NCSBN Focus

Toward a Standardized and Evidence-Based Continued Competence Assessment for Registered Nurses

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Abstract

The need for ongoing competency requirements for registered nurses and a process to objectively measure these competencies presents a challenge for healthcare regulators. The purpose of this article is to discuss the methodology and preliminary findings from the 2006 RN Post Entry-Level Practice Analysis. Findings of the study indicate that nursing practice is similar across settings, specialties, years of experience, and geographic region. These results can be used to develop core registered nurse competencies for a continued competence assessment instrument.

Introduction

Boards of nursing have a responsibility to assure the competency of their licensees. This pertains not only to new graduates or internationally educated nurses applying for licensure by examination but also to post entry-level nurses providing patient care. Currently, there is a lack of uniformity among states as to what, if anything, should be required of post entry-level licensees. Many boards of nursing find themselves struggling to answer questions concerning how to assure the public that nurses maintain competency throughout their careers and how to determine whether an individual who has left nursing practice for an extended period of time is competent to return to practice.

Although boards of nursing have attempted various approaches to ensure continued competency for nurses, there are no universally agreed-upon evidence-based methods that measure or support this endeavor. In a review of 58 Board of Nursing (BON) nurse practice acts conducted by the National Council of State Boards of Nursing (NCSBN) in November of 2005, 28 BON required continuing education (CE) for license renewal, 4 BONs required practice hours, 6 BONs had a combined requirement of both CE and practice hours, and 9 BONs (an additional 2 BONs had proposed legislation) provided licensees with various options such as peer review and reflective practice. Nine BONs had no continued competency requirements.[1] The issue of what method is most efficient and effective continues to confound nursing regulators.

The need for ongoing competency requirements is not isolated to nursing. Continued competency of healthcare providers has been addressed by the Institute of Medicine and a host of other commissions and organizations, including The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, The Citizens Advocacy Center, and the PEW Health Professions Commission.[2-10] All have advocated for a process that will objectively measure competence among post entry-level healthcare professionals. With a mission to provide leadership to advance regulatory excellence for public protection, NCSBN has long recognized the necessity to assess the competence of experienced practitioners and has been at the forefront in addressing this issue. Since 1985, NCSBN has been researching, supporting, and promoting the development of a continued competence assessment for nurses.[11]

The standard method, used by licensure programs, for developing an instrument that will evaluate competence for initial licensure begins with a practice analysis of the entry-level practitioner. The practice analysis method identifies core competencies that are central to a profession regardless of areas of specialization. An assessment instrument is then developed based on these core competencies. In addition to providing the foundation for a prelicensure assessment, the method assists in providing validation of the survey questionnaire and supports the assertion that the assessment instrument measures the essential competencies of the entry-level practitioner.[12,13] When developing an instrument to assess ongoing or continued competence of an experienced healthcare professional, the same methodology applies; however, the practice

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analysis is of the post entry-level practitioner.

The purpose of this article is to describe the methodology of a practice analysis and explain some brief preliminary findings from the 2006 RN Post Entry-Level Practice Analysis that will be the foundation for a continued competence assessment instrument for registered nurses (RNs).[14] Knowledge of the steps in a practice analysis is integral to understanding how a continued competence assessment instrument is developed.

Although many have assumed the method used to produce a licensure examination or develop a continued competence assessment to be a clandestine process, in reality, it is overtly transparent. In the case of the 2006 RN Post Entry-Level Practice Analysis, the research design involved subject matter experts (SMEs) representing 27 different nursing organizations and thousands of practicing nurses who participated as subjects in the practice analysis survey. The study is the first of its kind to describe post entry-level RN practice. The findings will determine whether there are RN activities that can be used to identify core RN competencies required for client care, regardless of practice setting, specialty area, or years of experience.

Although NCSBN has been performing practice analyses for entry-level nurses for many years, this was the first practice analysis that would describe post entry-level practice. Therefore, the methodology was reviewed and approved by 5 job analysis methodology experts who were external to and independent of NCSBN. To have a clear, accurate description of RN practice, NCSBN used multiple job analysis methodologies.

Methodology

The primary method used for the 2006 RN Post Entry-Level Practice Analysis was a large-scale survey of practicing RNs. The questionnaire consisted of nursing activity statements for which the respondent would have to indicate whether he/she considered that activity core to nursing practice and whether it was performed in his/her practice setting. If they did perform the activity, they were asked the frequency and its importance to nursing practice and client safety. Proper development of this survey tool (questionnaire) was integral to the success of the practice analysis. Construction of the activity statements used in the survey relied on multiple methods, which included direct observation, document review, interviews, brainstorming, and structured analyses. A description of the processes used in developing the survey follows.

Preliminary Interviews With Nurse Leaders

A preliminary step, not performed in entry-level practice analyses, was incorporated into the 2006 RN Post Entry-Level Practice Analysis. This involved interviewing nurse leaders to identify trends in nursing and predict possible changes in future nursing practice. Various nursing leaders from different specialties in the nursing profession were interviewed by telephone regarding their expert views on the future of nursing and healthcare. This added step was performed to provide NCSBN with advance information should changes in practice be expected.

The nurse leaders' telephone interviews were taped, and these were transcribed during the summer of 2005. After identifying information was removed to provide anonymity, the transcriptions of the telephone interviews were made available as source documents for the SME panels to use during the next phase of the study. In addition, nurses on staff at NCSBN reviewed the transcripts of the interviews and identified themes or trends to be considered in the development of activity statements for the survey instrument.

Panel of SMEs

The next phase of the study was to develop the RN activity statements (statements of activities that nurses perform while providing client care). Two SME panels consisting of a total of 27 RNs, each representing a different professional nursing and specialty practice organization, were assembled. The SMEs were nominated for the panel by their professional organizations because of their expertise in a specialty area of nursing. All were RNs in practice. They represented all NCSBN geographic areas, major nursing specialties, major practice settings, and a range of years of experience (see Appendix A). Two consecutive panels were used to facilitate participation by all panel members. Care was taken to ensure a range of specialty representation on each panel. One of the most important aspects of a practice analysis is ensuring that the SMEs have the knowledge and skills to perform their function on the panels. Thus, the panels were given a comprehensive orientation on the development of activity statements. The SME panels performed several functions crucial to the success of the practice analysis. The first panel developed an initial list of RN activity statements that reflected current RN practice. The second panel reviewed and refined the list. There was full participation by all panel members, and no one member was allowed to dominate either group. In addition, the members provided positive ratings of the meetings indicating that they understood their task and could accomplish it.

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Direct Observation

Activity statements were developed by the SMEs by reviewing daily logs maintained by RNs in practice. Each panel member was asked to request that 3 of their colleagues complete a detailed log of their daily activities. The daily logs were a proxy for the direct observation method of practice analyses because it would have been difficult and time consuming to conduct direct observations of RNs in a variety of work settings and specialty areas. Thus, asking the SMEs to provide daily logs seemed to be a reasonable proxy for the direct observation. The logs were analyzed by NCSBN nursing staff, summarized, and made available to the SMEs at each meeting.

Document Review

The SME panelists also submitted RN job descriptions, orientation manuals, performance evaluations, and institutional policies and procedures. This information was made available to the SME panels. In addition, the 2 SME panels reviewed the following:

1. nursing activity statements from previous prelicensure nursing practice analyses,
2. a literature review of nursing competencies,
3. competencies from various professional nursing organizations, and
4. transcriptions of the telephone interviews with nurse leaders.

Category Structure

The next step was to place the activity statements into categories of nursing care. The SMEs were given frameworks that could be used to categorize the activity statements. They were instructed to select a category structure and place each activity statement under one of the categories that best described it. The panels created a list of nursing activities performed within each category. Each nursing activity was reviewed for applicability to the delivery of safe client care and the scope of RN practice.

Attention was given to several details related to the nursing activity statements. First, the SMEs ensured that the activity statements were clear, understandable, and observable. Second, the SMEs made certain that the nursing activities were all at approximately the same level of conceptual specificity. Third, the groups checked to ensure that the activity statements were mutually exclusive and that there was no overlap within and between categories. Fourth, the SMEs made certain that the list of activities was comprehensive so no artificial restriction in the range of activities existed. Lastly, they took into consideration that the number of activity statements on the survey should not create an overwhelming burden for the respondents. After all the activity statements were finalized and categorized, the SMEs performed one final step and provided frequency and importance ratings for each nursing activity statement that would be on the survey. This was done to assist in evaluating the validity of the instrument.

Continued Competence Task Force

After the SME panels' work was completed, NCSBN's 2006 Continued Competence Task Force met to review and edit the activity statements and rating scales. The Continued Competence Task Force consisted of nurses with expertise in nursing regulation. The committee provided feedback for minor revisions and gave final approval for the instrument. The result was 129 nursing activity statements, which were incorporated into a survey format.

Questionnaire Development

Two forms of the survey were created to decrease the number of activity statements to which each individual participating in the study would have to respond. This was done to promote participation and increase the likelihood that the survey would be completed by the respondents. Twenty-three of the nursing activity statements were used on both survey forms. The remaining 106 activity statements were divided into 2 sets of 53 activity statements. One set was placed on each of the 2 survey forms. Thus, the resulting surveys each contained 76 activity statements. With the exception of the 53 activity statements that were different on the 2 forms, the survey tools were identical.

In addition to the activity statements, the surveys included questions about the nurses' practice settings, past experiences, and demographics. The surveys were divided into 4 sections. The first section contained demographic questions, including the average number of CE contact hours that the participants earned each year regardless of whether their jurisdiction required it. Section 2 asked about their work environment. Section 3 asked about their performance of nursing activities using 3 separate questions and scales: (1) the participants were asked ("Y" for yes or "N" no) if the activity was part of core RN practice; (2) participants were asked to provide a rating about the importance of each activity for RN practice considering client safety using a scale of "1 Not Important," "2 Somewhat Important," "3 Important," and "4 Extremely Important;" and (3) participants were asked to indicate if the activity was performed in their work setting on a typical day using a 5-point scale of 0, "performed less than once a day"; 1, "once a day"; 2, "twice a day"; 3, "thrice a day"; and 4, "4 times or more a day."

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The scale also included an "NA" "Not Applicable" rating. A space to write in any activities not mentioned in the survey was included at the end of Section 3. Section 4 asked for additional comments and contact information for recognition of participation and awards.

Survey Process

Sample Selection

A sample of 20,000 RNs was selected (10,000 RNs per survey form). This sample of 20,000 RNs was divided into 2 subsets of 10,000 RNs who had roughly the same geographic representation. The sample was stratified by jurisdiction and then randomly drawn from the population of active RN licenses within that jurisdiction. Given this procedure and the large sample size, it was reasonable to assume that the RNs receiving a survey should be proportionally equivalent to the RN population with regard to employment setting, clinical specialty, and other important nursing factors.

Mailing

Before the mailing of the survey, an announcement postcard was mailed to the sampled RNs telling them to expect an important survey within a few days. This mailing was followed by the survey, which was sent via first-class mail. A week later, a reminder postcard was sent, followed by a second reminder postcard sent 2 weeks later. A third postcard was sent approximately 3 weeks after the survey in anticipation of increasing the response rate. A second survey was sent to any participant who requested one.

Out of 20,000 RNs selected for the sample, 180 were eliminated after verifying addresses with the National Change of Address Database. The National Change of Address Database identified these as invalid addresses primarily because individuals moved without providing a change of address. Surveys were sent to the remaining 19,820 RNs throughout the United States and its territories. There were an additional 302 of these surveys returned because of incorrect addresses.

Representation

The sample selected for this study was proportionally equivalent to the RN population from which the sample was drawn. The survey respondents were not substantially different from the national RN population as estimated from the number of active licenses reported in the *2005 Nurse Licensee Volume and NCLEX Examination Statistics*.[15]

Return Rates

A total of 4,777 surveys were returned, for an adjusted return rate of 24.5%. The dataset was then cleaned by excluding surveys that did not meet 2 additional quality control criteria: (1) at least 25.0% of the survey was completed and (2) the respondent was currently employed as an RN. A total of 762 surveys were excluded from the sample based on the 2 quality assurance criteria, resulting in 4,015 responses for an analyzable return rate of 20.6%.

Results

Demographics, Experiences, and Work Environments of Participants

GEOGRAPHIC AREA

Respondents were asked the state or territory in which they were currently practicing. Respondents were next classified into the 4 geographic areas of the NCSBN member jurisdictions (Area 1: Western states, including American Samoa, Guam, and the Northern Mariana Islands; Area 2: Midwestern states; Area 3: Southern States; and Area 4: East Coast and mid-Atlantic states, including the District of Columbia and the Virgin Islands). Area 3 had the largest representation, with 30.9% of RNs responding being from this group. Area 1 had the lowest percentage of representation at 15.0%.

AGE AND SEX

Most respondent RNs reported being female (96.0%). The reported ages of respondent RNs ranged from 20 to 84 years. Overall, the average age of respondent RNs was 48.12 years (SD, 10.21 years).

YEARS OF EXPERIENCE AS AN RN

On average, RNs reported approximately 20 years of RN practice experience.

RACIAL/ETHNIC BACKGROUND

Most respondent RNs reported white (85.9%) as their racial/ethnic background. Approximately 5% of respondents selected African American, and 2.3% selected Hispanic. There were 17 respondents who did not answer this question.

NURSING EDUCATION BACKGROUND

Overall, the highest percentage of RNs indicated associate degree (36.4%) and baccalaureate degree (36.8%) as their highest level of nursing education. Completion of a nursing diploma accounted for 16.3% of the RN responses, and 9.0% indicated a master's degree as their highest level of nursing education.

FORMAL EDUCATION BACKGROUND

Overall, the largest percentage of RNs indicated baccalaureate degree (39.0%) as their highest level of formal education. Completion of an associate degree accounted for 33.7% of the RN responses, and 12.8% indicated a master's degree as their highest level of education.

CERTIFICATIONS

Respondents were provided with a list of nursing specialty

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certifications and were asked to designate the certifications they currently held. Of the total number of RN respondents, 44.0% held 1 certification, 9.0% held 2 certifications, 2.2% held 3 certifications, and 1.5% held 4 or more certifications. Registered nurses were most likely to hold certifications in critical care nursing (7.7%) and medical-surgical nursing (7.9%), as shown in Appendix B. About 24% of RNs reported holding a type of nursing specialty certificate that was not listed as an option, such as hemodialysis nurse and asthma educator.

CONTINUING EDUCATION

Registered nurses reported earning an average of 21 CE contact hours per year. On average, RNs who indicated public health department as their primary facility reported the greatest yearly CE contact hours. Respondents from business/industry and home healthcare settings reported the lowest average number of CE contact hours.

PRACTICE ENVIRONMENT

Hours Worked. On average, respondents reported practicing 36.3 hours per week as an RN. There was little variance across facilities and specialty practice.

Primary Facility. Most RN respondents (59.1%) reported practicing in hospitals. About 13.0% of RNs reported practicing in community-based/ambulatory care, and 6.3% practiced in long-term care, whereas 6.0% reported practicing in home healthcare.

Primary Specialty. About 22.0% of RNs reported practicing in a type of specialty area that was not listed as an option. Of the listed specified areas, RN respondents most frequently indicated medical-surgical (10.5%), critical care (10.4%), and operating room (7.2%) as their primary specialty area.

Primary Role. Most RN respondents (64.9%) reported staff nurse as their primary role. About 11.0% of RNs reported working as managers, and 3.2% worked as administrators. About 17.0% of respondents indicated a type of role that was not listed as an option.

Activity Performance Characteristics

RELATION OF ACTIVITY STATEMENTS TO PRACTICE

The participants were asked whether the activities on their survey form represented what they actually did in their positions. A majority indicated that the activities were representative of their current practice. This indicates that the survey was perceived by respondents as being a sufficient or a reasonable representation of their work. This was important for establishing the content validity of the survey. In addition, the respondents were asked to list any activity statements that they felt were "missing" from the survey. The NCSBN nursing content staff scrutinized all comments and found that the nursing activities cited by respondents as missing were activities that had been included on the other version of the survey form. This provided greater evidence of the content validity of the survey.

CORE RN PRACTICE

Respondents were asked to indicate "Y" (yes) or "N" (no) as to whether an activity was part of core RN practice. Core practice was defined as "the essential knowledge, skills, and abilities needed to practice safely regardless of practice setting." The activity statement ratings of core practice ranged from 0.42 (42% of the respondents thought the activity was part of core practice) to 0.99 (99% of the respondents thought the activity was part of core practice). "Manage the care of a pre-, peri-, and postnatal client" and "Evaluate occupational/environmental exposures" received the lowest ratings of 0.42, and "Use critical thinking skills to make decisions" and "Maintain confidentiality/privacy" received the highest ratings of 0.99.

APPLICABILITY OF ACTIVITIES TO PRACTICE SETTING

Respondents indicated that an activity was not applicable to or not performed in his or her work setting by marking the "NA" (not applicable) response. The activities ranged from 1.10% (more than 1% of the respondents reported that the activity was not performed within their work settings) to 72.59% (nearly three-fourths of the respondents reported that the activity was not performed within their work setting) not performed.

Of the 129 activities included in the study, the nursing activities reported to apply to the settings of the lowest numbers of participants were "Manage the care of a pre-, peri-, and postnatal client" (72.59% not performed), "Evaluate occupational/environmental exposures" (63.64% not performed), and "Identify and manage environment for symptom clusters across clients" (59.10% not performed). The activities with the highest number of participants reporting that the performance or the activity applied to their work setting were "Maintain client confidentiality/privacy" (1.10% not performed), "Collaborate with other disciplines/professions" (1.60% not performed), and "Use critical thinking skills to make decisions" (1.40% not performed).

Frequency of Activity Performance

Respondents were asked to rate the frequency of performance of all activities that were applicable to their work settings. They reported how frequently they performed the activity on a typical day of work using a 5-point scale of 0, "performed less than once a day"; 1, "once a day"; 2, "twice a day"; 3, "thrice a day"; and 4, "4 times or more a day."

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Average total group frequencies ranged from 0.52 for less than 1 time per day to 3.78 for approximately 4 or more times per day. The activities performed with the lowest total group frequency were "Report unsafe practice of healthcare personnel to internal/external entities" (0.52), "Report error/event/occurrence per protocol" (0.65), and "Participate in the development/revision of policies and procedures" (0.68). Those activities performed with the overall highest frequencies were "Apply principles of infection control" (3.78) and "Maintain client confidentiality/privacy" (3.65).

IMPORTANCE OF ACTIVITY PERFORMANCE

Respondents were asked to rate the importance of performing each nursing activity for RN practice considering client safety. Importance ratings were recorded using a 4-point scale, which ranged from "1 Not Important" to "4 Extremely Important."

Average total group importance ratings ranged from 2.80 to 3.87. The activities with the lowest importance ratings were "Evaluate the outcomes of health promotion activities" (2.80) and "Participate in community health outreach activities" (2.81). The activities with the highest importance ratings were "Apply principles of infection control" (3.87) and "Maintain confidentiality/privacy" (3.87).

Activity Performance Findings

Data were analyzed for all activities. Four separate analyses were conducted to determine if an activity statement should be considered part of the core RN practice:

1. core practice rating,
2. percentage not performing,
3. mean importance rating, and
4. mean frequency rating.

The summary statistics can be found in Appendix C. As can be seen in this appendix, 103 (79.84%) of the 129 activity statements were considered part of core practice by at least 75% of the respondents.

Of the 129 activity statements, 123 (95.34%) were, on average, performed at least 1 or more times in a typical day. Regarding importance of the activity statements, 123 of the 129 activity statements (95.34%) were rated a 3.0 (important) by the participants.

Subgroup Analyses

To ensure that practice was consistent across practice settings, specialty areas, years of experience, and geographic setting, separate analyses were conducted to determine if RN practice was viewed similarly among the nurses participating in the study. Importance ratings for all activity statements were calculated based on the aforementioned demographic subgroups noted in the "Demographics, Experiences, and Work Environments of Participants" section. These subgroups were derived from responses to demographic questions on the survey.

In most of the analyses, a majority of the respondents in the demographic subgroups indicated that the mean importance rating of each activity statement used for core competencies was at least 3.0, which corresponds to "important" on the rating scale.

Summary

A nonexperimental, descriptive study was conducted to explore the importance and frequency of activities performed by post entry-level RNs and those activities that are part of core RN practice. More than 4,700 RNs responded to the survey. The 2006 RN Post Entry-Level Practice Analysis study collected data on core practice and the frequency and importance of RN activity performance. The Continued Competence Task Force of NCSBN reviewed the results of the study and noted that importance ratings provided by the RN respondents were comparable across facilities, specialty practices, years of experience, and geographic regions.

Conclusion

In general, findings indicate that nursing practice, as it relates to client care, is essentially the same regardless of facility, specialty, years of experience, and geographic region. The results of this study can be used to develop core RN competencies for a continued competence assessment instrument. Although the practice analysis lays an essential foundation, extensive development and research are needed to produce a standardized, psychometrically sound, evidenced-based assessment instrument that will measure current nursing knowledge and skills and abilities for the postentry-level practitioner.

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APPENDIX A
Consecutive Panel of SME

Name	State Representation	Organization
August 28-29, 2005		
Monika Fischer, MN, RN, ANP, CCM, COHN-S	California	American Association of Occupational Health Nurses (AAOHN)
Rebekah S. Lynch, PhD, RN, CNS	Colorado	Colorado Board of Nursing
Jane Wilson, MA, RN	Oregon	Association of Women's Health and Neonatal Nurses (AWHONN)
Cynthia Galemore, MSEd, RN	Kansas	National Association of School Nurses (NASN)
Janet Kramer, MS, RN	Indiana	National League of Nursing (NLN)
Pamela Papp, MS, RN, FNP	Illinois	American Academy of Nurse Practitioners (AANP)
Lois Werning, BSN, RN, BC	South Dakota	Academy of Medical-Surgical Nurses (AMSN)
Benjamin Peirce, BA, RN, CWOCN	Florida	National Association of Home Care (NAHC)
Becky Provine, RN, MSN, CS	Georgia	National Gerontological Nursing Association (NGNA)
Marianne Markowitz, MSN, RN	New York	New York Organization for Associate Degree Nursing
Jean A. Proehl, RN, MN, CEN, CCRN	New Hampshire	Emergency Nurses Association (ENA)
Dolly N. Sullivan, RN, CNOR	Maryland	Association of Peri-Operative Registered Nurses (AORN)
Hussein Tahan, DNSc, RN, CAN	New Jersey	Sigma Theta Tau International (STTI)
August 31-September 1, 2005		
Patricia J. Johnson, RN, MS, NNP	Arizona	Academy of Neonatal Nursing (ANN)
Mary Ellen Morphet-Brown, MSN, ARNP	Washington	US Public Health Nursing Service—Indian Health Service
Kathleen D. Sanford, RN, MA, DBA, FACHE	Washington	American Organization of Nurse Executives (AONE)
Robert Billman, BSN, RN	Minnesota	American Psychiatric Nurse Association (APNA)
Shirley Fields-McCoy, MSN, RN	Ohio	American Nurses Association (ANA)
Sheila Haas, PhD, RN, FAAN	Illinois	American Association of Colleges of Nursing (AACN)
Anne M. Richter, RN, BS, CCRN	Michigan	American Association of Critical Care Nursing (AACCN)
Candace N. Taylor, RN, CPAN	Missouri	American Society of Peri-Anesthesia Nurses (ASPAN)
Eugene Young, BSN, RN	Illinois	American Academy of Ambulatory Care Nursing (AAACN)
Patricia Calico, DNSc, RN	Kentucky	Health Resources and Service Administration (HRSA)
Jean Ivey, DSN, RN, CRNP	Alabama	Society of Pediatric Nurses (SPN)
Mary Elizabeth Myers, RN, BSN, CHPN	Kentucky	Hospice & Palliative Nurse Association (HPNA)
Beth Budny, MS, RN, CNA, CRRN	Massachusetts	Association of Rehabilitation Nurses (ARN)
Sarah E. Harne-Britner MSN, RN, CCRN	Pennsylvania	National Association of Clinical Nurse Specialists (NACNS)

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APPENDIX B
Certifications Held

	Frequency	%
Ambulatory care nursing	105	2.6
Cardiac rehabilitation nursing	32	0.8
Critical care nursing	310	7.7
Emergency nursing	128	3.2
General nursing practice nursing	114	2.8
Gerontological nursing	115	2.9
Home health nursing	113	2.8
Hospice/palliative care nursing	57	1.4
Medical-surgical nursing	316	7.9
Nurse manager	102	2.5
Nursing administration	58	1.4
Nursing administration, advanced	10	0.2
Nursing continuing education/staff development	37	0.9
Obstetrical nursing	155	3.9
Pediatric nursing	118	2.9
Perinatal nursing	41	1.0
Psychiatric and mental health nursing	101	2.5
Rehabilitation nursing	51	1.3
School nurse/college health	107	2.7
Other	978	24.4

APPENDIX C
Activity Statements Sorted by Core Practice Rating Order

ID	Activity Statement	Core Rating	Mean Imp	% Not Applicable	Mean Frequency
c.18	Manage the care of a pre-, peri-, and postnatal client	0.42	3.07	72.59	1.90
2.70	Evaluate occupational/environmental exposures	0.42	2.94	63.64	1.05
1.49	Evaluate the outcomes of health promotion activities	0.46	2.80	58.89	1.46
c.13	Participate in community health outreach activities	0.48	2.81	53.88	0.74
1.45	Identify and manage environment for symptom clusters across clients	0.53	3.12	59.10	1.05
1.48	Network with providers for similar populations and communities, to promote quality care	0.55	2.91	47.63	1.22
1.47	Perform targeted screening for specific client populations	0.55	3.00	50.97	1.87
2.57	Incorporate alternative/complementary therapy into client's plan of care	0.58	2.82	42.53	1.62
1.68	Manage client receiving moderate/conscious sedation	0.59	3.43	51.39	1.82
2.61	Maintain desired temperature of client using external devices	0.62	3.20	46.84	1.87
1.67	Manage blood product administration	0.64	3.48	46.84	1.32
1.46	Identify client health risks based on assessment of population or community characteristics	0.67	3.10	39.41	1.71

(continues)

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APPENDIX C
Continued

ID	Activity Statement	Core Rating	Mean Imp	% Not Applicable	Mean Frequency
c.12	Monitor and document adherence to health maintenance recommendations	0.68	3.19	37.14	2.12
c.7	Use standardized language in client care	0.69	2.92	31.18	2.57
2.29	Participate in the development/revision of policies and procedures	0.70	3.11	28.15	0.68
1.70	Insert intravenous access devices	0.72	3.43	34.59	2.17
2.58	Manage client with an alteration in nutritional status	0.73	3.33	33.14	2.38
2.55	Manage client with an alteration in elimination	0.73	3.28	33.80	2.12
2.59	Assess and intervene in client's performance of activities of daily living and instrumental activities of daily living	0.73	3.27	34.06	2.50
1.61	Monitor and maintain devices and equipment used for drainage	0.73	3.43	35.54	2.48
2.27	Manage conflict among clients/staff	0.74	3.19	22.84	1.22
2.68	Administer intravenous medications	0.74	3.54	33.31	2.83
2.64	Manage a client with an endocrine disorder	0.74	3.33	31.86	1.86
2.60	Manage the client with impaired ventilation/oxygenation	0.74	3.56	31.78	2.51
c.20	Monitor and maintain infusion access devices, infusion site, and rate	0.74	3.59	33.08	2.95
c.14	Manage client's mental health needs	0.74	3.28	28.36	2.03
2.38	Implement principles of case management to address client needs	0.76	3.23	25.91	2.40
2.62	Manage wound care	0.76	3.45	29.03	2.08
1.58	Manage clients with alteration in hemodynamics, tissue perfusion, and hemostasis	0.77	3.53	29.39	2.82
1.62	Identify causes of and manage inflammatory response	0.77	3.35	28.31	2.06
2.50	Assist client to develop achievable goals and plans to promote a healthy lifestyle	0.77	3.21	24.60	2.20
2.47	Participate in shared decision making	0.78	3.20	22.89	2.26
1.59	Perform skin assessment and implement measures to prevent skin breakdown	0.78	3.56	28.94	2.97
2.36	Assess/triage client to prioritize the order of care delivery	0.79	3.46	26.89	2.97
1.66	Adjust/titrate dosage of medication based on assessment of specified physiologic parameters	0.79	3.65	28.68	2.70
c.10	Comply with federal/state/institutional policy regarding the use of client restraints and/or safety devices	0.79	3.47	31.87	1.76
2.67	Comply with regulations governing controlled substances	0.79	3.63	27.59	2.76
1.64	Manage client with alterations in neurologic function	0.79	3.43	26.81	2.01
2.46	Provide therapeutic milieu for clients	0.79	3.23	24.40	2.65
2.74	Educate staff/students	0.80	3.39	18.95	1.36
2.69	Evaluate the results of diagnostic testing and intervene as needed	0.80	3.51	23.63	2.58
2.76	Assist client to identify reliable health information resources	0.81	3.25	20.12	1.72
1.60	Perform point-of-care testing	0.81	3.47	23.12	2.42
1.63	Manage specimen collection	0.81	3.37	23.97	2.43
c.17	Perform emergency care procedures as appropriate	0.81	3.68	25.45	0.72

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APPENDIX C
Continued

ID	Activity Statement	Core Rating	Mean Imp	% Not Applicable	Mean Frequency
2.26	Supervise care provided by others as defined by the State Nurse Practice Act	0.82	3.41	20.11	3.08
2.71	Report unsafe practice of healthcare personnel to internal/external entities	0.82	3.50	24.41	0.52
1.52	Assess family dynamics	0.82	3.29	19.56	2.25
1.54	Incorporate behavioral management techniques when caring for a client	0.83	3.25	19.94	2.31
c.22	Perform a risk assessment and implement interventions	0.83	3.49	22.14	2.59
2.56	Perform procedures using sterile versus clean technique	0.83	3.59	22.28	2.34
1.56	Manage client's hydration status	0.83	3.57	22.23	3.15
2.49	Evaluate and promote healthy behaviors	0.84	3.23	17.50	2.37
2.66	Accurately calculate dosages for medication administration	0.84	3.77	21.32	2.81
c.11	Provide information regarding healthy behaviors	0.84	3.35	18.06	2.28
2.30	Verify client is aware of rights and responsibilities	0.84	3.40	17.56	1.91
2.48	Provide anticipatory guidance based on client's individual risk assessment	0.85	3.31	18.45	2.32
c.5	Incorporate evidenced-based practice/research results when providing care	0.85	3.26	16.59	2.43
1.76	Assess client understanding of and ability to manage self-care	0.85	3.45	20.56	2.34
1.57	Manage client with impaired mobility	0.85	3.46	18.89	2.61
c.15	Use therapeutic communication techniques to develop coping and problem-solving skills	0.85	3.28	16.77	2.40
1.39	Perform activities related to client admission, transfer, or discharge	0.85	3.42	18.08	2.69
2.24	Make referrals and coordinate continuity of care between/among healthcare providers/agencies	0.86	3.35	14.16	2.17
1.42	Use ergonomic principles	0.86	3.46	17.49	2.78
2.75	Plan and provide comprehensive teaching to address the needs and concerns of clients	0.86	3.41	15.47	2.36
1.53	Assess and plan interventions that meet the client's cultural, emotional, and spiritual needs	0.86	3.29	17.66	2.24
2.65	Prepare and administer medications	0.86	3.78	19.10	3.29
1.75	Evaluate and document client learning	0.86	3.39	16.96	2.49
1.41	Incorporate cost consciousness and resource management in providing care	0.86	3.22	11.52	2.59
1.55	Perform comprehensive health assessment	0.87	3.54	17.56	2.71
2.37	Validate data from pertinent sources to evaluate client response to interventions (ie, family and significant others)	0.87	3.37	14.64	2.60
2.51	Recognize impact of illness/disease on individual/family lifestyle, environment, physical relationships, and multiple role responsibilities	0.87	3.33	15.81	2.36
1.33	Assign or delegate aspects of care as defined by the State Nurse Practice Act	0.87	3.40	17.00	2.89
2.52	Provide support to clients coping with life changes	0.87	3.43	15.73	1.97

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APPENDIX C
Continued

ID	Activity Statement	Core Rating	Mean Imp	% Not Applicable	Mean Frequency
2.73	Implement safety precautions/protocols for identified risks	0.87	3.57	16.83	1.98
1.71	Verify appropriateness and/or accuracy of a treatment order	0.87	3.60	17.26	2.69
c.3	Participate in performance/quality improvement	0.88	3.26	11.01	1.62
c.23	Assess client's readiness to learn, learning preferences, and barriers to learning	0.88	3.41	14.42	2.38
1.50	Identify nonverbal cues to physical and/or psychological stressors	0.88	3.29	13.84	2.38
1.43	Handle biohazardous materials according to regulatory guidelines	0.88	3.65	14.80	2.65
1.65	Review pertinent data prior to medication administration	0.88	3.76	16.44	3.25
1.40	Identify limitations within the healthcare delivery setting and respond	0.89	3.29	11.64	2.08
1.72	Identify and intervene in potentially life threatening situations	0.89	3.75	15.04	1.43
1.73	Verify proper identification according to guidelines	0.89	3.72	15.20	3.06
2.63	Use technology to manage, access, and process information	0.90	3.39	8.93	3.08
c.19	Evaluate appropriateness/accuracy of medication order	0.90	3.76	13.62	3.15
2.54	Perform focused health assessment/reassessment	0.90	3.62	12.06	3.19
2.45	Protect client from injury	0.90	3.69	13.01	2.90
2.28	Recognize ethical dilemmas and take appropriate action	0.91	3.37	10.81	0.85
c.21	Evaluate therapeutic and potential adverse effect of medications	0.91	3.71	13.79	2.92
c.16	Assess pain/comfort level and intervene as appropriate	0.91	3.68	12.96	3.27
1.51	Address client's communication needs based on visual, auditory, or cognitive limitations/distortions	0.91	3.45	11.02	2.43
2.53	Establish a therapeutic relationship with client	0.91	3.54	10.85	3.11
1.74	Identify language and communication barriers and intervene	0.91	3.49	11.38	1.77
1.69	Respond appropriately to client experiencing side effects and reactions of medication	0.91	3.74	13.75	1.67
2.72	Communicate appropriate information succinctly in emergent situations	0.92	3.68	12.58	1.13
2.42	Provide appropriate and safe use of equipment in performing care	0.92	3.70	10.35	3.25
2.44	Comply with emergency/security plans	0.93	3.61	9.48	1.19
2.41	Identify client's allergies and intervene as needed	0.93	3.74	10.43	2.88
1.36	Recognize patterns in client assessments and intervene appropriately	0.93	3.56	9.48	3.01
2.35	Report error/event/occurrence per protocol	0.93	3.61	10.41	0.65
1.31	Comply with state and/or federal regulations for reportable conditions	0.94	3.57	12.00	1.10
c.6	Provide individualized/client-centered care	0.94	3.68	8.60	3.44
1.30	Use self-evaluation, peer evaluation, and feedback to modify and improve practice	0.94	3.32	6.42	2.00
1.34	Evaluate and document the client's response to interventions, changes in the client's condition and modify the plan of care as appropriate	0.94	3.70	9.93	3.31
2.25	Verify client understands and consents to care/procedures	0.94	3.70	8.22	2.97
1.44	Accommodate individuals with disability or limitations	0.94	3.57	9.21	2.11

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APPENDIX C
Continued

ID	Activity Statement	Core Rating	Mean Imp	% Not Applicable	Mean Frequency
2.39	Communicate client's status to appropriate healthcare provider	0.95	3.66	7.66	2.92
2.40	Anticipate the need for additional resources to implement interventions	0.95	3.49	5.45	2.53
1.26	Serve as a resource person or mentor to other staff	0.95	3.45	2.63	2.90
1.27	Encourage feedback from clients/staff and take action as appropriate	0.95	3.43	3.50	2.75
c.8	Provide care appropriate to client's age, physical, developmental, cognitive, cultural, and psychosocial needs	0.95	3.67	7.50	3.39
c.4	Act as a client advocate	0.96	3.68	4.69	2.83
2.31	Participate in educational activities to maintain/improve professional knowledge and skills	0.96	3.52	4.30	1.00
1.35	Respect and accommodate clients' differences, beliefs, preferences, and expressed needs	0.96	3.59	6.05	2.98
2.34	Use standard nomenclature when documenting care	0.96	3.55	5.02	3.63
1.29	Use the nursing process as the basis of practice	0.96	3.48	4.97	3.33
1.25	Document nursing care consistent with guidelines	0.96	3.72	5.39	3.54
2.43	Apply principles of infection control	0.96	3.87	4.80	3.78
1.37	Value clients' differences, beliefs, preferences, and expressed needs	0.97	3.62	4.87	3.27
2.33	Provide care consistent with state nurse practice act, regulatory, and accreditation requirements	0.97	3.74	5.18	3.53
1.28	Respect and support coworkers	0.97	3.74	2.36	3.56
1.32	Function effectively as a team member	0.98	3.75	2.36	3.63
1.38	Demonstrate appropriate organizational skills	0.98	3.66	1.60	3.62
1.24	Recognize limitations of self/others and seek appropriate assistance	0.98	3.51	2.78	2.08
c.2	Use available information, technology, and resources to make informed decisions	0.98	3.60	1.72	3.17
c.1	Collaborate with other disciplines/professions	0.99	3.60	1.60	3.18
2.32	Maintain confidentiality/privacy	0.99	3.87	1.10	3.65
c.9	Use critical thinking skills to make decisions	0.99	3.80	1.40	3.59

ID indicates activity statement identification number; Imp, importance.

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Errata

In a case discussed in Filing a State Board of Nursing Complaint Against a Union Nurse During a Campaign (vol 9 issue 1), Norton Healthcare, Inc., d/b/a Norton Audubon Hospital and Nurses Professional Organization, affiliated with the United Nurses of America, American Federation of State, County and Municipal Employees, AFL-CIO, Cases 9-CA-36909 and 9-CA-37091, the National Labor Relations Board's Decision, Order, and Amended Remedy were issued on January 30, 2004, not January 12, 2007.

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