

Conclusion: The results of the review showed an improvement in the development and availability of tools. However, the tools are still lacking in dimension and further investment in this area of research is needed.


VIGNETTE

Sarah is a clinical nurse educator on a ward at a large urban hospital. Once a month, the clinical nurse educators gather to discuss current issues and concerns. She begins by telling the others that she is working with a registered nurse (RN) who has multiple complaints against her and is showing signs of incompetence. Some of the staff have complained that the RN is being stubborn and refusing to do her share of the work. Others are unsure whether the RN knows how to perform the necessary skills. Although assessment of staff is usually included in the nurse manager’s role, this task is often delegated to the clinical nurse educator, who is typically in the practice area more frequently and may be able to assess the clinical situation more accurately. Therefore, the nurse manager has asked Sarah to perform an assessment of the RN to evaluate the problem and seek resolution. It is Sarah’s job to find an assessment tool that will be adequate in measuring not only the RN’s technical skills and abilities but also her motivation and attitude.

One requirement for RNs is to meet the expectations of their regulatory body. Poor and unsafe patient care is a result of failing to meet these expectations. Clinical nurse educators help in understanding the complex issue of competency and behavioral concerns. This role requires both sensitivity and professionalism. Discerning between skills and attitude and finding the right assessment tools is a challenge. This article examines the expectations of the RN and the meaning of continuing competency and also critiques self-reporting tools for...
evaluating continuing competency that were published in the past decade. In a previous review, Robb, Fleming, and Dietert (2002) covered the time frame up to the year 2000, focusing on the research measuring an RN’s clinical performance. Similarly, Watson, Stimpson, Topping, and Porock (2002) completed a review of articles from 1998 to 2000. In a review of articles published from 2001 to 2011, the author found four additional articles and compared the tools on dimensions and psychometric properties. For the purpose of this review, the term dimension is used to indicate a domain or subset of items representing a component of competency.

DEFINING NURSING COMPETENCE, COMPETENCY, AND CONTINUING COMPETENCY

Locsin (1998) presented two meanings of competence. First, competence is likened to performance, and second, competence can be seen as a quality of an individual (Locsin, 1998). Woodruffe (1993) defined competency as “the set of behaviour patterns that the incumbent needs to bring to a position to perform its tasks and functions with competence” (p. 29). He stressed that competencies are essentially concerned with the individual’s behavior and not necessarily with the job itself (Woodruffe, 1993). Girot (1993) equated competency with both performance (the ability to perform nursing tasks) and a “psychological construct” (the integration of cognitive, affective, and psychomotor skills) (p. 84). Nolan (1998) agreed that competency is an individual’s actual performance, whereas competence describes the capacity of individuals to perform the functions of their job. Assessment Strategies, Inc. (2012) defined competencies as being “generally written as behavior statements that reflect the knowledge, skills, abilities, attitudes and judgment required for effective performance in the profession at the level being tested” (¶ 3).

The Canadian Nurses Association (2000) defined continuing competency as the “ongoing ability of a nurse to integrate and apply the knowledge, skills, judgement and personal attributes required to practise safely and ethically in a designated role and setting” (p. 1). Nurses are responsible for “life-long learning, reflective practice and integrating learning into nursing practice” (Canadian Nurses Association, 2000, p. 1). They are responsible for “ensuring that their competencies are relevant and up-to-date on a continuing basis in relation to the clients they serve; seeking out quality education experiences relevant to their area of practice; and supporting each other in demonstrating, developing and maintaining competence” (Canadian Nurses Association, 2000, p. 1). Nurses are responsible for “working with employers to ensure that their workplaces support continuing competence; and meeting the requirements of their regulatory body for continuing competence” (Canadian Nurses Association, 2000, p. 1). Each regulatory body has standards to protect the public, advance practice, provide a reference for resolving concerns related to practice, approve education programs, develop guidelines, assist with legal decisions, provide public information, and ensure nurses’ competency (Saskatchewan Registered Nurses Association, 2006). In the introductory vignette, as a clinical nurse educator, Sarah has the responsibility to provide the RN with the opportunity to learn as well as to promote professional growth and development.

In recent years, the definition of continuing competency has been under debate. Traditionally, the evaluation of clinical skills has been measurement used to assess continuing competency rather than the actual abilities or an understanding of the knowledge behind the skills (Allen et al., 2008). Nolan (1998) defined the latter understanding as competence rather than competency. Assessing continuing competency based solely on skills and knowledge does not provide a holistic picture. Including dimensions to assess communication, motivation, and behavior is important in evaluating the overall competency of the practicing RN. Communication is defined as the sending or receiving of information, motivation is the desire or willingness to do something, and behavior is the way one acts or conducts oneself (Oxford University Press, 2011).

Other barriers to developing a common definition of continuing competency include the difficulty in creating a standard for competency evaluation and the need to decide what competencies all practicing RNs must be able to demonstrate and whether these should be general or fundamental (Allen et al., 2008). There is also the question of how a specific level of skill can be evaluated without being too labor or resource intensive and how often competency evaluations should occur (Allen et al., 2008). Although it is difficult to define “nursing continuing competency” universally, the concept is important to the RN and to Sarah, the clinical nurse educator, in assessing, evaluating, and acting on the process of evaluation and implementation of outcomes.

The concept of continuing competency must be made clear to understand what types of assessment are available to RNs and what needs to be developed further. Most of the existing literature focuses on the competency of students or the entry-level competency of new graduates. Redfern, Norman, Calman, Watson, and Murrells (2002) reviewed the assessment of competency in nursing students. They outlined available evaluation approaches, such as questionnaires, observations, and reflection on practice (Redfern et al., 2002).
Although it is important to verify the competency of entry-level nurses, there is also a need for ongoing assessment to ensure that RNs remain competent for the duration of their practice.

This concept of continuing competency or professional competency is a relatively new term. Nursing associations, such as the Saskatchewan Registered Nurses Association, only instituted a focus on self-reporting in approximately the past 8 years. The recognition by nursing associations that today’s work force is changing and that global migration is increasing led to a realization that the competency of experienced nurses who are moving fluidly from one workplace to another must be more closely monitored.

With an understanding of these concepts, Sarah can begin to look for tools that assess RNs’ competency rather than just their competence. Knowing that the RN may have the knowledge, skills, and behaviors to complete the job but not the knowledge to integrate it, Sarah can better understand the importance of continuing education and assessment of competency.

METHODS

Search Methods

The literature was searched using the following keywords: clinical nurse educator, behavioral problems, professional development plan, professional assessment, nurse attitudes, continuing competency, competency, assessment tools, clinical competency, professional competence, nurses, competency, readiness, and new graduates. These words were searched for individually and in combination. The criteria for including articles were as follows: (1) publication in English; (2) focus on new graduate nurses and practicing RNs; and (3) focus on an assessment tool. The criteria for exclusion of articles were as follows: (1) use of unidimensional tools; (2) lack of reliability or validity testing; and (3) publication more than 10 years ago.

Search Results

The indexes used were CINAHL, ERIC, and PsycINFO. The perspectives of nursing, education, and psychology were sought to obtain a comprehensive review. CINAHL’s keyword search included the following words: clinical competence, competence, competency assessment, new graduate nurses, nurse attitudes, nurses, nursing knowledge, nursing skills, professional competence, staff nurses, and RNs. This search resulted in 105,011 results. When the parameters were refined, the findings became very narrow. The ERIC search included the following keywords: competency, readiness, new graduates, tools, evaluation, assessment tools, assessment, and nursing. This search resulted in 65 articles.

In the end, no articles were included. The PsycINFO search included the following keywords: behavior, assessment tools, measurement, competency, and nurses. This search resulted in one article.

RESULTS

A summary of the articles reviewed, focusing on self-reporting tools for use with practicing RNs or graduate nurses, is shown in the Table. The articles did not use the specific term “continuing competency,” but because all of the articles included participants with workplace experience, it is just a difference in language use.

Cowan, Wilson-Barnett, Norman, and Murrells (2008) recognized the mobility of the international nursing work force as the global shortage of workers increases. To ensure that competent care is delivered across the European Union, Cowan et al. (2008) designed a 108-item questionnaire with eight dimensions: (1) assessment, (2) care delivery, (3) communication, (4) health promotion, (5) personal and professional development, (6) professional and ethical practice, (7) research and development, and (8) teamwork. Cowan et al. (2008) devised a self-assessment tool, given the available time and resources and the importance of critical self-reflection on practice. After the tool was developed, Cowan et al. (2008) translated it into Flemish, German, Greek, and Spanish, and then translated it back into English. Cowan et al. (2008) used a convenience sample of 588 postregistration RNs (response rate = 40%) from medical or surgical inpatient wards in acute care hospitals in the United Kingdom, Belgium, Greece, Germany, and Spain (Table). Findings were reviewed for each individual country before they were reviewed as a whole (Cowan et al., 2008). The Cronbach’s alpha coefficient values for each country exceeded 0.7, except for two dimensions from the Spanish data set: (1) health promotion and (2) research and development. The alpha coefficient value for the combined data set was 0.96 across dimensions and countries.

Lin, Hsu, Li, Mathers, and Huang (2010) identified a need for the development of core competencies for public health nurses in Taiwan. Although Lin et al. (2010) believed that the tool was needed to ensure safe care, they also understood that the recognition of competence helps to motivate practicing RNs in the provision of quality care, gives RNs an opportunity to reflect on their practice and understand their roles, and helps public health systems to meet population-based health improvement goals. The tool has four dimensions: (1) basic care competency, (2) community health management competency, (3) teaching competency, and (4) self-development competency. The instrument includes 38 items (Table). After the tool was developed, seven
<table>
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<tr>
<th>Author/Year</th>
<th>Sample</th>
<th>Tool Design</th>
<th>Validity</th>
<th>Reliability</th>
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<tr>
<td>Cowan, Wilson-Barnett, Norma, &amp; Murrells (2008)</td>
<td>588 registered, general nurses from inpatient units in acute care hospitals in 5 European countries</td>
<td>108-item self-assessment questionnaire (4-point Likert scale) in 8 dimensions: (1) assessment, (2) care delivery, (3) communication, (4) health promotion, (5) personal and professional development, (6) professional and ethical practice, (7) research and development, and (8) teamwork</td>
<td>Tool was discussed, reviewed, re-reviewed, and assessed by 20 professors of nursing, senior nurse educators, nurse managers, researchers, and other academics who deemed the scale relevant to the characteristics intended for measurement, giving it strong content validity. Factor analysis was used for construct validation. Total variance explained was 66.5% and preliminary support was given for 8 dimensions. External validity was not assessed because no “gold standard” tool for the measurement of nurse competence exists in Europe.</td>
<td>Interrater reliability was not tested. Test-retest reliability was not tested. Data sets from each individual country were assessed for reliability before the combined data set was assessed. All but 2 dimensions, both in the Spanish data set, surpassed a Cronbach’s alpha coefficient value of 0.7. Reliability was high for the total questionnaire (alpha = 0.96).</td>
<td>Translation from English may have some effect on validity. Questionnaire is lengthy, and its use may not be feasible in the clinical setting. Very good validity and reliability were shown by the evaluation of individual countries and the group as a whole. Useful for assessing nurse competency when moving from one country to another. Behavioral assessment is limited to communication and professionalism.</td>
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<td>Lin, Hsu, Li, Mathers, &amp; Huang (2010)</td>
<td>1,431 full-time public health nurses in Taiwan</td>
<td>38-item self-assessment questionnaire (4-point Likert scale) in 4 dimensions: (1) basic care competency, (2) community health management competency, (3) teaching competency, and (4) self-development competency.</td>
<td>Seven expert public health professionals with academic or practical experience calculated each domain to have content validity indexes ranging from 0.90 to 0.96, indicating excellent content validity. Items with a correlation coefficient value &lt; 0.4 were eliminated from the scale. Tool may not be suitable for assessing competencies of advanced public health nurses or head nurses; tool is most suitable for the Taiwanese culture.</td>
<td>Interrater reliability was not tested. Correlation coefficients ranged from 0.50 to 0.81, showing acceptable test-retest reliability. Cronbach’s alpha ranged from 0.93 to 0.97, indicating strong internal consistency reliability.</td>
<td>Questionnaire is short and may not encompass all that needs to be assessed. Tool most likely is not created in English, limiting its use anywhere but Taiwan. Only one component on research was included. No competency dimensions on management or advanced skills and no behavior dimension.</td>
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<td>Liu, Kunaiktilkul, Senaratana, Tonmukayakul, &amp; Eriksen (2007)</td>
<td>815 Chinese clinical registered nurses working at 1 metropolitan central hospital, 2 university hospitals, and 1 provincial tertiary hospital in China</td>
<td>58-item questionnaire (5-point Likert scale) in 7 dimensions: (1) critical thinking and research aptitude, (2) professional care, (3) leadership, (4) interpersonal relationships, (5) legal/ethical practice, (6) professional development, and (7) teaching/coaching</td>
<td>Six experts evaluated the initial 112 items, for an overall content validity index of 0.85 and an item evaluation content validity index of 0.85. The correlation coefficients between 8 dimensions ranged from 0.34 to 0.73, and dimensions compared with the total ranged from 0.52 to 0.81. Sample did not include other health stakeholders and did not cover different regions and therefore may not represent the overall status of the Chinese nurses.</td>
<td>Interrater reliability was not tested. Questionnaire was administered to the sample three times, with a 10-day break. Test-retest reliability ranged from 0.76 to 0.91. Total scale internal consistency of Cronbach’s alpha was 0.91. The dimensions Cronbach’s alpha ranged from 0.77 to 0.87, which indicated strong reliability.</td>
<td>Not many items were included in each dimension. Questionable what language was used to develop the tool. Research dimension is included Behavioral assessment is limited to interpersonal relationships and professional development. Useful for feedback, program creation, teaching strategies, performance appraisals, promotions, recruitment, and assessment of learning needs.</td>
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<td>Safadi, Jaradeh, Bandak, &amp; Froelicher (2010)</td>
<td>258 Jordanian nursing graduates from 2001 to 2004 currently working full-time</td>
<td>27-item questionnaire (5-point Likert scale) in 5 dimensions: (1) management, (2) professionalism, (3) problem solving, (4) the nursing process, and (5) knowledge of basic nursing principles</td>
<td>Face validity, evaluated by 5 nurse academics and 2 nursing directors, was strong. Although face validity was strong, construct validity was not tested. A nonprobability convenience sample was used, limiting the generalizability of findings.</td>
<td>Interrater reliability was not tested. Test-retest reliability was not tested. Cronbach’s alpha was 0.97, indicating strong reliability.</td>
<td>Developed in Arabian. No focus on research or behavior. At least 1 dimension included only 3 items.</td>
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experts were asked to evaluate it on a four-point Likert scale and the content validity index was calculated to be greater than 0.8 (Lin et al., 2010). After the review, Lin et al. (2010) recruited 1,534 Taiwanese RNs (response rate = 67.3%) by mailing questionnaires to the head nurses of public health stations in Taiwan and asking them to distribute the documents. Results showed that the Cronbach’s alpha coefficient ranged from 0.93 to 0.97, indicating strong internal consistency reliability. The test-retest correlation coefficients ranged from 0.50 to 0.81, indicating acceptable reliability (Lin et al., 2010).

Liu, Kunaiktikul, Senaratana, Tonmukayakul, and Erikson (2007) developed a tool to measure generic nursing competencies of Chinese RNs because they found no existing instrument for Chinese RNs. Phase I of development included 97 Chinese nurse professionals who clarified the concept of nursing competency and reviewed the tool (Liu et al., 2007). The following categories (dimensions) were developed: (1) leadership, (2) clinical care, (3) interpersonal relationships, (4) legal/ethical practice, (5) teaching/coaching, (6) professional development, (7) critical thinking, and (8) research aptitude. A literature review of existing competency instruments was used to develop a pool of 112 items. A panel of six experts evaluated the items using a four-point Likert scale, ranging from not relevant to very relevant, and gave the tool an overall content validity index of 0.85 for item evaluation (Liu et al., 2007). Conducting pretests with 12 clinical RNs was the last part of this process and resulted in an overall Cronbach’s alpha coefficient of 0.82 (Liu et al., 2007), with alphas for dimensions ranging from 0.69 to 0.89.

Phase II involved a field test evaluating reliability and validity (Liu et al., 2007). The authors recruited 815 clinical RNs in China (91.8% response rate for the psychometric evaluation of the questionnaire) (Table) (Liu et al., 2007). The seven dimensions included: (1) critical thinking and research aptitude, (2) clinical care, (3) leadership, (4) interpersonal relationships, (5) legal/ethical practice, (6) professional development, and (7) teaching/coaching. The results showed a Cronbach’s alpha coefficient of 0.91 for total scale internal consistency, and the coefficient ranged from 0.77 to 0.87 for dimensions (Liu et al., 2007). The item total correlation coefficient ranged from 0.52 to 0.81, and the overall scale Cronbach’s alpha was 0.89 (Liu et al., 2007).

Safadi, Jaradeh, Bandak, and Froelicher (2010) developed a self-reporting tool because of the increasing number of nursing graduates from different universities without a central regulating body, a recent increase in the interest of Jordanian men in nursing, the increase in the population of Jordan, the increased focus on high-quality care as a result of patients’ increased knowledge of health issues, and the need to provide evidence to support nurses’ competence. A pilot test of the tool ($n = 50$) was conducted, and the Cronbach’s alpha was 0.97 (Safadi et al., 2010). The competence assessment scale included 27 items in five dimensions: (1) management, (2) professionalism, (3) problem solving, (4) the nursing process, and (5) knowledge of basic nursing principles (Safadi et al., 2010).

**DISCUSSION**

The continuing competency of RNs is essential to their professional growth and confidence in the workplace and the safe and positive experience of patients. Therefore, a review of self-reporting tools is an important undertaking. Familiarity with the available literature and the appropriate use of tools will aid in Sarah’s ability to confidently provide direction to RNs in the assessment of their capability to carry out the competencies included in their job description. Knowing the tool’s credibility will allow Sarah to feel confident in the results and in using the results to design teaching strategies for further education of RNs.

Although there is a large literature base on the competency assessment of students, the author’s search of articles published during the past decade showed only four self-reporting tools that included psychometric evaluations for RNs. There is a need for greater focus on competency development once nurses have completed their formal education. Without the right tools to assess competency, it is difficult to know whether nurses are safe to practice years after entering the workforce. Future research on the continuing competency of practicing RNs is needed. None of the assessment tools with acceptable validity and reliability were tested with practicing RNs in Canada. Although the tools may be adapted for use with Canadian RNs, revisions would need to be made and their reliability and validity would need to be tested further before their use.

Each article showed strong validity. They were reviewed by a panel of experts and had strong results. The reliability of the articles was strong, except for the article by Safadi et al. (2010) (alpha = 0.97). Cowan et al. (2008) stated that one of the limitations of their study was that the pool of data needed to be increased and more RNs trained in the United Kingdom needed to be included to enable use of the tool in all European countries. However, reliability was strong despite this known need.

The language used to develop the tool has the potential to make a difference in the validity and reliability of the instrument. Cowan et al. (2008) developed their tool in English. Then they translated it into Flemish, Ger-
man, Greek, and Spanish, and then back into English. However, throughout the translation process, no significant changes in meaning were identified (Cowan et al., 2008). The article by Lin et al. (2010) did not identify the language used to develop and use the tool, but it is clear that the instrument was designed for nurses in Taiwan, so the tool was potentially developed in Taiwanese. Liu et al. (2006) also did not include this information. However, the tool was designed and tested in only one Chinese nursing population. Therefore, it may have been developed in Chinese. Safadi et al. (2010) specified that their Competency Evaluation Questionnaire was developed in Arabic and that the published version in English is a translation. Translating these tools may change the meaning of the components and give inaccurate results. Comparison of the items in the European Union tool (Cowan et al., 2008) with those in the Jordanian tool (Safadi et al., 2010) shows that culture has an effect on which items represent the dimension of professionalism.

When choosing a tool, Sarah may consider its user friendliness. The reviewed tools were all developed in a self-reporting format. The tool designed by Cowan et al. (2008) is lengthy and may not be as easy to use as some of the other instruments, but its length may give it more reliability. Lin et al. (2010) designed a shorter tool that may be more user friendly, but because one of the domains has only five items, the results may not be as reliable as with a longer instrument. The tool designed by Liu et al. (2007) appeared stronger because each dimension had at least six items. The questionnaires were timed to take 26 minutes each. Safadi et al. (2010) included six dimensions with 27 items. However, at least one of the dimensions had only three items, which may not be enough to assess that area accurately (Safadi et al., 2010).

Another aspect to consider is what dimensions are included in the tool. All of the reviewed instruments were multidimensional, and each included a dimension on care delivery and personal and professional development. Cowan et al. (2008) and Liu et al. (2006) specifically focused on research, whereas Lin et al. (2010) included only one item on this topic because it was determined that a public health nurse’s workload does not involve a large amount of research. Lin et al. (2010) did not include any dimensions on management abilities or the teaching of nursing students because these topics were not relevant to the public health nurse role in Taiwan. Lin et al. (2010) did not include competencies involving advanced skills, new job items, or head nurse responsibilities. The instrument developed by Safadi et al. (2010) was designed to be used by the supervisor rather than the nurse, creating potential bias. This variation in identified domains adds value to the self-reporting tools and provides different perspectives on the assessment of RNs. One of the differences is the area of work on which the tool focused. However, the topic of ethics crosses borders and the specificity of the workplace should not be a barrier to proper assessment.

One gap in the literature is the lack of self-reporting tools that could differentiate a competency issue from a behavioral issue. RNs who are unwilling or unable to complete their work because of burnout, laziness, intimidation, fear, or low confidence may be able to pass the evaluation, given the self-reporting format. However, these nurses may not be able or willing to perform the tasks at hand competently in the clinical setting. Other methods, such as observation and reflective journaling, may be more useful. Understanding the competency of an RN involves more than just technical skills. Competency is multidimensional; therefore, a multidimensional instrument is needed. Although Cowan et al. (2008), Lin et al. (2010), and Liu et al. (2006) included at least one item on communication or self-assessment, Safadi et al. (2010) did not. These items are important in assessing behavioral issues rather than just skills.

With an understanding of the gaps in the literature and the lack of availability of holistic self-reporting tools, Sarah would be wise to explore alternate methods of assessment of staff while trying to find a useful and suitable tool. She may want to consider methods such as self-study packages, skills days, or the Performance-Based Development System designed by Dr. Dorothy Del Bueno (Whelan, 2006). Portfolios and reflective journaling are also useful tools for assessing professional competency (Byrne, Schroeter, Carter, & Mower, 2009; Harrison & Fopma-Loy, 2010). Other methods of assessment include simulation, the Objective Structured Clinical Examination, and basic pen-and-paper examinations (Allen et al., 2008; Watson et al., 2002). These “hands-on” assessment tools can place the RN in a more real-life situation and may be more helpful in predicting the outcome when the nurse is faced with a difficult decision. Whichever method or tool Sarah should choose, it should be the one that supports the staff and their teaching and assessment strengths. Being informed and knowledgeable about the tool that is used will help to ensure a smoother and more accurate assessment.

CONCLUSION

Understanding the importance and requirements of the continuing competency of RNs is the first task in choosing a self-reporting tool. Sarah, the clinical nurse educator, must understand the meaning of continuing competency and how it applies to the clinical setting. Being aware of the requirements for professional regis-
triation and the responsibility to the public will aid her in choosing an appropriate instrument. Knowing which tool to use, how to use it, and how to respond to the results will help her to ensure that competent care is provided by every practicing RN. It is also important to understand that an instrument will not be able to measure every factor, even when it includes dimensions on behavior. Sarah will need to use her judgment when evaluating staff. Building a professional relationship and keeping in mind that the goal of assessment is to further the RN’s development rather than cause discouragement will support the process of education and professional growth. Recognizing gaps in knowledge and the need for further research will encourage Sarah and other clinical nurse educators to evaluate the tools critically and can potentially lead to the development of a more comprehensive assessment instrument.

REFERENCES

key points

Continuing Competency

1. Assessing continuing competency based solely on skills and knowledge does not provide a holistic picture of the ability of a registered nurse (RN) to provide quality patient care.

2. It is important to understand the concept of continuing competency and the types of assessments available to practicing RNs.

3. RNs’ continuing competency is essential to their professional growth and confidence in the workplace as well as the safe and positive experience of patients.