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Primary and Community Health Nurses' perception of evidence needed to demonstrate that their clinical practice meets the ANMC competencies

Dr Sandra Walker, Department of Nursing & Health Studies, Central Queensland University, Rockhampton, s.walker@cqu.edu.au
Ms Shirley Godfrey, District Director of Nursing - Central West, Longreach, Shirley_godfrey@health.qld.gov.au

Abstract

In Australia all registered nurses are required to meet the Australian Nursing and Midwifery Council (ANMC) Competencies. These are the base level that all registered nurses must meet when delivering care to clients. This study explored generalist primary and community health nurses' perception of the evidence they believe necessary to demonstrate that their nursing practice meets the ANMC competencies. Eleven generalist primary and community health nurses working in a large regional city in Queensland were recruited to take part in the study. A combined interview and questionnaire was used to collect the data. The questionnaire responses were analysed using percentages, while the interview transcripts were analysed by content analysis. The results of the study showed that many of the participants had little knowledge of the ANMC competencies with some struggling to explain how they measure their performance beyond clinical task skill and mandatory training attendance. Participants also grappled with the inclusion of organisational obligations, tasks and skill sets when attempting to define how they demonstrate that their practice meets the ANMC competencies. However participants identified strongly with clinical supervision, peer/team feedback and reports/documents as major ways in which they demonstrate meeting the ANMC competencies. The results of the study showed a need for further education as to the value of the ANMC competencies to nursing practice, generated valuable information to assist primary and community health nurses prepare for performance appraisals and identified key factors that managers of community health nurses need to be aware of when assessing staff performance.

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Introduction

In Australia all registered nurses are required to meet to Australian Nursing and Midwifery Council (ANMC) Competencies (ANMC, 2005). These are the base level that every registered nurse must meet when delivering care to clients. In

addition, nurses have a professional obligation to assess their practice to ensure they provide safe care (Rowell, 2001). Community health nursing is less oriented to tasks and has an emphasis on context-based processes in diverse environments, with the nurse often working as a sole practitioner. Measuring competencies of community-based nurses is very complex due to the comprehensive nature of primary and community health nursing and the lack of control the nurse has over client outcomes (Hawranik, 2000). Two major domains central to clinical competency evaluation of the community-based nurse are the socialisation of the role and the clinical practice of the role. The socialisation is the familiarity by the nurse with community health philosophies, practice priorities, scope and context while the clinical practice is the compilation of skills, knowledge and professional behaviours (Kaiser & Rudolph, 1996).

In addition some community health service areas in Australia have introduced a matrix system of organisational lines of accountabilities whereby an individual staff member may have up to three different reporting managers. These managers can be line manager, clinical manager and professional manager. Within this system a professional manager may not be the direct line manager and therefore has to rely on methods other than direct supervision to ensure the professional accountability of those staff for whom they are held responsible. Furthermore, with the development of mobile and outreach services, particularly in the community health services, none of the managers may ever witness the working of those staff for whom they are responsible. This raises the question as to how a manager ensures professional accountability using employee interview when undertaking performance and development plan assessments. Therefore it is important that competency evaluation of the ability of the nurse to undertake the role addresses both task orientation and context-based processes. Consequently this limits the value of acute care nursing based process with focus on tasks and availability of direct clinical supervision to evaluate competency level for the nurse (Campbell, Roland, & Buetow, 2000).

According to Pearson, Fitzgerald, Walsh, and Borbasi (2002), competency based assessment focuses on outcomes rather than the means taken to achieve ability. They point out that continuing competence is closely aligned with nursing legislation in many Australian states and territories; however, none of the nursing acts specifically address indicators of continuing competence other than recency of practice.

Although there are a number of publications identifying competency standards and competency indicators for nurses, there is a paucity of documents, which identify an effective tool or process that evaluates how the primary and community health nurse applies those standards to their practice. The majority of articles available for review were based on the USA and UK health care systems, which is different to the Australian health care system. Literature could not be accessed to show what Primary and Community Health Nurses believe demonstrates competence. One such article by US based researchers Cross, Block, Josten, Reckinger, Keller, Strohschein, Ripple, and Savik, (2006) discussed the development of a tool to measure competency. These researchers surveyed 153 community nurses pre- and post-completion of an educational course in the process of developing a competence tool. Although this research adds value to the debate it is skill based rather than considering the contextual nature of community health nursing.

Two unpublished Australian reports were uncovered during a search of the literature (Ryan, 1996 and McMurray, 2001 written in Queensland and Western Australia respectively). Both offer suggestions for competency standards and

outcomes but no effective measurement process. Hawranik (2000) suggests that measuring competency standards in the community is contrary to the acute care system where competency level is determined by the attendance at mandatory training and clinical supervision, often informal. This lack of standardised competency measure for primary and community health nurses limits the ability of the nurses and/or their supervisor to evaluate their practice against an established standard.

The concept of competency-based practice is not new to nurses and most would be familiar with the acute care based process of attendance at mandatory training and informal clinical supervision. Recent research to investigate sustained home visiting in early childhood by community health nurses was undertaken by Australian researcher Kemp, Andreson, Travaglia, and Harris (2006). These researchers compared the ANMC competencies and those published by the child and family health nurses to informal interviews data gathered with nurses working in a sustained home visiting in early childhood programs to determine whether these were useful tools to assist the community nurse. Unfortunately these researchers did not identify their sample, nor did they provide information on how they analysed their data. In addition their conclusions focused on knowledge, skill and aptitude gaps rather than the application of the competencies to assist in evaluating nursing competence. Although the research Kemp et al. generated useful information for primary and community health nurses it did not address the issues of competency assessment.

Further searching of the databases failed to uncover information on an effective tool or process to assist the primary and community health nurse or their supervisors' measure evidence that shows nurses meeting the required competency standards. The paucity of published articles on standards or standard indicators for the primary and community health nurse compounds the problem. Therefore, this study sought to fill this gap by exploring generalist primary and community health nurses' perception of the evidence they believe necessary to demonstrate that their nursing practice meets the ANMC competencies.

Methods

A constructivist research methodology was be used to gather data for this study According to Neuman (1991), an interpretive approach to a research issue is concerned with uncovering how ordinary people manage their affairs in everyday life. Schwandt (1994) supports this view and argues that terms such as interpretivist, interpretivism, constructivist and constructionism, are not methodological paths but a collection of loose terms that are able to guide the reader in a direction to view and understand the complex world of the lived experience. Crotty (1998) agrees with these thoughts and adds that from a constructivist's view, meaning is not discovered but constructed. The researcher is able to construct the meaning of lived events and issues that confront people as they go about their daily lives; however, Greene (1998) argues that constructivism is more than just the telling of a story. She believes that it requires the evaluation of social action and as such is in harmony with interpretivism. According to Fairweather and Gardner (2000), the principal aim of constructivist methodology is to examine how individuals produce and organise differences in their world. They argue that the goal of constructivist inquiry is to develop an understanding of the presentations and meaning of the individual's world, within a situation specific context. This was an ideal methodology to use when examining how the generalist primary and community health nurses construct the meaning of their role as it

enabled the uncovering of nurses' beliefs about what is needed for them to demonstrate that their practice meets the ANMC competencies.

Research questions

1. How do generalist primary and community health nurses construct the meaning of their role to meet the ANMC competencies?
2. What evidence do generalist primary and community health nurses believe is needed to enable them to demonstrate that their practice meets the ANMC competencies?

Data collection process

Ethical approval to conduct the research project was received from the hospital and University ethics committees, which function in accordance with the NHMRC guidelines (NHRMC, 1999). The sample consisted of eleven primary and community health nurses working in a large regional city in Queensland. Each participant was given an information letter and asked to sign a consent form prior to taking part in the study.
Data were collected using interview technique and questionnaire. Interview questions were designed to elicit information about participants' knowledge of the ANMC Competencies, tools used in self evaluation, and knowledge of other professional competency standards used to guide nursing practice. Interview questions asked were:

1. Are you aware of the ANMC competencies? If so, are you aware of the revised competencies?
2. Have you engaged in using the competencies in measuring your performance as a community nurse? If so, how?

At this point the volunteer was asked to complete the questionnaire to generate thoughts for questions 3 and 4. Participants were able to tick more than one response and write their on thoughts in response to the cues on the questionnaire.

1. What do the competencies mean for your nursing role?
2. Are there any other competencies that guide your nursing role?

The questionnaire was developed by the researchers to ascertain participants' view of their nursing practice against the domains of the ANMC competencies. The questionnaire was developed to present cues against the domains of the ANMC competencies and a variety of options were provided for participants to identify with, including: diary entry, rostered time, chart entry, clinical supervision, peer/team feed-back, reports/documents, PAD, Education/training and Portfolio. Participants also had the opportunity to add other options if they so wished. Participants were able to identify more than one activity for each competency. The questionnaire was reviewed by two expert primary and community health nurses not involved with the study and pilot tested with a small group not in the intended sample catchment but who were familiar with the role of the primary and community health nurse.

Basic demographic data were also collected using the following questions:

1. How long have you worked in community health nursing?
2. Do you have a community health nursing qualification?

Data analysis

The questionnaire responses were analysed using percentages, while the interview transcripts were analysed by content analysis in the form of reading the transcripts, deletion of the interview questions from the full interview transcripts, deletion of words that may detract from key sentences, and re-reading remaining text to uncover meaning.

Results

Of the 11 participants 10 were female and 1 male. Of the 11 participants six had a community health nursing qualification, while four did not. The results also showed participants had worked in primary and community health nursing for various periods of time from less than 1 year to more than 10 years (Table 1).

Table 1: Amount of time working in primary & community health nursing

• Less than 1 year	2
• 1–2 years	1
• 5–6 years	2
• 9–10 years	2
• Greater than 10 years	4

Results of questionnaire

The results of the questionnaire showed that participants did identify strongly with concepts of clinical supervision, peer/team feedback and reports/documents as major ways in which they demonstrate that they are performing their job competently. In addition the results of the questionnaire showed that participants who had formal competencies designed by their specialty area could confidently answer that they regularly undertook peer assessment or self review against agreed competencies (Table 2).

Table 2: Results of questionnaire

Activity	**%**	**(n)**
Portfolio	3%	(13)
Rostered Time	5.3%	(24)
Diary entry	5.5%	(25)
Performance and development (PAD)	8.6%	(39)
Chart entry	13.3%	(60)
Education/training	15%	(68)
Reports/documents	15.4%	(70)
Clinical supervision	15.7%	(71)
Peer/team feedback	18.2%	(82)

Results of the interview data

Analysis of the interview data added to the information generated by the questionnaire and four key themes were clearly identified. These were:

1. understanding ANMC competencies.
2. being a primary and community health nurse competencies versus clinical tasks
4. self assessment versus peer review.

1. Understanding ANMC competencies

The results of the study showed that many of the participants had little knowledge of the ANMC competencies. One participant stated they were unaware of the ANMC competencies while two indicated they were unsure as to what they were. The remaining participants stated they were aware but none were able to identify how many ANMC competencies there were or the content of the competencies. With the number of participants lacking depth knowledge of the competencies, it was not surprising that only one was aware that the ANMC competencies had recently been reviewed. Not exactly, no, I think I have a general overview but I couldn't tell you what they were. No. (Participant 4)

Only one participant was able to identify competencies for their specific area of practice and also knew that the ANMC competencies were the framework for these clinically specific competencies.

> Breast cancer, yes because most of the time the ladies that I see have got a diagnosis of breast cancer so that's where I follow them from that point of diagnosis through all their treatment so looking at - mainly against the competencies and the domains that the Breast Care Nurses have developed but it's still fairly rudimentary. (Participant 8)

Participants also grappled with the inclusion of organisational obligations when attempting to define how they demonstrate that their practice meets the ANMC competencies.

> District policy and procedure, yes, and also our Breast Screen policy and procedure manual because we have to work to their policy and procedure and we also have to develop one that is specific to our service. (Participant 5)

2. Being a primary and community health nurse

Being a primary and community health nurse theme emerged as participants discussed their particular roles and the impact these have on the communities with which they work. Participants clearly indicated this involved teamwork, client centred care and gaining the trust of communities they serve. Participant 10 provided a good explanation of what it means to be a primary and community health nurse:

> I've been told that in smaller communities that once somebody finds out what somebody said to you - you know if there's ever any breach of confidentially that would be it. So I guess the fact that people haven't found it - yes, I've been visiting these areas for ten years and nobody's heard what, you know, Mary next door's had told me and so that's gaining the trust of the community. (Participant 10)

A number of participants did try to explain the conceptual role of the primary and community health nurse in attempting to explore how they construct their role:

> Well we are supporting and coordinating, we're not here to fix the problem; we're here to support the family unit in obtaining independence. So it's listening to them, letting them go, finding out that's not the best choice, coming back, reviewing and then trying again. (Participant 10)

Several participants discussed the independent role of the primary and community health nurse and how this is a valuable resource for the communities they serve:

> I work by myself and I'm the referral source for many clients. So if I don't do a comprehensive nursing assessment this may affect my clients and the services they receive so the fact that I do means that I send off people for all ranges of further treatments they need. (Participant 4)

While discussing their primary and community health nursing role a number of participants indicated that they received supervision as part of the skills acquisition process. However, they did not see this as peer review but instead viewed this as a form of assessment in the development of their role as a primary and community health nurse.

> To help me learn my role I get supervision at my clinics. Someone will come in with me in the clinic, watch me, watch my practice, and assess that I am meeting the goals of my job. (Participant 1)

3. Competencies versus clinical tasks

Many of the participants struggled with expanding how they measured their performance against the ANMC competencies beyond clinical task skill and mandatory training attendance. Comments by Participant 3 clearly show this.

I had to go to Brisbane and actually do a week of training under a senior CNC at North side—at Chermside at Breast Screen—so she did tick me off with competencies as I—she taught me, I practiced them for that week and then at the end of the week she then had to tick me that I was competent in doing those. (Participant 3)

The difference between primary and community health nursing and hospital nursing was also discussed by a number of participants. Although participants acknowledged there was a difference between the two roles, they still linked competence to skills. The following comment from Participant 2 supports this conclusion:

> ... Well for instance that there's obviously a total difference with working in community than there is in the hospitals because we don't down here give medications or anything like that but we still do skills. (Participant 2)

Participants clearly indicated the concrete evidence from their day-to-day work that they would use to meet the ANMC competencies but were unable to explain how they would demonstrate competence in less obvious client care practice such as support that often takes up a great part of the primary and community health nurses' day.

> I think my role is fairly hard to explain and the way they (ANMC Competencies) are written is a little, I mean, it's hard to demonstrate sometimes, what the comments that you get, when you are not in a

> place where you can count every number and you've got other people working, so I think for a community nurse it's harder. (Interview 9)

4. Self assessment versus peer review

Self assessment versus peer review was clearly evident in the analysis of the interview data. Participants new to community health clearly relied upon peer review to give feedback on their performance whereas more experienced staff indicated a preference for self evaluation of their performance. A comment from experienced primary and community health nurse, Participant 7, clearly shows this:

> It's (PAD) based on self assessment of the amount of research and up to - you know, what sorts of things that you've read, the time you've spent on there. (Participant 7)

The results also showed that nurses new to primary and community health nursing valued peer review and team feedback.

> Peer/team feedback is always there, because you're always asking "how do you do it? Is this what you're doing? Yep. That one's right there. (Participant 3)

Participants working as sole practitioners indicated that they asked other nurses at the same level to undertake a review of their abilities to deliver their service to clients.

> … I'm the only one in the district who works in this area so we have instituted peer review within the service so that we get another practitioner of the same level to sit in on a consultation and do some sort of peer review with us. (Participant 11)

Other participants saw peer review as an informal process that assisted in solving clinical problems.

> … I guess when I talk about peer review I talk about, like maybe our informal peer review that we would probably discuss individual cases or things like that. (Participant 2)

The results of the study also showed that participants who identified the availability of formal competencies designed by their specialty area could confidently answer that they regularly undertook peer assessment or self-review against these competencies.

> Well when we write our key criteria we have a list of competencies. With Breast Screen we are assessed every two years by a peer as well. Plus the fact that with feedback of working with other people with our Q groups. (Participant 6)

Discussion

The results of the study showed a need for further education as to the value of the ANMC competencies to nursing practice. The study showed that primary and community health nurses who took part in this study were not aware of the ANMC competencies and construct their role around traditional skill based concepts rather than the more generic competencies outlined by ANMC. Many struggled to explain what the competencies meant for their role and how they would assist them to define their place in nursing. By narrowing the focus of nursing competencies to skill sets and mandatory training, the nurses struggled to define themselves as a

nurse particularly in the community health setting and within a matrix system of accountability.

Not surprisingly, the question that asked participants what the competencies mean for their nursing role was answered with difficulty. Participants struggled with inclusion of organisational obligations, task competencies and skill sets in attempting to define how they demonstrate or apply their ANMC competencies to their practice or construct their nursing role. Such findings generate valuable information to assist nurse managers to understand how primary and community health nurses construct the meaning of their role and may aid in the development performance appraisals tools that are more inline with how primary and community health nurses see their role. Recent research to investigate sustained home visiting in early childhood by community health nurses, undertaken by Australian researcher Kemp, Andreson, Travaglia, and Harris (2006), supports these conclusions.

The results of this study showed that the primary and community health nurse participants were able to explain how evidence based on skills and activities from their day-to-day work showed that they were able to meet ANMC competencies but struggled to explain how they would demonstrate competence in the more intangible concepts such as client support and counselling that form a major component of the community health nursing role. These findings add to what is already known about the topic by showing that although primary and community health nurses work in a less structured environment and develop long term relationships with clients than their acute care hospital based colleagues, they still rely heavily on the development of clinical skills rather than the development of the broad concepts needed to deliver care effectively to clients in their communities when constructing their nursing role. Such findings are interesting as they show primary and community health nurses draw on previous experience and training when constructing their role.

Although this study adds to current knowledge there were some limitations including the use of only one community health centre to collect the data and the small number of participants. Therefore further research is needed to determine if the finding of this study can be replicated on a larger scale. Nevertheless this research does add important information to what currently know about the topic and identifies areas for further research including exploring how primary and community health nurses apply the ANMC competencies to their day-to-day practice and investigating how the ANMC competencies can be better integrated in the performance assessment tools and processes.

Conclusion

The results of the study showed that many of the participants had little knowledge of the ANMC competencies and related competency to skills development. The results of this study also showed that the primary and community health nurse relies on skill development and activities from their day-to-day work that showed they were able to meet ANMC competencies but struggled to explain how they would demonstrate competence in the more intangible concepts such as client support and counselling. In addition the results showed primary and community health nurses had difficulty explaining what the ANMC competencies meant for their nursing role and that they draw on previous nursing experience from the acute care setting when constructing the current role. In summary, the results of the study showed a need for further education as to the value of the ANMC competencies to

nursing practice, generated valuable information to assist primary and community health nurses prepare for performance appraisals and identified key factors managers of primary and community health nurses need to be aware of when assessing staff performance.

References

Australian Nursing and Midwifery Council (ANMC). (2005). Australian Nursing Council principles for the assessment of national competency standards for registered and enrolled nurses. Dickson, ACT: Australian Nursing and Midwifery Council.

Campbell, S., Roland, M., & Buetow, S. (2000). Defining quality care. *Social Science and Medicine,* 51, 1611–1625.

Cross, S., Block, D., Josten, l., Reckinger, D., Keller, L.O., Strohschein, S., Ripple, M., & Savik, K. (2006). Development of a public health competency instrument. *Public Health Nursing, 23*(2), 108–114.

Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process, Sydney: Allen & Unwin.

Fairweather, C., & Gardner, G. (2000). Specialist nurse: An investigation of common and distinct aspects of practice. *Collegian*, 7, 26–33.

Greene, J.C. (1998.) Qualitative program evaluation: Practice and promise. In N.K. Denzin & Y.S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 372–399). Thousand Oak: Sage.

Hawranik, P. (2000) The development and testing of a community health nursing clinical evaluation tool. *Journal of Nursing Education, 39*(6), 266–272.Kaiser, K., & Rudolph, E. (1996). In search of meaning: Identifying competencies relevant to evaluation of the community health nurse generalist. *Journal of Nursing Education, 35*(4), 157–162.

Kemp, L.A., Andreson, T., Travaglia, J., & Harris, E. (2006). Sustained nurse home visiting in early childhood: exploring Australian nursing competencies. *Public Health Nursing, 22*(3), 254–259.

McMurray, A. (2001). *Competency standards for the community health nurse* (2nd ed.). Perth, Western Australia: Dept. Of Health. Unpublished.

Neuman, W.L. (1991). *Social research methods,* Boston: Allyn and Bacon.

National Health and Medical and Research Council. (1999). *National statement on ethical conduct in research involving humans*. Canberra: AGPS.

Pearson, A., Fitzgerald, M., Walsh, K., & Borbasi, S. (2002). Continuing competence and regulation of nursing practice. *Journal of Nursing Management,* 10, 357–364.

Rowell, P, (2001). Beyond the acute care setting: Community-based non acute care nursing-sensitive indicators. *Outcomes Management for Nursing Practice, 5*(1), 24–27.

Ryan, C. (1996). *Standards of practice community nursing,* Brisbane Queensland: Queensland Health. Unpublished.

Schwandt, T.A. (1994). Constructive, interpretivist approaches to human inquiry. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118–137). Thousand Oaks: Sage Publications.