Third Edition

Competency Assessment

A Practical Guide to the Joint Commission Standards

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MBA/MHA, MSN, RN, CNAA-BC

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About the authors

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WendySue Woods, RN, CSHA, MHSA, brings exceptional accreditation compliance and process improvement expertise to her clients. She has more than 20 years of consulting experience and frontline, real-time success in Joint Commission accreditation, regulatory/risk management compliance, medical staff leadership, process improvement strategies, customer service, and administrative facility operations.

Prior to becoming a full-time consultant for The Greeley Company, Woods served in varying hospital administration roles related to quality management and medical staff leadership. She has successfully led organizations to Joint Commission accreditation compliance, achieving accreditation without recommendations for improvement. Woods served as Administrator of Operations and Ancillary Services for a hospital-owned, Joint Commission-accredited physician group. Her customer satisfaction programs have resulted in increased annual scores and greater market share. Her varied experience and ability to understand compliance, implement process improvement strategies across all levels, and provide staff education across the continuum, bring a comprehensive and realistic approach to reengineering and regulatory compliance.

Woods' ease with her clients and audience allows organizations to better understand the value of process improvement, customer service, and regulatory compliance and gain the ability to incorporate it into daily operations. She brings enthusiasm and a practical approach to healthcare accreditation. She has addressed healthcare audiences throughout the Southeast on topics varying from medical staff leadership, organizational improvement, team building, and Joint Commission accreditation. Woods is a registered nurse and also holds a master's degree in health science administration.

Brenda G. Summers

Brenda G. Summers, MBA/MHA, MSN, RN, CNAA-BC, is a senior consultant with The Greeley Company of Marblehead, MA, focusing on the areas of accreditation and regulatory compliance. She brings more than 16 years of experience in healthcare leadership to her work with healthcare centers across the country. Summers applies her years of healthcare leadership and clinical and regulatory expertise to help clients understand and meet accreditation standards and compliance expectations. Her in-depth understanding of organizational dynamics and the nature of change, even in times of turbulence, allows her to bring a realistic approach to organizational problem solving and strategic and operational process design.

She presents at state and national seminars, participates in topical audio conferences, and has authored several trade publications. Summers has particular expertise in the area of effective competence validation and performance review processes redesign, and consults in all areas of accreditation and regulatory compliance, process improvement, sustained change, and effective models for education.

Prior to joining The Greeley Company, Summers held senior leadership positions in hospitals in both North and South Carolina. Immediately prior to joining The Greeley Company, she served as vice president for administration and chief nursing officer for The Mercy Hospitals in Charlotte, North Carolina. She had direct reporting responsibility for all patient care areas, as well as many other clinical and non-clinical departments of the organization. She successfully introduced a number of change initiatives that resulted in improved patient, staff, and physician satisfaction, improved patient outcomes, and financial success of the organization. While in her senior leadership position, she also had responsibility for accreditation and regulatory affairs for the organization, and was able to coordinate sustained compliance activities in these arenas.

Summers holds an MBA/MHA from Pfeiffer University. She received a B.S. and M.S. in nursing from the University of North Carolina, Chapel Hill. She is certified by the ANCC in Nursing Administration, Advanced and is a member of Sigma Theta Tau, the International Honor Society of Nursing.

Preface

Complying with The Joint Commission (TJC) standards and maintaining accreditation can be challenging, time consuming, and frustrating. It's not uncommon to hear staff in healthcare facilities complain that the time they spend dealing with compliance issues and survey preparation takes away from their top priority: caring for patients. In some instances, staff members are just expressing their frustrations, but in others, they have lost sight of one important fact: Joint Commission standards are intended to promote safe, effective patient care.

Once organizations begin to view TJC standards as a vehicle for maintaining and improving quality of care and patient safety, they're likely to spend less time reading the fine print in their accreditation manual and more time talking about what's best for patients. Organizations should not assess competency simply because a regulatory body mandates it be done. Competency assessment should bring value to the patient, the employee, and the organization. It is a critical component of any process design or redesign, whether in response to opportunities identified through the facility's internal monitoring and evaluation activities or directed by an external source.

Competency assessment does not have to be a laborious, repetitious, paper-only process. Organizations should design a process that is both efficient and meaningful, and when appropriate, fun and memorable. To streamline the process and give it meaning, organizations should embrace the synergy between human resources (HR) and the environment of care (EC), infection control (IC), and performance improvement (PI) functions, and use aggregate data from all these sources.

Today, healthcare leaders are challenged to lay a firm foundation for competency assessment and implement an ongoing and interactive verification of knowledge and skills, while promoting a culture of safety. The goal is to provide high-quality patient care through skilled, competent personnel whose competency is validated and maintained via a structured program. This book provides organizations with the essential definitions and tools they need to understand

competency assessment requirements and develop and implement effective competency assessment programs in their facilities. It has been updated to address competency as it relates to tracer methodology, the evaluation of orientation, and the process for competence validation. We provide a model for competency validation and discuss the six steps to a successful program. A detailed discussion of the role data can play in the assessment of ongoing competence is also included.

CHAPTER ONE

COMPETENCY

BASICS

Competency basics

Establishing and implementing a thorough and effective, competency assessment program is the key to complying with the Joint Commission's (TJC's) competency-related standards. A competency assessment program should focus on identifying, verifying, and validating the skills and abilities of staff members to ensure that they meet the organization's standards. If the quality of staff skills and abilities remains high, then it is likely that the quality of patient care and services will also remain high. This chapter defines key competency-related terms and explains the various ways in which healthcare organizations apply the term "competency assessment."

What is competency?

Competency is the demonstrated ability to fulfill the primary responsibilities of the position for which a person was hired. Observing and measuring competency for every position in the facility, including health-occupation students (i.e., students of nursing, pharmacy, imaging, and rehabilitation, etc.) and volunteers who work in the same capacity as staff in providing care, treatment, or service, gives leaders confidence that healthcare providers are exercising care, caution, and concern for the patients.

Why develop a competency program?

Healthcare facilities should develop competency programs for several reasons, one of which is that TJC requires such programs. However, competency programs are important for reasons other than TJC compliance. Well-designed competency programs have three important functions:

- To help facility leaders stay focused on their primary objective: the facility's mission statement

- To assist in matching applicants to open positions

• To ensure ongoing assessment of staff competency from system entry through the remainder of the person's association with the organization

The following TJC HR standards provide the framework for a comprehensive competency program. They also guide HR department personnel and department leaders in developing a program that fulfills the above three functions and supports their expectations of performance in the facility and their departments:

• HR.1 requires leaders to identify the qualifications for each position in the facility, addresses at-hire competency validation, and requires leaders to ensure staffing effectiveness.

• HR.2 requires facilities to orient new staff, students, and volunteers to the organization, the department/unit/area in which they will work, and their job; establishes a process to validate staff, student, and volunteer competency by the end of orientation; and provides continuing education and training.

• HR.3 requires leaders to establish a process for validating ongoing competency of staff, students, and volunteers who work in the same capacity as staff providing care, treatment, or service; and to periodically conduct staff performance reviews.

Developing a specific goal with clearly defined objectives will assist leaders in implementing a meaningful competency assessment program. Below is a sample goal for a competency assessment program:

The goal of the competency assessment program is to fulfill the mission, vision, and value statements of the hospital by ensuring that qualified and competent staff provide high-quality services.

Objectives of the competency program are to:

• Establish a policy that defines the competency program on the facilitywide and department-specific levels

• Develop and implement the following department-specific components:

  - Competency-based job descriptions for every position in every department
  - Orientation programs for every department/unit that includes the department's functions and responsibilities

- Develop each leader's interview and critical judgment skills in order to enable him or her to identify those candidates who will successfully fill open positions

- Establish a background check that includes:

  - A completed application

  - Primary source verification and validation of licensure, certification, or registration, when required by law in order to practice

  - Verification and validation of licensure, certification, or registration, when required by the organization

  - Reference checks of personal and professional contacts

  - Criminal and other background checks as required by the organization

- Establish a mechanism to ensure that every employee attends all aspects of orientation required by the organization for completion by clinical staff before the individual begins providing care, treatment, or service to patients; attends the aspects of orientation to the job for which the organization has determined the employee can be oriented as he or she provides care, treatment, or service; and orientation to the facility within the time defined by organization leaders

- Establish a plan to ensure that competency is validated within the designated orientation period

- Ensure that performance evaluations are completed and given to the employee in the time frame established in the facility's policy

- Participate in an ongoing educational program and a competency validation process that are based in part on the results of performance evaluations and other data sources

- Design department-specific educational programs that target improvement in staff competency

- Establish a database to ensure that licenses, certifications, and registrations are current

Who needs to be assessed?

All staff members—including those providing care, treatment, or service under contractual arrangements—students, and volunteers who work in the same capacity as staff providing care, treatment, or service need to be assessed. Every employee in the facility is responsible for certain duties, and each employee must be able to perform his or her duties competently. Every employee should also be familiar with the policies and procedures relevant to his or her duties and know how those duties contribute to quality patient care, treatment, and service, and how they support the functioning of his or her department.

Department leaders should ensure that each employee understands the expectations/responsibilities/activities/competencies required for his or her position. Armed with this information, each employee will better understand his or her department leader's expectations regarding qualified and knowledgeable staff.

Who conducts competency assessments?

The department leader ensures the completion of competency assessments in one of four ways. He or she does one of the following:

- Designates a person who is responsible for all new-hire orientation and competency validation

- Establishes a proctoring system in which qualified personnel perform competency verification at the time of orientation and on an ongoing basis thereafter

- Obtains competency-related information from a combination of input from supervisors and direct observation

- Chooses to perform all competency assessments for all employees himself or herself

It's important to remember that the person validating someone else's competency must be qualified to do so. For example, if the pharmacy director isn't a pharmacist, he or she cannot validate the clinical competency of the pharmacist working in the department. Another example involves the director of a home care program validating clinical competency of all staff, including the clinical staff in rehabilitation, nutrition, etc. Since the director is likely not clinically competent

in all these disciplines, he or she is not qualified to validate clinical competency of staff. In either example, the director can complete the staff's performance reviews, but he or she cannot validate their clinical competency. We will discuss this idea more in Chapter 3.

Who determines which competencies need to be assessed, and how are those competencies chosen?

The leaders of the organization determine which competencies must be assessed. This responsibility includes initial competencies, competencies to be assessed (i.e., validated) by the end of orientation, and those to be assessed (i.e., validated) on an ongoing basis.

Initial competency must be met in order for the individual to join the organization. This is sometimes known as at-hire competency validation. It is a process a representative from the human resources department and the unit/department leader often share. It involves verifying whether the prospective employee or volunteer meets the qualifications specified in the job description/ position description. It includes verifying his or her licensure, registration, certification, education, and any other requirements specified. It is the role of leaders to identify the qualifications needed for each position in the organization. If the job is one in which care, treatment, or service is provided to patients, the qualifications should be identified after considering the patient populations to whom this care, treatment, or service is to be provided.

It is also the role of leaders to identify the responsibilities or activities the individual will be expected to perform. These responsibilities can also be thought of as competencies. They are identified in the job description/position description as primary responsibilities. The individual must prove competent to perform each of the primary responsibilities by the end of the orientation period. Because these are primary responsibilities of the position, they are likely to be performed with some degree of regularity by all staff members in the job group or all staff members having the same job title, i.e., all respiratory therapists, all cashiers, etc. As such, they represent "core competencies" or "core responsibilities." Some staff members in the job group may have additional responsibilities because of the unit/department in which they work or the patient population for whom they provide care, treatment, or service.

Following the orientation period, the individual begins to perform his or her job without supervision, moving into ongoing competency validation. Figure 1.1 includes definitions and examples of low-volume/high-risk, changed or new, mandated by a regulatory agency or by the organization as requiring annual education and revalidation of competency, and problem-prone responsibilities that could be identified as ongoing competencies for various staff situations.

Definitions and examples of low-volume/high-risk, new or changed, problem-prone, and mandated duties

Low-volume/high-risk duties are rarely performed duties that carry a significant risk of hazard or harm. Examples of such duties include a respiratory therapist stabilizing a premature infant for transport to a tertiary care neonatal intensive care unit, a nurse assisting with the insertion of a chest tube on a medical-surgical unit, and a staff member monitoring a patient receiving sedation for an invasive procedure.

New duties are responsibilities that will be performed for the first time, and changed activities are those that are planned to be performed in a different way. Examples include the use by respiratory therapists of newly purchased ventilators, the introduction of physician computerized order entry, and bar coding for medication administration.

Problem-prone duties are frequently or infrequently performed duties for which some data source has indicated a problem in performance. Examples include staff response to a fire drill, performance of CPR, administration of medications, collection of blood specimens for testing, and staff response to a faulty generator switch during generator testing.

Activities/responsibilities mandated for ongoing competency may be frequently or infrequently performed duties that an external regulatory agency, the organization itself, or the unit/department in which the individual works has mandated to be assessed for ongoing competency on an annual basis. Examples include waived testing proficiency, and restraint usage.

When do employees need their competencies assessed?

Note: Chapter 4 discusses the competency assessment cycle in more detail.
The organization must assess every employee's competency:

- Before the employee is hired (initial competency assessment)

- During orientation (validation primary responsibilities/activities can be performed satisfactorily)

- On an ongoing basis after orientation (ongoing competency assessment)

Initial competency assessment

This review helps eliminate candidates who do not have the necessary education, training, or experience for the open position. Through this process of elimination, the department leader avoids wasting time interviewing unqualified candidates. Once the applicants' qualifications are verified, the unit/department leader then interviews the remaining applicants, confirming each applicant's work experience and exploring his or her knowledge base.

A critical component of initial competency verification is "primary source verification" of the individual's current license, registration, or certification when this document is required by law to practice in that job title. Often the requirement is found in a practice act, such as the practice act issued by a state board of pharmacy, or by a board of nursing.

The concept and process for primary source verification is one in which staff members in the medical staff office are well versed, but it is still relatively new for staff outside this area. The requirement for primary source verification of a nonphysician license, registration, or certification was extended by TJC to nonphysician staff within the last few years, and still leaves some organizations struggling to understand the expectations and design a process to ensure not only that the individual possesses a current and valid license, registration, or certificate prior to employment, but also that he or she renews the license, certificate, or registration prior to its expiration. It is important to stress that this is not a concept applied only to RNs. All staff members for whom the license, certificate, or registration is required by law in order to practice must be part of the identified process for primary source verification.

Examples of nonphysician staff members for whom a license, registration, or certification is required in order to practice include the registered nurse, licensed practical nurse, certified nursing assistant, pharmacist, dietitian, respiratory therapist, rehabilitation professional (PT/OT/SLP), and social worker. With primary source verification, the agency/board issuing the document is contacted to verify that the individual received the document in question. In many situations this can be done electronically between you and the agency.

Leaders must define a process to verify any license, registration, or certification required by the organization but not required by law in order to practice. In this situation, the organization must identify, by job title, all licensure, certification, or registrations it requires of staff members in certain job groups/job titles and to determine the process for verifying that the individual possesses the required certificate, license, or registration. It is up to the organization to determine the process it will follow for this verification.

An example might be the organization that requires all respiratory therapists (RTs) to maintain current certification in basic life support (BLS). The process for verifying this certification should, at a minimum, include viewing the original document issued to the individual.

An additional consideration of leaders is the process to use in verifying any education required for the position. Options include primary source verification of education, prior to or during the interview process. In this scenario, the school(s) the individual attended would be contacted and asked to verify that the individual graduated. The alternative to primary source verification is to request to view the originals of all these documents. Many organizations simply accept the job applicant's documentation that the applicant attained the required education. Licensure, registration, or certification cannot be obtained in the absence of clinical education.

Validation of core competency by the end of orientation

Verification that the primary responsibilities of the job can be performed according to unit/department standards occurs during the individual's orientation to his or her unit/department and job. This ensures a consistent level of performance by all individuals in the same job group or having the same job title, regardless of the unit/department to which they are assigned. Before being assigned to tasks and duties, the new employee must be prepared to perform them in accordance with the organization's policies and procedures. Orientation serves to educate the individual on unit/department expectations, train the individual in the accepted way to perform the primary/ essential responsibilities of the job, and allows the individual to demonstrate his or her ability to competently perform the primary responsibilities of the job for which he or she was hired.

The identification of primary activities/responsibilities expected of staff in any job title/job group begins by identifying those activities/responsibilities expected of all staff in a job group (e.g., all RNs, all pharmacists, all registrars, all security officers, all insurance verifiers, etc.). Because these activities/responsibilities are expected of all staff, they can be thought of as core responsibilities/ activities. For many employees, this represents the entirety of their job responsibilities/activities. For others, there are additional responsibilities/activities expected of all staff in a job group/job title, employed in a specific unit/area/department of the organization, in addition to those activities/

responsibilities already identified as core competencies. These activities are reflective of the additional patient populations, activities, or technology found only in these sites. Examples include an RN in an oncology unit administering chemotherapy, and a pharmacist in the hospital's outpatient dispensing pharmacy responsible for enrolling patients in the community's medication purchase assistance program.

For those staff members in clinical positions providing care, treatment, or service to patients, there is an additional consideration—patient age or patient population. If the patients are of different age groups or different populations that requires their care, treatment, or service be altered in some way when it is provided to them, then it is a competency with an age-related or a population-related aspect to it. Assessing a staff member's ability to competently perform a responsibility with an age-related or population-related aspect means the staff member's ability to appropriately alter the way he or she carries out the responsibility must be validated. This is done at the same time the competency itself is validated, and will be discussed more in Chapter 2.

An example of an activity with an age-related aspect is taking vital signs, because the healthcare provider must select a different size cuff for taking blood pressure based on patients' ages, use different methods to take a temperature in different age groups, and know the different ranges that qualify as normal for various age groups for all vital signs taken.

**TJC switch from age-related to population-related care**

For all the frenzy associated with the need to demonstrate "age-appropriate care" delivery ("care appropriate to the needs of the populations served" in the 2004 standards), it is only referenced twice in the standards. It's found in the standards directing the organization to consider the patient age groups served (populations served after 2004) when planning or sponsoring staff attendance during ongoing training or continuing education programs. The other is in the standards related to leaders considering the ages of the patients (patient populations after 2004) to whom care is provided when determining the qualifications for particular jobs and again when directing leaders to periodically evaluate/assess/validate staff competency to provide patient care. Does this mean the need to demonstrate age-appropriate care has been eliminated? No. Patient age groups can represent patient populations. But, in addition, there are other ways to get staff to identify a group of patients whose care must be altered in some way to meet their unique needs. Examples of other ways to cohort patients (i.e., patient populations) include situations such as the patient with sensory impairments if providing patient education, the bariatric patient when positioning for operative and invasive procedures, the patient at the end of life when managing pain, etc. Recognizing patient age groups as populations is as relevant today as it ever was, but it is not the only way to cohort patients with unique needs.

Ongoing competency assessment

The ongoing competency assessment consists of selected skills, duties, or tasks performed in the department that the unit/department leader has determined to be important enough to measure and evaluate throughout the year. Ongoing competency assessments ensure that staff have improved or maintained skills in the important areas under review. Unlike competency validation at the end of orientation, the ongoing competency assessment is not comprehensive. Ongoing competency assessments entail a short list chosen from analysis of available data such as the results of performance-improvement activities, infection-control reviews, and risk-management reviews, additions of new technology or changes to existing processes, those competencies mandated by an external regulatory agency as needing annual reeducation and competency validation, and responsibilities occurring infrequently. Some of the responsibilities on the list will appear year after year, while others, such as those that are new or changed, are only identified for a particular year. The list of competencies chosen for any year is small. After choosing the ongoing competencies, the unit/department leader develops guidelines for evaluating and measuring each competency. If an activity on the ongoing competency list is one that has already been identified as having

an age or population-related aspect to it (see previous sidebar), then it is a given that the activity continues to have this age or population-related aspect to it each time it is validated. Below is a representation of the thought process inherent in the identification of ongoing competencies. It represents the four questions applied to the primary responsibilities/activities/competencies of any job, and is to be asked for both the core responsibilities and the additional responsibilities for all staff members.

Ongoing competence decision tree
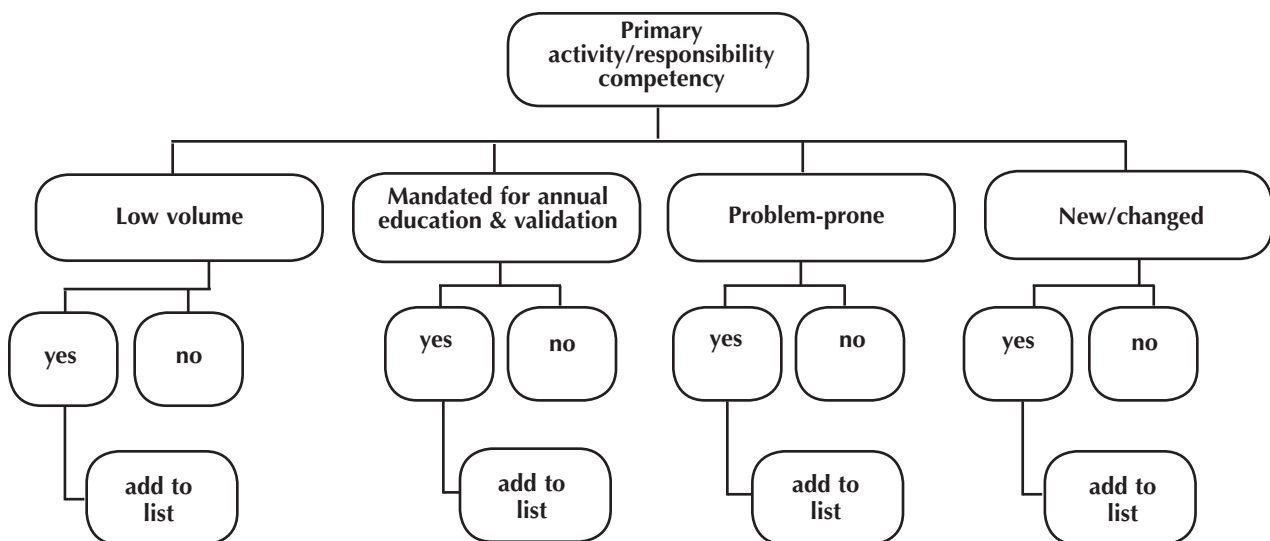
The process of identifying the activities/responsibilities/competencies for ongoing (i.e., annual) education and validation of competency is not something to be done only once. An analogous process in healthcare is the budget cycle. No organization casts a budget only once. It is an annual process, with monthly analysis of data in order to spot variances, so that action might be taken to return to the budgeted parameters. The same concept applies to that of ongoing competency.

Leaders project the activities/responsibilities/competencies for the coming year for which staff members will be provided education and then have competency validated. They then monitor the available data for signs of variance that require unplanned action. In the case of ongoing competency, this means adding activities/responsibilities/competencies to the existing list and providing staff with education, then validating/revalidating competency.

Deciding which activities/responsibilities/competencies from the entire list of activities/responsibilities/competencies must be addressed through ongoing competency validation must be specific to the job itself. The questions that determine the composition of the list must be asked first of all staff in a job title (core expectations of all staff in a job group) and then the same questions asked for staff having additional responsibilities beyond core.

Just as with core competencies, some ongoing competencies could have an age- or population-related aspect to them, so competency assessment must include an assessment of the person's ability to appropriately alter the care, treatment, or service he or she performs, when this is needed.

Here are two examples that should serve to clarify these concepts. For the first example, let's use an RT. One of the primary activities/responsibilities/competencies of an RT is that of medication administration via the inhalation route. Competency to perform this activity would begin during orientation. The new employee would receive education about how this is to be done at the organization at which he or she is working and then have his or her competency validated to perform this activity. In the case of medication administration, competency validation should reflect the individual's ability to alter the performance of the task as appropriate to the age of the patient. Once this competency is validated, this activity is one the individual respiratory therapist is likely to perform regularly. Unless a problem is identified through a review of the data or the process to follow in providing this care to patients is planned to change in the immediate future, the individual demonstrates ongoing competency in this core responsibility each day he or she works. If this were not the case, some data source would reveal a problem in the performance of the activity.

For the second example, let's use an RN. The orientation for an RN includes a comprehensive review of the organization's expectations (i.e., policy and tools for assessing pain) regarding a comprehensive pain assessment. All newly hired RNs would be required to attend orientation and complete the competency validation. This would not be expected of staff members who do not have pain assessment listed as a primary job responsibility. During the year, the organization collects pain-assessment data through performance improvement monitoring activities, patient perception surveys, complaint logs, etc. Leaders use these data to identify the ongoing competency of staff. In our example, let's pretend the data show that two areas of pain assessment are not in compliance with the targeted indicators. Leaders include these two indicators on the list of ongoing

competencies to be assessed/validated for the year. In this process, leaders utilize the performance improvement resource to identify areas in which the employees are no longer demonstrating continued competency, as well as to identify the areas in which they do continue to demonstrate competency. Since the tools to use in assessing pain for patients of different ages should differ, this also represents an activity/responsibility with an age-specific aspect to the process.