
**CONSUMERS PERCEPTIONS OF
COMPETENCE IN NURSING**

Presented at the Annual Meeting of the 1999 National
Council of State Boards of Nursing, Inc. Educational
Sessions

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Montgomery, Alabama

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Authors of the Abbreviated Article published in ISSUES Vol. 20 Number 3.

By Jean B. Mann, EdD, RN
Anne Permaloff, PhD
Gregory Howard, LPN
Yvonne Albert, LPN
Charlie J. Dickson, EdD, RN, FAAN
B.J. Scharath, MSN, RN
Jeanne Sewell, MPH, RN

Acknowledgements

This paper has been developed as part of a major research project sponsored by the Alabama Board of Nursing under the direction of the Committee on Continued Competence and Continuing Education.

Committee Members

Charlie J. Dickson, EdD, RN, FAAN, Chairperson; Greg Howard, LPN, Co-Chairperson and Board Vice-President; Yvonne Albert, LPN; Anne Permaloff, PhD, Consumer; B.J. Scharath, MSN, RN; Jeanne Sewell, MSN, RN.

Board of Nursing Staff

Jean B. Mann, EdD, RN
Pamela Carpenter, MSN, RN

Data Collection and Analysis

Jerry Ingram, PhD
Southeast Research
Montgomery, Alabama

Instrument Validation

Linda Davis, PhD, RN
University of Alabama at Birmingham

Administrative Support

Lynn Norman, MSN, RN
Interim Executive Officer

Consumers Perceptions of Competence in Nursing

Introduction

States generally give authority and power to regulatory boards, under the Tenth Amendment of the Constitution of the United States, to take steps necessary to protect the public from unqualified and unscrupulous practitioners. The Board of Nursing in Alabama is obligated to "Adopt standards for registered and practical nursing practice and for continued competency of licensees..." (Code of Alabama 1975, §34 -21-2 (21)). As early as 1915, three mechanisms were established to accommodate this function: (1) the approval of schools of nursing for the preparation of individual licensees for entry into practice, (2) the subjecting of qualified licensees to a written entry level examination that measures knowledge and the application of knowledge to selected clinical situations and (3) discipline of licensees who failed to meet a particular standard. These mechanisms have continued throughout the century. In the mid 1980's a special Board task force proposed implementing a continued competence model that would provide some degree of assurance that nurses were current in practice. This model was shelved to accommodate a legislatively mandated continuing education program. The legislative oversight committee acknowledged, with the Board, controversies about the effectiveness of mandatory continuing education but stated unreadiness to deal with a comprehensive competence model.

Challenges against the effectiveness of entry level models and continuing education models as means of assuring competence have increased in the 1990's and merged with other national concerns about competent practice, competency of practitioners and the role of regulatory agencies in assuring public protection. A major compounding situation is the reality of increasing numbers of complaints submitted to the Board of Nursing of perceived incompetence in practice.

With these considerations, the Board authorized a formal research project to address potential need for and processes necessary to institute a comprehensive competence model. In an effort to assess nursing competence, two different philosophies have been examined. The first relates to mandating continuing education. The second involves the assessment of nursing quality via identifying indices used by various publics to assess competence. Four publics, consumers, educators, organizational representatives and licensees are the focus populations for the research. The first of the four deals with consumers and their perceptions of competence. The purpose of this project is to report the process and findings of a consumer based study to measure nursing competence as perceived by the public.

Background and Framework

Competence

In simplest terms competence is the possession of knowledge, attitudes and skills necessary to meet a certain standard of practice. The National Council of State Boards of Nursing (1996) adopted the following definition, "...the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public

health, safety and welfare.” Assuring competence creates controversy in that questions must be answered relative to what competence entails, who says what it entails as well as the expected level, how and how often it will be measured, who will do the measuring, and who will be accountable for ensuring the expected level of competence is met.

The definitions of competence provide a structure of what is entailed. The usual anticipation has been, until recently, that the members of a particular profession or occupation will set the parameters for competence. In this time of managed care employers have assumed a major role. Today there is major shifting focus to the consumer. Measurements of competence are very liquid. Various approving and employing agencies have set standards for performance. These standards usually emanate from standards of practice set by an official regulatory body.

Regulation for Competence

“Regulation implies the intervention of the government to accomplish an end beneficial to its citizens... The power to regulate occupations is based upon the police power of the state to enact reasonable laws necessary to protect its citizens” (Sheets, 1997). In performing its regulatory function, a state may grant to professions/occupations a degree of self-regulation on the assumption that each profession will develop appropriate ethical and competency standards. This assumes that the profession will require a higher standard of practice and ethical behavior of its members than is required by society in general particularly when the profession’s practice encroaches upon the public’s physical, mental or economic well being. The usual approach has been to assure that those who enter practice are competent to do so and to punish those who thereafter fail to meet a standard of practice. Controversies over the value of continuing education (CE) in assuring competence and pragmatics of implementing mandatory CE programs have led to inconsistencies in across-state and within-state regulations. Continuing competence models are few and seem to rotate around continuing education and/or discipline.

Ontario’s College of Nursing has initiated a comprehensive program using a quality assurance mechanism to measure continued competence of practitioners. Briefly, the components of this plan include entry into practice, on going (self-reflective practice with plans for improvement), re-entry into practice and resolution after a complaint (Campbell, 1998). While dialog has taken place and some states are considering a comprehensive model, a majority of states have not developed a plan to measure continued competence for general nursing or for advanced practice nursing.

Legal opinions about regulating for competent practice have been issued along with challenges by groups with vested interest. A recent study of continuing education and case law revealed an increasing number of decisions over the past five years have linked competence to continuing education (Mann, et. al., 1998). In the Matter of Wolfram, 174 Ariz. 49, 847 P.2d 94 (1993), the Supreme court of Arizona “held that lack of competence and diligence, failure to communicate with client, and failure to cooperate with state bar inquiries warrants suspension from the practice of law, additional legal education and full restitution to client.” (p. 94) Individual attorneys state that the primary role of boards of nursing is to protect the public, and that focus should be on detecting incompetence for violation of a standard rather than defining or measuring

the licensee's competence. Reeves (1998) said, "I believe that it is much easier to recognize incompetence than competence, and therefore, believe the disciplinary function should be emphasized more than it currently is." Other agents, however, question how one could measure or determine incompetence if the elements of competence have not been defined, delineated and measured. Trebilcock (1998) indicated the need for the legal profession to devote less regulatory compliance resources of its members to input regulation and devote a higher proportion of its resources to output regulation." Also, he stated that the intent should be to generate "a set of product or service qualities and costs that informed consumers would want." (p. 14).

The 1998 Pew Taskforce on Health Care Work Force Regulation states, "The ostensible goal of professional regulation - to establish standards that protect consumers from incompetent practitioners - is eclipsed by a tacit goal of protecting the professions economic prerogatives." These dichotomous goals of professional regulation create shortcomings in public accountability and support monopolies that limit access to care. A major focus of the Pew Commission's projects is to enhance consumer protection through challenging professional regulation so that "it unequivocally serves the public good."

Consumers

Consumers are a "broad class of people who are affected by pricing policies, credit reporting, debt collection and other trade practices for which state and federal consumer protection laws are enacted." (Black, et al., 1990) They are users of products and services. Health care delivery provides services that are bought. This concept is recorded in ancient history, and places considerable reverence in those who provided the service. Accountability was not always exacted but in some cultures specific outcomes were expected. Failure to meet a particular outcome could result in loss of life or limb (Kelley and Joel, 1995). More often, however, consumers were "patients" waiting for a particular service. They received their services without participating in the decisions affecting their lives.

A consumer revolution began, it is thought, in the early part of the twentieth century, with the signing of the 1906 Pure Food and Drug Act. It remained relatively static through the course of several years until the 1960's, when a gradual upsurge of interest began. Kelley and Joel (1995) stated that John F. Kennedy, in 1962, gave a message to Congress that included four basic human rights: right to safety, right to be informed, right to choose and right to be heard. More emphasis in the 1960's centered on the civil rights movement rather than consumers rights. In the 1970's however, a number of interested groups formed including the Citizens Advocacy Council and the Society for Healthcare Consumer Advocacy. Work from groups such as these spurred a movement toward the development of the American Hospital Association's "Patient's Bill of Rights." (see <http://www.hcqualitycommission.gov>). This document focuses on the formalized health care delivery environment and encourages patients and their families to be participatory in their care. As changes in health care delivery have occurred, attention has begun to focus on a broader community care delivery and the "consumer." On March 26, 1997, President Clinton appointed an Advisory Commission on Consumer Protection and Quality in the Health Care Industry, to "advise the president on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value and protect consumers and workers in

the health care system.” (p.6) This Commission drafted a Consumer Bill of Rights and Responsibilities that purports to seek greater patient participation in improving and assuring their health, developing a strong relationship in working with their professionals and reaffirming the role consumers play in safeguarding their own health. (See <http://www.hcqualitycommission.gov>). Although they imply accountability, neither of the Bills of Rights contains elements of regulation of individuals who deliver their care. Thus the challenge for accountability in quality of health care comes from the consumers and those who have a desire to remain self-regulated.

Assumptions

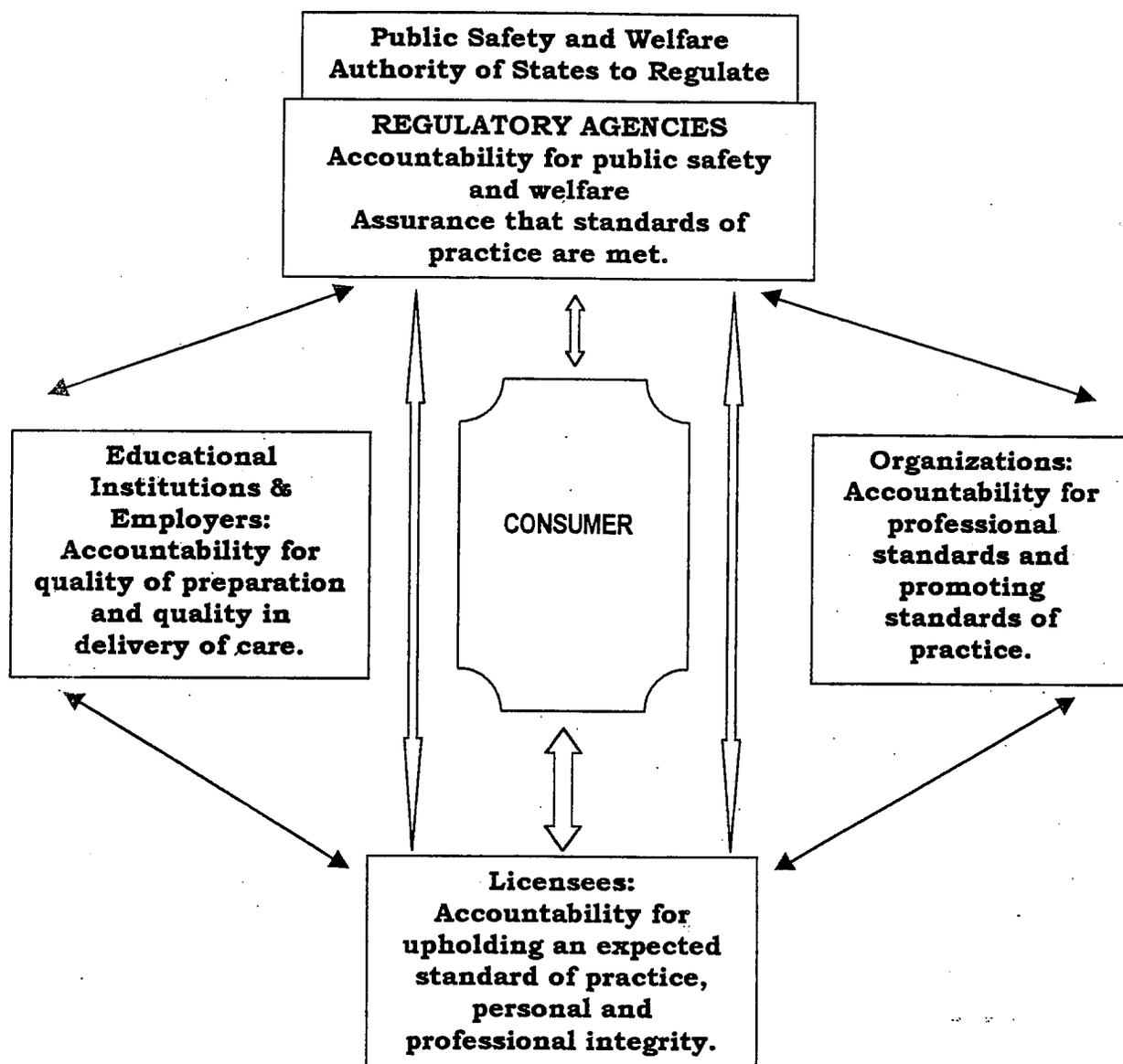
While not all inclusive, the elements described in the preceding narrative led to several assumptions that formed a framework for this research project.

1. There is a professional and ethical responsibility to make every effort to assure public protection as statutorily authorized.
2. There is need to clarify benchmarks of competence and to refine the standards of practice.
3. A competence model should include evidence of quality assurance and improvement using the APPLE model (Administratively feasible, Publicly credible; Professionally acceptable; Legally defensible and economically affordable) (NCSBN, 1998). Because research has shown that continuing education is a contributing factor to competence, but does not, as an individual entity, assure competency, (Mann, et al., 1998), a model for measuring competence in practice will include expected outcomes that exceed the continuing education model.
4. No universal system has been accepted for determining those actions needing public protection, but there is a professional obligation to assure competence and to set standards.
5. A profile of the competent nurse can be assembled and used to facilitate model development. Such a profile can be developed through systematic and rigorous study of populations with vested interest.
6. Consumers of health care, educators and employers, organizations and licensees are populations or publics with vested interest and should be consulted in matters relating to regulation for nursing competence.
7. Because public protection is the primary purpose of regulatory agencies, first focus should be on the consumer.

An Organizing Framework

The model that follows as Figure 1 takes into account the above stated assumptions and previous work by the National Council of State Boards of Nursing, Inc. (Sheets, 1997) and a multidisciplinary group of researchers from the Alabama Board of Nursing, the University of Alabama at Birmingham and the State of Alabama Supreme Court Library (Mann, et al, 1998). At the core of the model is the consumer. The driving factor is accountability for public safety and welfare. Those accountable for assuring safety and welfare include licensees, regulatory agencies, educators, employers and members of professions. The model exhibits interactions between accountable parties.

Figure 1. Accountability Model for Competent Nursing Practice: An Organizing Framework



Research Questions

Research questions for the project evolved from a group process in which a focus group of consumers, through a guided interview, determined nursing competency indicators, attached a measure of quality to competence, identified potential threats to nursing competence, public safety and welfare, and suggested mechanisms for assuring competence of nurses. The focus group's

responses were video taped by permission. Additional questions were generated from the Committee on Continued Competence and Continuing Education. They centered on regulation for entry and continuance in practice as well as appropriate actions to take in event of failure to meet a standard. The interview guides are included as Appendix A.

Specific research questions:

1. What attributes do consumers identify as significant indicators of a competent nurse or competent nursing practice?
2. What desired level of performance do consumers place on each indicator of competence?
3. How do consumers rate selected competency indicators of Alabama nurse licensees?
4. What rating do consumers give to quality of care provided by Alabama nurse licensees?
5. Do consumers view the competency of nurses as a threat to the quality of nursing care in Alabama?
6. What factors do consumers perceive as contributing to a threat to the competency of nurses today?
7. What are consumers' perceptions about who should be accountable for determining and assuring that nurses are competent to practice in Alabama?
8. What are consumers' perceptions about requirements for nurses to practice in Alabama?
9. What are consumers' perceptions regarding requirements for continuing in nursing practice? Life long license? Demonstrating continuing competence? Skills required?

Research Methodology

Instrumentation

In order to accomplish the objectives of this study, both qualitative and quantitative research were conducted. The qualitative research involved a process of obtaining data from a focus group of individuals who helped identify factors of nursing competence. Here an interview guide was employed to generate discussion about the project's purpose and to identify attitudes and attributes/indicators about nursing competence, and ways and means of assuring competent nurses. The information gleaned from this group was incorporated into a questionnaire for the quantitative component of the project. Review protocols were implemented according to requirements for the protection of human subjects.

The instrument was pretested first on a group of nursing care consumers to determine validity and logistic soundness from the consumers' perceptions. An outside reviewer as well as members of the Continuing Competence and Continuing Education Committee further evaluated it. The instrument was revised then tested a second time. It was found to require 18 minutes to obtain data that the Committee deemed essential for the project's purpose. Even so it tested reliable for administration to the sample.

Study Sample

The focus group participants consisted of a random sample of 12 men and women heads of the households. All were over the age of 18 and fiscally accountable residents of the metropolitan and rural areas of Montgomery County Alabama. These individuals were selected by telephone survey and were not related to any member of the research team, nor were they licensed nurses.

The survey sample consisted of a statewide sample of 600 randomly selected men and women adult heads of households with no nurse or nurses aid in residence. The respondents were selected through a process of random digit dialing. The margin of error due to sampling for the survey is +/- 4.0 percentage points at the 95% confidence level.

Analysis

Data were tabulated, organized and subjected to a variety of statistical tests. Descriptive statistics were employed to organize demographic variables and categorical data. Non-parametric tests were applied to determine relationships of practice characteristics to various demographic variables.

Findings

Qualitative data from the focus group revealed consumers' perceptions of standards of practice, technical skills, behaviors and the knowledge base expected of nurses to assure public protection. They also identified consumers' knowledge of regulation that could impact multi-state licensure. These data were incorporated into the instrument for the survey of the sample of 600.

Demographic data were studied in order to describe the sample. Table 1 shows frequencies and percentages of the study sample tabulated for age, race, gender, and education.

Table 1. Demographic Variables of Study Sample for Competence Survey of 600

Variable	Frequency	Percentage
Gender		
Male	284	48
Female	316	52
Age		
18-24	43	7
25-44	229	38
45-64	210	35
65 and over	114	19
NA	4	7
Education		
Some high School	84	14
High School Graduate	174	29
Some College	179	30
College Graduate	94	16
Graduate/Professional	69	11
Race		
Black	116	19
Caucasian	462	77
Other	19	3
NA	3	<1

The study population consisted of 284 males, 316 females between the ages of 18-65+, with at least a minimum of some high school education. The racial mix was comprised of 462 Caucasians, 116 blacks, 19 "other" and 3 undesignated. In the survey, the proportion for the black population is slightly lower (19% vs. 22%) than the Alabama average. This can be explained by the lower incidence of black households having a telephone.

In Table 2 the first two columns present aggregate data that respond to the first three research questions. Specifically, it shows the attributes consumers identified as significant (very important) indicators of a competent nurse or competent nursing practice, and establishes a desired level of performance for each indicator of competence. The attributes listed in the first column were derived from those identified by the focus group. The second column shows the percentage of consumers in the study sample that rated the attribute as "very important." In the remaining columns, consumers actually rated nurse licensees' performance based upon their own experiences.

Table 2. Comparison of Consumers' Desired Attributes to Actual Performance

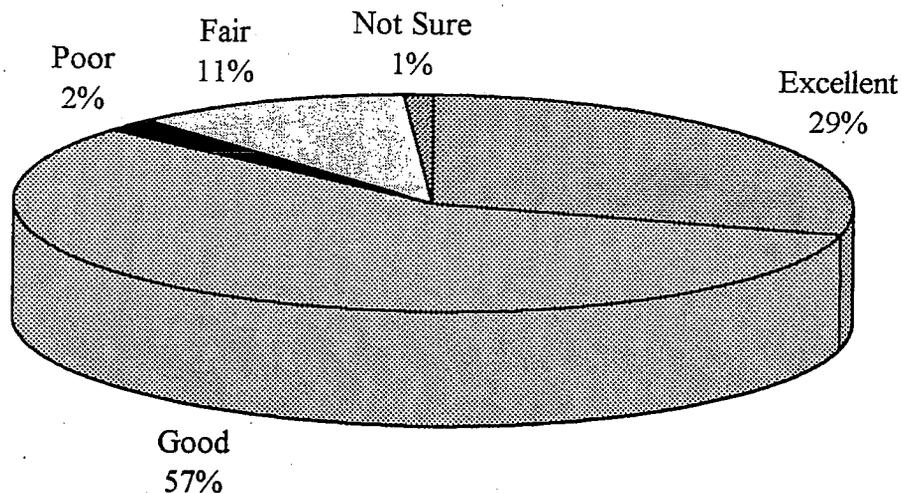
Attribute	Percent "Very Important" Rating	Percent Actual Performance Ratings		
		Excellent	Good	Fair + Poor
Knowing how to use equipment properly	99	39	47	11
Being able to handle a crisis situation	96	34	47	10
Communicate well with patients	94	29	53	16
Responding to the needs of patients' quickly	92	24	43	31
Being confident in the way they do their job	92	32	50	16
Caring attitude	91	29	49	21
Good attitude	90	25	56	17
Being courteous	88	28	53	18
Going about their job in a professional manner	88	29	53	16
Knowledge necessary to provide patients with reliable health care information	87	27	53	18
Treating all patients the same	85	26	47	21
Working well with other health care professionals	83	27	54	13
Neat, clean appearance	83	48	43	8
Good bedside manner	81	27	50	19
Showing respect for patients' privacy	80	35	47	16
Knowing the needs of patients' families	56	19	46	31

The attribute with the greatest number of respondents (99%) in the sample of 600 was "Knowing how to use equipment properly." This desired attribute was, in terms of actual performance however, rated as "excellent" by 39 percent of the sample while 47 percent rated actual performance as "good." Eleven percent rated the actual performance as fair - poor.

The attribute with the lowest percent respondents who rated the desired outcome as "very important" was "Knowing the needs of patients families." The performance ratings were "excellent" (19%), "good" (46%) and "fair-to-poor" (31%). Only one of the attributes, "Being able to handle a crisis situation," had a combined "excellent to good" performance rating of 90%. All others fell short of this usual expected quality assurance level.

The fourth and fifth research question focused on what consumers perceived relative to quality of care based on their experiences. A general rating was first established relative to percent responses. The general rating was then crosstabulated with age, gender, education and race. Figure 2 shows the general rating of quality of care by percent responses on a scale ranging from "excellent," "good," "fair" to "poor" and "not sure."

Figure 2. Rating of the Overall Quality of Care Being Provided by Nurses in Alabama (N = 600)



Close to 30 percent (n = 172) of nursing care consumers in Alabama rated the overall quality of care provided by Alabama nurses as excellent, while another 57 percent (n = 342) considered the quality of nursing care as good. Eleven percent (n = 67) rated it as fair, and two percent expressed the nursing care quality as poor. A cross tabulation of gender with quality showed females slightly more likely (30% to 27%) to rate quality as excellent. Fifty-seven percent in each case rated it good. Females rated the quality of care fair or poor 11 percent of the time while the male rating was approximately 15 percent.

Age differentiation regarding quality of care shows a third or more of those 65 and above or 18-24 rated the overall quality of care as excellent, while 53 and 49 percent of these age groups respectively rated care as good. In the 25-44 age range 24 percent rated care as excellent while 59 percent rated it as good. Among those 45 to 64 these figures were 29 and 59 percent respectively. The greatest variance occurred in the fair to poor ratings. In ascending order of age fewer respondents used the lower ratings. For comparison, 19 percent of the participants in the 18-24 age range rated care as fair; only 7 percent of those 65+ rated care as fair or poor. Pearson Chi-square tests were performed on the crosstabs of age to overall quality of care. These numbers were found to be statistically significant at the 0.05 level when the Excellent/Good, Fair/Poor ratings were collapsed and when the age groups were collapsed to <45 and 45+.

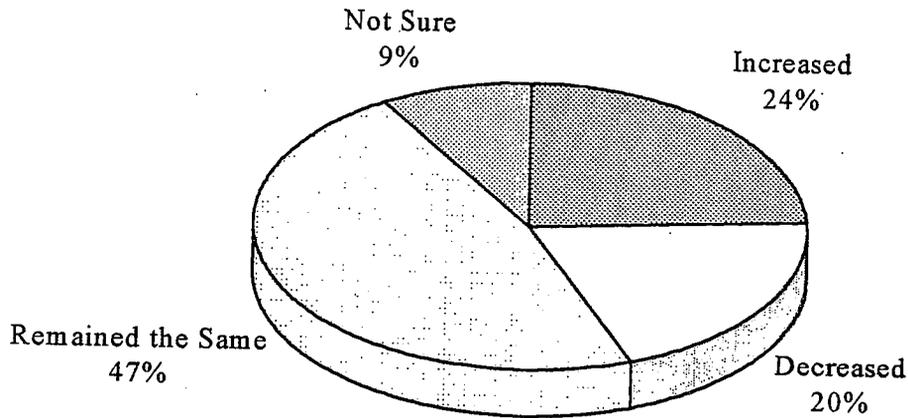
In terms of education, five groups were identified: high school or less, high school graduate, some college, college graduate and post baccalaureate degree. Approximately one third of all groups except the college graduates rated quality of care as excellent, and approximately 54 percent rated quality of care as good. The college graduates used the excellent rating only 17 percent of the time while giving an aggregate rating of 69 percent as good.

Tabular data regarding quality of care by race indicate that approximately 85 percent of the participants used the excellent or good rating. Blacks were more likely than Caucasians to rate care as excellent (35 to 28 percent). Sixteen percent of blacks rated care as fair to poor in comparison to 12 percent of Caucasians.

When considering personal experiences with nurses by type of agency in which the participant or household members had contact most recently (within the last three months), 10 categories of health care agencies were identified. The overall quality of care being provided by nurses was cross tabulated with these agency contacts. For purposes of analysis, the good and excellent ratings were combined. Perceived quality of care by agency and nurse contact ranged in the good to excellent categories from 78 percent to 85 percent with a mode of 85 percent. In descending rank order, the agency contacts were doctors office, public health, other (85%); in-home care (84%); hospital (83%); urgent care facility (82%); outpatient facility (81%); nursing home and rural health clinic (80%); and emergency room (78%). Those who reported no contact with an agency (21% of the sample) used the excellent or good rating 87% of the time. Respondents often reported contacts with more than one agency, and it should be remembered that they are not rating the agencies.

In addition to assessing quality of care provided by nurses in Alabama, consumers were asked about trends in quality of care over the last five years. Specifically, they were asked to rate the quality of care as increased, decreased, or the same. They were also given an option to state "not sure." Figure 3 illustrates graphically their percentage responses.

Figure 3 . Opinions Concerning Trends in the Quality of Care Provided by Nurses in Alabama during the Last Four or Five Years (N = 600)



Most of consumers (47%) rated the quality of care provided by nurses over the past five years as remaining the same while 24 percent said that the quality of care had increased. Twenty percent, however, were explicit in their statements that quality of care provided by nurses had decreased. Another 9 percent stated they were not sure of a change in quality of care. Crosstabulations were conducted to determine any association of selected demographic variables and responses regarding quality of care over time.

Minimal differences were discovered in percentages of males (21%) and females (25%) who indicated an increase in quality of care provided by nurses. Men were less severe than women in their assessment regarding a decrease in quality (18% and 23% respectively). Fifty-one percent of males and 43 percent of females stated that care was the same. A narrow margin of difference in percentages of males (10%) and females (9%) was noted in those who indicated that they were not sure about a change in the quality of care during the last four or five years.

Some variance was found in the percentage of responses regarding quality of care and age. Nineteen percent in the 18–24 age range category stated care quality had increased while 19 percent of those 25–44 indicated an increase. As age increased so did the numbers of participants who said that quality of care had increased, 25 percent for those aged 45–64 and 32 percent for those 65 and over. The Pearson Chi-square test was applied to age and trends in quality of care. These numbers were found to be statistically significant when age groups were collapsed to <45 and 45+.

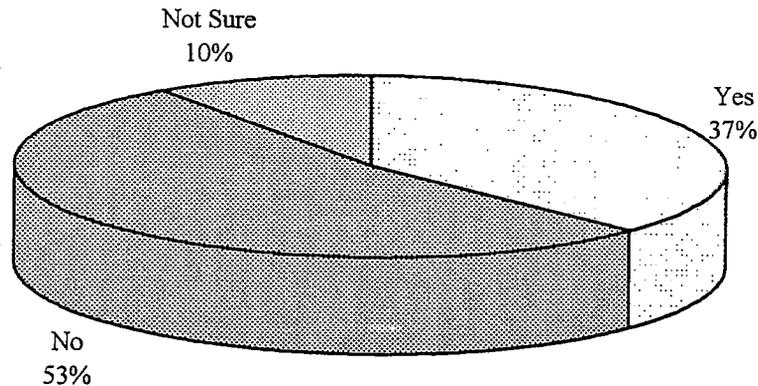
When considering respondents' education, variance was found in the opposite direction from age. Twenty-seven percent of those who had some high school as well as those who graduated from high school stated that there was an increase in quality of care over the past four or

five years. Twenty-four percent of those with some college indicated there was an increase while those who had graduated from college and those with a professional or graduate degree stated an increase at 17 percent each. Less indicated care had decreased in all categories of education. Here a zig-zag pattern emerged with some high school (21%), graduated high school (18%), some college (20%), graduated college (23%), and graduate or professional degree (22%). The range of respondents who said that quality of care by nurses in Alabama had remained the same was relatively close except in one category. The percentage responses were, some high school or less (42%), graduated high school (45%), some college (49%), graduated college (48%) and graduate or professional degree (54%). Those who indicated that they were "not sure" regarding changes in quality of care over time were less than 10% of the total.

The cross-tabulation of race with change in quality of care over four to five years provided some diversity of response. The category "increased" varied between Caucasians and Blacks by 16 percentage points (20% to 36% respectively). While not validated by research, some comments have indicated that this may be due to greater access of care to all individuals. Slightly more Blacks than Caucasians stated quality of care had decreased (22% and 19% respectively). By far, a majority indicated that the quality of care remained the same over time. In another category of respondents entitled "other" an equal response of 32 percent was calculated for each of the three categories. In the category "not sure" the percentage of consumers responded in varying order, Caucasian (11%), "Other" (5%) and Blacks (2%). These numbers were found to be statistically significant at the 0.05 level when the "other race" group was left out (low frequencies) and only black and white groups were used.

When the study sample's responses were cross tabulated in regard to estimated changes in quality of care over time with experiences in health care agencies, most (36 to 47%) indicated that the quality of care had remained the same; however, 22 to 26 percent of the sample stated that care quality had decreased. Twenty-two to 37 percent stated there was an increase in care. The agencies that were considered in this question were doctors' offices, hospitals, emergency rooms, urgent care facilities, outpatient clinics, nursing homes, in-home health care, public health departments and rural health clinics. The fifth and sixth research questions relate to consumers' views of competency and a potential threats to the quality of nursing in Alabama as well as to the nurses' competency. Figure 4 provides an overview of consumers' estimate of nurses' competency as a threat to the quality of nursing in Alabama. As shown in the graph, only three categories of responses were used: "yes", "no" and "not sure."

Figure 4. View of the Competency of Nurses as a Threat to the Quality of Nursing in Alabama (N = 600)

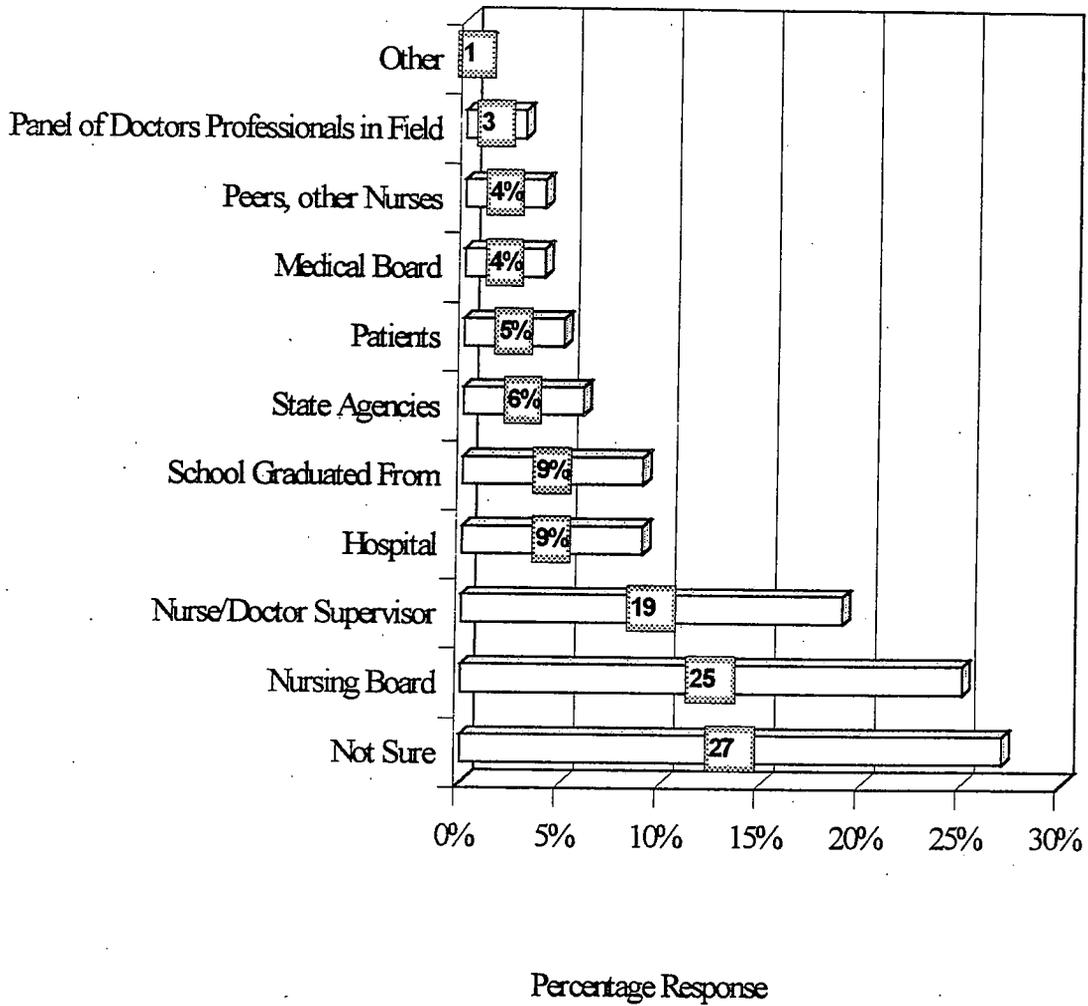


Raw data for this figure were considered in relation to three concerns identified by the focus group; replacing registered nurses with practical nurses, replacing practical nurses with nurses aids and giving nurses too many patients to care for. In the category "yes," 37 of the participating consumers stated today's nurses' competency is a threat to quality of nursing care in Alabama. Fifty three percent stated that nurses' competency is not a threat to quality of care and 10 percent stated they are not sure.

A large majority of the respondents stated that replacing registered nurses (RN) with practical nurses, and practical nurses (LPN) with nurses' aids is a threat to nurses' competency (58% and 67% respectively). The greatest threat as identified by the consumers is giving nurses too many patients to care for (92%). Only two percent indicated giving too many patients per nurse was not a threat to quality of care. Approximately 10 percent of all respondents indicated "not sure" in each of the potential effectors of threat to competence.

The consumers who participated in the focus group were given an open ended question regarding who should assume or be responsible for determining if a nurse is competent to practice (Research question 7). Their responses served to structure the consumer survey question. Figure 5 identifies consumers' perceptions of agents, agencies and individuals they believe should be responsible for determining nurses' competence to practice.

Figure 5. Perceptions Regarding Responsibility for Determining Nurse Competency (N = 600)

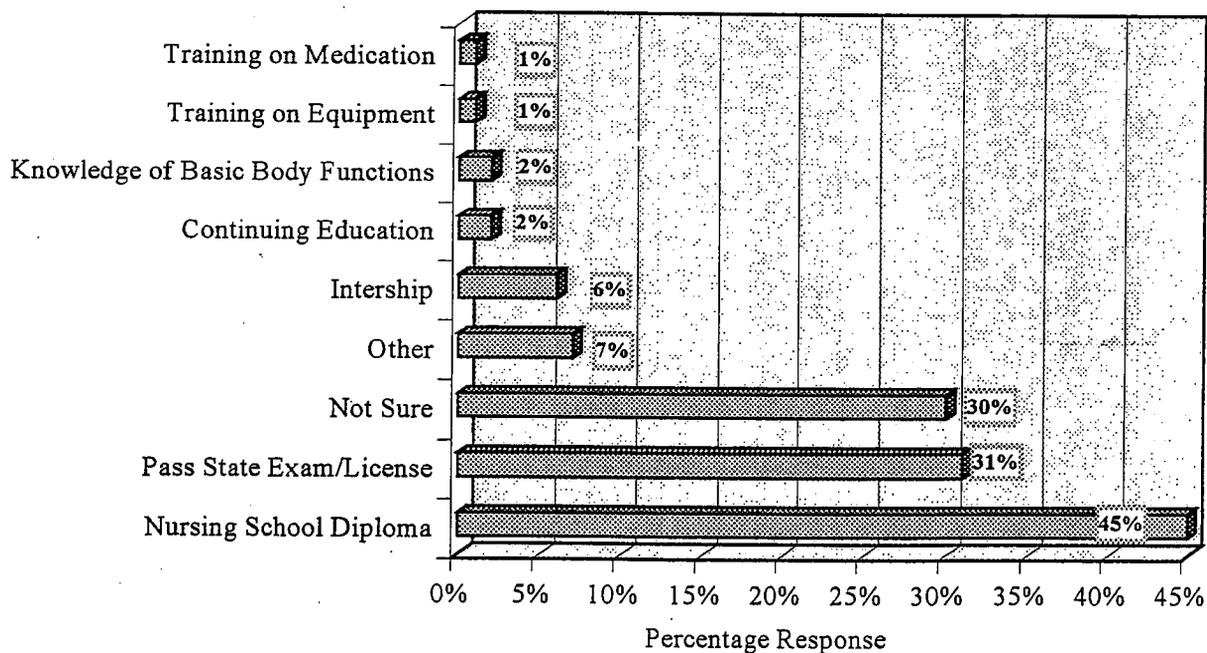


* Total exceeds 100% due to multiple responses

Ten categories of agents, agencies and individuals were perceived by the consumers as responsible for assuring nurse competence. Twenty five percent of the respondents stated that the Board of Nursing should be the responsible agency. The next greatest percentage of responses was nurse/doctor supervisors (19%), hospitals (9%) and the school from which they graduated (19%). The remaining 23 percent divided similarly, the state (6%), patients (5%), medical board (4%), and peers and other nurses (4%). Doctors and other professionals in an associated field completed the assessment at three percent. An undifferentiated "other" category was calculated at one percent. Perhaps one of the most revealing findings was the number of consumers (27%) who were "not sure" of who should be responsible for assuring nurses competence for practice. Varying reasons were projected regarding the high "not sure" response. Among these was a probable lack of knowledge about regulation and criteria for licensure.

Figure 6 specifies consumers' perceptions of requirements that nurses must meet in order to practice nursing in Alabama. The requirements, as shown, were generally oriented to knowledge and psychomotor skills needed for safe practice.

Figure 6. Perceptions Regarding Requirements Nurses Must Meet to Practice Nursing in Alabama (N =600)

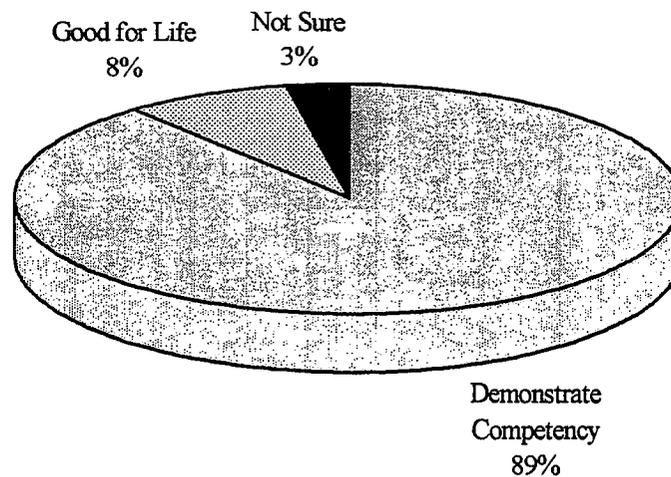


*Total exceeds 100% due to multiple responses

The categories of requirements for practice in Figure 6 were derived from actual comments made by consumers in response to an open-ended question during the telephone interview. It is conceivable that a greater percentage of respondents would have acquiesced to a variety of "canned" categories. The categories as stated, however, reflect their actual perceptions. Forty-five percent of the consumers stated that the nurse must have a nursing school diploma to practice and 31 percent responded that the licensee must pass a state examination to be licensed. Specific knowledge and skills were identified as "Training on Medication" (1%), "Training on Equipment" (1%), "Knowledge of Basic Body Functions" (2%), and "Continuing Education" (2%). Six percent of the respondents stated there is a need for an internship. There were diverse responses to a variety of requirements, small in number, so these were categorized as "other" (7%). A considerable number of respondents (30%) indicated they were not sure of requirements nurses must meet to practice nursing in Alabama.

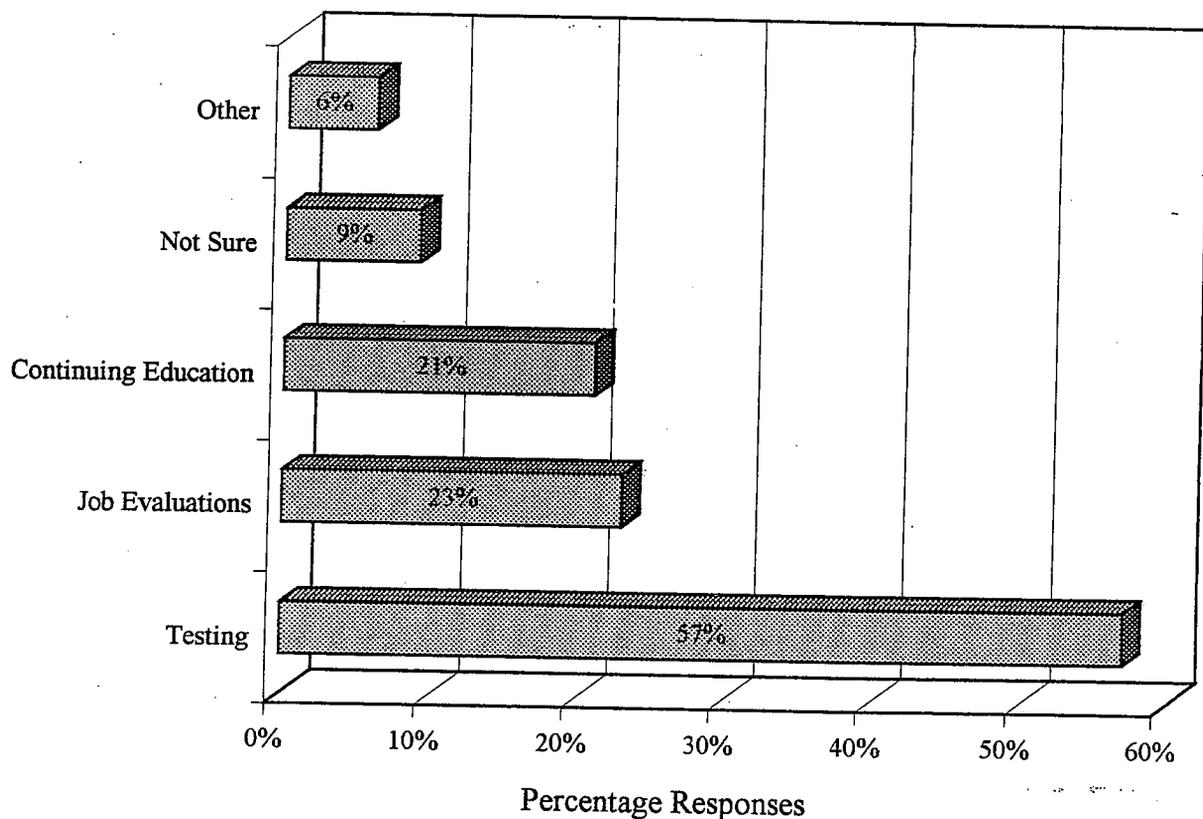
Even with the uncertainty of requirements, the consumers readily provided opinions regarding whether a nurse should demonstrate competency periodically or whether the license should be good for life. Figure 7 provides the breakdown of responses.

Figure 7. Opinions Concerning Whether Nurses Should Demonstrate Competency Periodically vs. Their Being Good for Life (N = 600)



Consumers, by an extraordinary majority (89%) stated there is a need for nurses to demonstrate competency periodically rather than being good for life (8%). Three percent said they were not sure. Determining how nurses should demonstrate continuing competency, as previously indicated, creates controversy. This issue was addressed by including an open-ended question in the survey. The consumers who stated there is a need for nurses to demonstrate continuing competency (89%; $n = 536$) were asked to provide input on methods that might be employed for licensees to demonstrate competence on an on-going basis. Figure 8 provides a graphic summary of methods that the consumers believed could be used for nurses to demonstrate competency.

Figure 8. Opinions Concerning How Nurses Should Demonstrate Continuing Competency ($n = 536$)



**Total exceed 100% due to multiple responses.

Most of the consumers (57%) identified testing as a method for demonstrating continuing competence to practice. Second and third ranked were job evaluations (23%) and continuing education (21%). Six percent gave varied answers too small for statistical breakdown. Nine percent were not sure of how competence should be demonstrated. Qualitative responses provide insight into the methods consumers perceived important to demonstrate competence as well as the varied sophistication of the consumer. Examples include:

- “Well I imagine they have to take a test. Something periodically. I mean like every five to 10 years, or 15 years – something like that.”
- “A series of hands-on and textbooks or continuing education to renew their credits. They should do hands-on or physical tests just to keep them sharp.”
- “I guess someone should be going with them on the rounds to make sure they are doing stuff right.”
- “I think by taking written tests and also by being graded while they are doing their jobs.”
“...taking a test doesn’t really do it. I guess being evaluated by their peers.”
- “I guess on the job wherever they work they should be watched and told what they should have done. Helpful critics. Only true test would be any kind of situation where they have to work with patients directly.”
- “There’s many ways. I’m sure they’ve got a performance rating by their doctors or their peers. The hospital or the doctor they’re working for. Somebody should listen to the complaints of the patients. On an ongoing basis on the job.”
- “By their attitude and performance in decision making.”
- “I guess they should go back to school and learn more and catch up on the new technology. Things change every day and you can always learn more.”

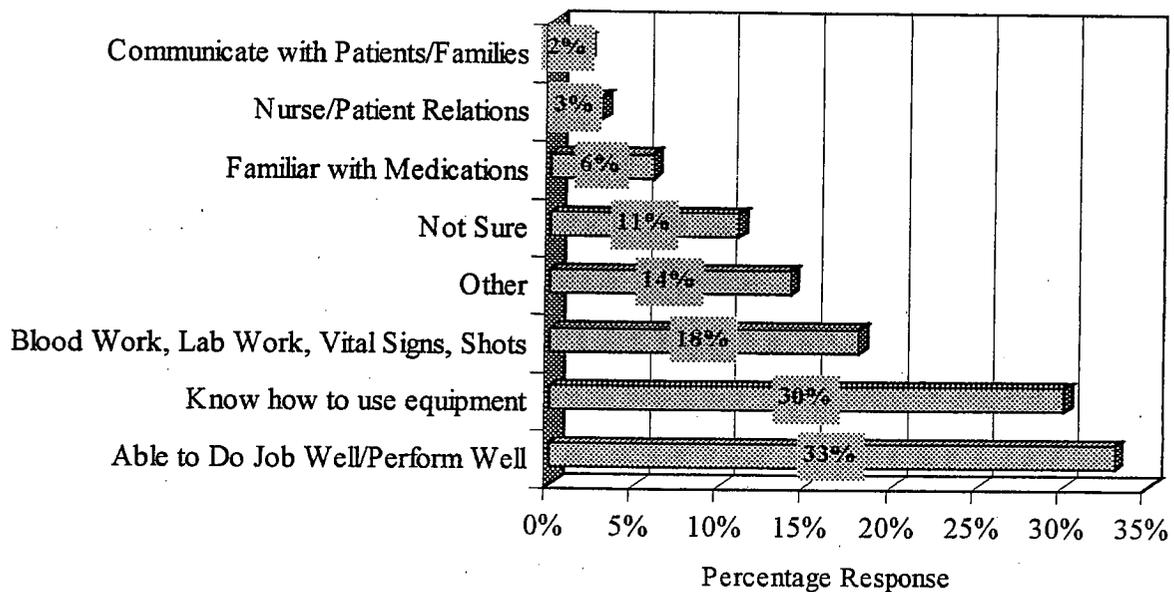
Consumers were asked in an open-ended question to specify particular skills in which nurses should demonstrate competence. Figure 9 provides a compilation of responses in eight categories. The categories include affective, relational and psychomotor skills. Qualitatively, some consumers were very explicit in describing clinical experiences in their lives. Others were more academic. For instance:

- “Knowing how to use the equipment, like heart monitor, knowing how to interpret the data that’s given to them.”
- “Well I think, well let’s go back to basics. They need to do the blood pressure thing. They need to monitor you, give shots and things, IVs and things. They need to have competence. They also need to do electrocardiograms, or understand what they’re seeing on them. They probably have technicians to do that.”
- “They should have good technical skills, know what they’re doing. Well, if one comes in to take some blood out of your arm, I want them to have some experience. Where to stick that needle. They are supposed to be a little smarter than normal. They have to have better education in order to be a technical. Well, it’s like uh, if they came to give you a shot, I want them to know what they’re doing. They’re just much better educated.”
- “That they would understand the doctor’s instructions. Understand how to give doctors instructions. Understand the medications that they are ordered to give. Understand the human

body. You should know the names of medications. You should know how to use the equipment and whatever it does to you. Whatever it takes to do the job. Just things like that.

- The technical stuff. Terminology, I call a leg a leg and they might call it a femur. Anatomy. The body.”
- “Technical skills means medications, being able to recognize a problem in a patient. Being able to recognize if a doctor gives you the wrong instructions.”

Figure 9. Perceptions of Competence and Technical Skills (N= 600)



*Total exceeds 100% due to multiple responses

Quantitatively, with responses from the overall population of 600 two categories stood out more than the others with 63% combined percentage points. The first category perceived to be essential to demonstrate competence was being able to do a job well and to perform well (33%). The second was knowing how to use equipment (30%). The third highest ranked was doing blood work, lab work vital signs and shots (18%). No specifications were given to how well the task should be performed, only that these were expected skills to be performed with competence. Fourteen percent of the consumers gave a variety of individual skills that they believed were essential for demonstrating competence. These were categorized as “other.” Being familiar with medications was included in an individual listing at six percent. Interpersonal skills were mentioned by two percent and nurse patient relations were described, then categorized at three percent. Eleven

percent of the sample stated they were not sure of the skills needed to demonstrate continued competence.

Conclusions and Discussion

This study was the first of a major four phased research project regarding nursing competence. The research process involved two phases: (1) a qualitative component to obtain data from a focus group of consumers that could be used on a larger sample of consumers and (2) a quantitative component in which a survey was conducted by telephone from a random sample of adults between the ages of 18 and 65+. The survey instrument was constructed by obtaining input from the focus group and validated by an outside reviewer as well as the Committee on Continued Competence and Continuing Education. The data were tabulated and organized in table format, then analyzed using descriptive and parametric statistics. One may note when reviewing the research instrument that selected data were used to answer the research questions for this phase of the study. Remaining data will be applied to other studies that have been planned in relation to competence. An example includes the concern of substance abuse, the impact on competence of licensees, and regulatory agencies' responsibility for public safety and welfare. Findings from this study will be further analyzed as related to the competence of nurse licensees and selected groups with vested interest. Findings from the comprehensive study will be used in decision making about implementing a comprehensive competency model.

Consumers are that "broad class of people who are affected by pricing policies...users of products and services..." (Black, et al., 1990). They are concerned about the quality of care they receive and were willing to give an average of 18 minutes per telephone interview to share their beliefs and assessment of nursing competence. Their responses were articulate in most instances, often extensive in the open ended questions. The majority believed that nurses who have a license to practice should demonstrate competence in cognitive, affective and psychomotor domains. While the examples given in Figure 9 primarily referenced psychomotor/technical skills, numerous incidents were described in which attitudes and affective behaviors were paramount to competence. During the focus group's discussion, several of the participants stated there are "givens." It is expected that nurses will be competent in technical skills, but you cannot treat attitudes and technical skills as separate entities. Both are critical to nursing practice. Their concepts of competence address all components of the NCSBN, Inc. definition.

Comments made in the focus group were explicit about endorsement of individuals with licenses from other states. Consumers expect them to meet a certain standard and demonstrate competence through avenues such as examinations, background checks and continuing education. These comments were not stated as such in the general survey, but they were implied by numerous qualitative comments made during the interviews.

While this study has addressed only one of four components of a major project, the process has shown that consumers are willing to participate in research activities that impact their health and welfare. The process of data collection revealed a considerable willingness to give time and information both objectively and subjectively that may be applied to decision making about the regulation of those who would deliver nursing care.

Regulatory agencies have an obligation to meet all legal mandates regarding the licensing of individuals for practice. Likewise they have a need to work cooperatively with other professions in the development of standards for practice. They have an obligation to work with educators for who have responsibilities to prepare applicants for examination for entry into practice, and they have a responsibility to work directly with licensees in assuring competence for practice in the interest of public protection. Finally, there is an obligation to consult with the consumers who are the recipients of care.

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