A competency framework for nurses in specialist roles

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Abstract

As nurses undertake more specialist roles, strategies need to be in place to ensure competencies are maintained. University College London Hospitals has developed a competency framework to support personal and professional development of nurses in specialist roles.

Concerns that specialist nurses undertaking endoscopies may not be carrying out enough procedures to maintain their skills (White, 2004) highlight one of the difficulties facing nurses working in specialist roles. Maintaining competencies and meeting the demands of continuing professional development can pose problems. Isolation and role ambiguity can also impinge on job satisfaction for those working in specialist roles. Understanding the realities of these roles and considering how nurses can be supported in practice is therefore a priority.

Specialist roles
The International Council for Nurses (1992) identifies three major forces underpinning the movement towards nurse specialists: new knowledge, technological advances and public need/demand. Despite the fact that the role of the nurse specialist has been in existence in the UK for the past 20 years, it is still surrounded by uncertainty and has been variously interpreted and implemented. There is confusion over titles, professional backgrounds, educational requirements, and the extent to which such roles afford public protection and pay.

The UKCC attempted to address the difference between a nurse working in a specialism and a specialist nurse by focusing on ‘higher-level practice’ (UKCC, 1999).

Specialist nursing
Specialist nursing posts have developed nationally in numbers and diversity over the past 10 years (Humphris, 1994). A range of factors has contributed to this growth and development. Many clinical nurse specialist (CNS) roles developed as a response to the publication of The Scope of Professional Practice (UKCC, 1992). The rise of specialisation in health care and developments in treatment have provided additional opportunities for specialist nursing roles to evolve. A developing interface between primary and secondary care, the reduction in junior doctors’ hours and shortages of medical staff have provided a further influence (Harrison, 1998).

Innovative nursing roles have evolved to meet the emerging needs of a dynamic and ever-changing service. However, this development has taken place in the absence of any clear national definition of these roles and their related functions. Many roles are centred on medical diagnosis, treatment or patient-monitoring functions. There is often a lack of consideration for outcomes that can be demonstrated not only in medical terms but also in terms of nursing and improved patient care (McGee and Castledine, 2002). As a result, there is an array of titles attributed to specialist nursing posts, which has served to create confusion among practitioners, colleagues and the public (Roberts-Davis et al, 1998). It was not until the publication of The Standards for Post-registration Education and Practice Project (UKCC, 1994) that specialist nursing was defined.

The literature from the US more clearly defines the criteria required for specialist nurses. Hamric and Spross (1989) have contributed to an understanding of sub-functions within specialist roles, identifying these as expert practice, education, consultation, collaboration, leadership and research. Further conceptual understanding was developed through clarification of advanced and specialist practice functions (UKCC, 1999), but there is still no clear generic framework to support preparation and practice at this level.

Defining higher-level practice
The lack of clarity surrounding specialist nursing roles highlights concerns in relation to the regulation of such posts. A clear understanding of function (of these roles) is important for the nursing profession, the wider health care team and the general public.

The UKCC recommended that nurse specialists should be defined as those who are expert within a specialty as opposed to simply working within one (UKCC, 1999). The previous concepts of ‘specialist’ and ‘advanced practice’ can now be seen within an overarching level of higher-level practice (NMC, 2002).

Higher-level or advanced practice focuses on the ‘how’ and ‘what’ practitioners do rather than their qualifications. The UKCC viewed education as a support to practice rather than a determinant of it (UKCC, 1999). Academic qualifications, however, are seen as key to the development of nurses’ cognitive, reflective and rational ability.

It is envisaged that all higher-level practitioners of the future will be required to demonstrate evidence of competence-based standards on a three-yearly basis, and...
References


This article has been double-blind peer-reviewed.

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BOX 1. EXISTING STRUCTURES RELATING TO SPECIALIST PRACTICE

- Hamric and Spross’ six sub-roles of specialist practice (1989)
- The NHS Knowledge and Skills Framework (Department of Health, 2003)
- The chief nursing officer’s ten key roles (DoH, 2000)
- NMC higher-level practice standards (NMC, 2002)

can be registered with the NMC, which is defining a new standard of higher-level practice that will be known as ‘Advanced Practice’ and benchmarked against a nationally regulated standard of proficiency at master’s level.

This fits with the emerging framework of Agenda for Change, which establishes a national competency-based framework for most job roles within the NHS. A further guide to the role function of specialist posts can be obtained from the chief nursing officer’s Ten Key Roles for Nurses (DoH, 2000).

Developing a framework

UCH employs 90 nurses in specialist posts. It established a steering group to develop a support framework for a range of specialist nurses. The key aims were to:

- Develop a consistent role definition for specialist nursing, underpinned by a competency framework;
- Identify the structures needed for role development, communication and support for specialist nursing posts;
- Make sure the role review is integrated into both national and local imperatives.

The initial stage of work was to complete a mapping exercise to identify existing local and national structures and competencies relating to specialist practice and to identify links between these (Box 1). The six sub-roles of specialist nursing identified by Hamric and Spross (1989) were selected as the structure on which to develop a detailed competency framework.

It was identified that the competency framework should reflect the continuum of development evident among specialties. Some staff may enter such roles at a developmental level, progressing to become proficient and then continuing to become expert practitioners. The competency framework reflects these levels, providing a framework for continuing development and identifying academic requirements to underpin each level.

Detailed competencies were subsequently developed within each of the six sub-functions. These reflect the higher-level practice standards and are integrated to the care and specific competencies of The NHS Knowledge and Skills Framework (DoH, 2003). Competencies further reflect the operational and practice requirements of specialist roles in the trust and incorporate the CNO’s 10 key roles (DoH, 2000).

Following completion of the competency framework, trust-wide generic job descriptions and person specifications have been developed to reflect the three identified levels of specialist practice. This ensures future roles are developed within a core framework and will facilitate consistency of role perception across the organisation.

Job descriptions and person specifications are competency based and are mapped to The NHS Knowledge and Skills Framework (DoH, 2003). It is intended that these will serve as generic tools, which can be adapted to reflect the local context of specific roles within specialties.

An assessment framework

A framework for the assessment of competencies has been developed. This will be used in conjunction with an Individual Performance Review (IPR) and personal development planning process in order to identify a nurse’s current level of practice and to clarify her or his ongoing development needs. Nurses will then use the competency framework to develop a portfolio of practice competencies relating to their relevant level of expertise in that role. These can be illustrated through a range of evidence, including observation of practice. Evidence of practice competencies is assessed within one year of the postholder being appointed, the individual’s line manager and a minimum of one other person who may be an expert nurse, doctor or user of the service, lead the assessment process.

Support structures

The review group considered organisational structures enabling support and communication. A central live register of all those nurses working within specialist roles has been developed, and there is trust-wide electronic access to the competency framework, generic job descriptions and person specifications. Clinical supervision was considered a priority for nurses working within specialist roles.

The original steering group will continue (as a steering group) to pilot the framework, evaluate it and then to support the process of roll-out across the organisation.

Conclusion

A portfolio of practice competencies will allow nurses in specialist roles to track their development against the higher-level practice standards (UKCC, 1999) and maintain their evidence of fitness for registration. Such a portfolio could also be used in the accreditation of prior and experiential learning (APEL) process within institutes of higher education.

The belief is that such a process will serve to establish and strengthen the role of specialist nurses within the trust, ensuring that these roles focus not only on medical priorities but also on those of nursing and patient care. This will provide postholders with the confidence to work within their clinical teams and collaboratively with peers across the organisation both to their own benefit and that of their patients.