

ADAPTING THE PNDS TO
STAFF NURSE COMPETENCIES
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How do we define clinical competence? Patricia Benner, RN, PhD, stated that competence is demonstrated by the nurse who has been working two or three years and is able to view their actions in terms of long range goals or plans.⁶ These plans include establishing a perspective and using problem solving skills as well as critical thinking. Another expert identified

competence as an outcome of four principles: learning, assessment, development, and experience.⁷ AORN defines competency as "the knowledge, skills, and abilities necessary to fulfill the professional role functions of a registered nurse in the operating room."⁸

The professional literature abounds with approaches, models, and methods of competency

assessment. All focus on the objective measurement of an individual's ability to perform in clinical practice. This article describes how the PNDS language facilitates identifying competency assessment by providing a common vocabulary. The language delineates delivery of care, which is the content critical to our practice and can be utilized to identify performance expectations.

TABLE 4-5

PERIOPERATIVE COMPETENCY STATEMENT/CRITERIA — REGISTERED NURSE (SwedishAmerican Health System)

Competency/ Outcomes	PNDS Interventions Listed to Indicate Behavioral Criteria
Maintains a safe operational work environment	<p>ASSESSMENT</p> <p>I-1 Acts as a patient advocate by protecting the patient from incompetent, unethical, or illegal practices. Respects the Patient's Bill of Rights, complies with agency policies of competent performance, complies with federal regulations (eg, OSHA) and state nurse practice act, complies with accrediting agencies (eg, JCAHO). Adheres to professional standards of practice (eg, AORN), and confirms clinicians' privileges and credentials. Intervenes to protect the patient's safety by reporting incompetent, unethical, or illegal practices; documents observations and occurrences objectively; complies with agency policies; and uses agency procedural mechanisms to address harassment and abuse.</p> <p>I-138 Implements protective measures in preparation for invasive or operative procedure. Ensures that the patient is safely prepared for the technology and equipment used in an invasive or operative procedure.</p> <ul style="list-style-type: none"> • Confirms identity before operative or invasive procedure • Verifies NPO status • Confirms surgical site with patient and perioperative team. <p>I-97 Preserves and protects the patient's autonomy, dignity, and human rights. Confirms consent, uses restraints only when the patient poses a danger to self or others, implements agency advance directive policy, and participates in preoperative teaching.</p>
	<p>PLAN</p> <p>I-30 Develops individualized plan of care. Considers all assessment information for the plan of care and demonstrates individual choice reflected identified need and patient participation in the plan.</p>
	<p>IMPLEMENTATION</p> <p>I-118 Transports according to individual needs. Ensures transfer without tissue injury; altered body temperature; ineffective breathing patterns; altered tissue perfusion; and undue discomfort, pain, or fear.</p> <p>I-122 Uses supplies and equipment within safe parameters. Ensures that use of supplies, equipment, and instruments do not compromise patient safety.</p> <p>I-11 Applies safety devices. Prepares, applies, attaches, uses, and removes devices (eg, restraints, padding, support devices).</p> <p>I-96 Positions the patient. Determines the need for, prepares, applies, and removes devices designed to enhance operative exposure, prevent neuromuscular injury, maintain skin and tissue integrity, and maintain body alignment and optimal physiological functioning.</p> <p>I-8 Administers or prepares for administration prescribed medications and solutions. Ensures that medications or solutions are given according to agency policy.</p> <p>I-72 Implements protective measures to prevent injury due to electrical sources. Prevents injury secondary to return electrode placement, active electrode handling, electrosurgical unit use, or stray radio frequency current.</p> <p>I-73 Implements protective measures to prevent injury due to laser sources. Provides safety equipment such as protective eyewear, instrumentation, and moistened sponges.</p> <p>I-74 Implements protective measures to prevent injury due to radiation sources. Provides safety equipment such as gonadal protection.</p> <p>I-75 Implements protective measures to prevent skin and tissue injury due to chemical sources.</p>

This clinical project was comprised of three steps. First, the nursing staff members reviewed our institution's competency document and identified how it could be adapted to reflect the PNDS. Second, a competency tool that incorporated the PNDS was drafted. Finally, perioperative nurses were surveyed to determine whether the revised behavioral criteria accurately reflected perioperative nurse competency.

Clinical Competency Project

Review of our existing competency statements found that most statements were generic across clinical settings and general in nature. For example, the hospital's first statement was "Demonstrates use of the nursing process in the delivery of care to patients, including assessment, plan of care, implementation, and evaluation."

TABLE 4-5 (continued)

PERIOPERATIVE COMPETENCY STATEMENT/CRITERIA — REGISTERED NURSE (SwedishAmerican Health System)

Competency/

Outcomes PNDS Interventions Listed to Indicate Behavioral Criteria

Maintains a safe operational work environment.		Prevents skin and tissue trauma secondary to antimicrobial agents, chemical disinfectants, liquid sterilants, irrigation solutions, ethylene oxide, methyl methacrylate, and tissue preservatives
	I-76	Implements protective measures to prevent skin or tissue injury due to thermal sources. Prevents skin and tissue trauma secondary to hot instruments, solutions, casting materials, thermal regulation devices, and light sources.
	I-77	Implements protective measures to prevent skin/tissue injury due to mechanical sources. Prevents skin and tissue trauma secondary to the use of devices such as positioning equipment, tourniquets, sequential compression devices, hair removal devices, tape, and OR bed
	I-93	Performs required counts. Ensures that the patient is free from injury related to retained sponges, instruments, and sharps
	I-94	Performs skin preparations. Carries out necessary actions to prepare the epidermis for an operative or invasive procedure
	I-98	Protects from cross-contamination. Applies methodologies that prevent patient exposure to infective agents from endogenous sources (as from one tissue to another within the patient) and from exogenous sources (as acquired from objects, personnel, or other patients).
	I-99	Provides care in a nondiscriminatory, nonprejudicial manner regardless of the setting in which care is given. Adheres to AORN, Joint Commission on Accreditation of Healthcare Organizations, and other standards of care. Provides comparable levels of care regardless of the physical setting in which care is given (eg, inpatient, outpatient, public, private, home, emergency department)

EVALUATION

I-36	Evaluates for signs and symptoms of chemical injury. Observes for allergic reactions, burns, rashes, blistering, respiratory distress, or other signs and symptoms of a chemical injury.
I-37	Evaluates for signs and symptoms of electrical injury. Observes for redness, blistering, or burn to the skin.
I-38	Evaluates for signs and symptoms of injury as a result of positioning. Observes for signs and symptoms of injury to integumentary, neuromuscular, and cardiopulmonary systems as a result of the patient's position during the procedure.
I-39	Evaluates for signs and symptoms of injury to skin and tissue. Observes for signs and symptoms of injury from equipment used.
I-40	Evaluates for signs and symptoms of laser injury. Observes for injury unrelated to the intended therapeutic effects of the laser beam
I-41	Evaluates for signs and symptoms of physical injury. Observes for signs and symptoms of injury after an operative or invasive procedure
I-42	Evaluates for signs and symptoms of skin and tissue injury as a result of transfer or transport. Observes for signs and symptoms of injury related to transfer or transport
I-43	Evaluates for signs of radiation injury to skin and tissue. Observes for signs and symptoms of injury unrelated to the intended diagnostic or therapeutic effects of radiation.
I-55	Evaluates response to thermoregulation measures. Observes and verifies body temperature and adverse effects

We examined AORN's competency model and noted that 18 statements were required to address all aspects of the nursing process. We also found that AORN's competency statements were much more specific than our institution's statements.

Subsequently, we reviewed the existing behavioral criteria for the department competencies and found that they were nonspecific in nature. Examples include, "Independently assesses and documents patients' physical/psychosocial status according to unit specific guidelines and demographics" and "Appropriate age specific interventions are identified and implemented in a timely manner." AORN's competency model reflected specific behavioral criteria such as "Verifies operative procedure" and "Notes condition of skin." Our group recognized the potential benefits of having more specialty and setting specific competency statements. This led us to explore a revision of our existing statements.

Tool Construction

The group decided to continue to use the template format from the institution-wide competencies. To support ease of use and offer consistency, nurses decided to keep competency statements listed currently on our original document. The group did, however, combine the two statements regarding safety, "Uses equipment correctly" and "maintains a safe operational environment," into one statement which now reads "Maintains a safe operational environment."

A list of the PNDS interventions were reviewed and segregated into groupings that reflected the general institution-wide competencies. First, the interventions were categorized into those relevant to

- ◆ basic practice with nursing process,
- ◆ pain management,
- ◆ maintenance of safety, and
- ◆ patient education.

Each group of behavioral criteria was then listed sequentially following the steps of the nursing process. See the examples presented in Table 4-4 (pain management) and Table 4-5 (maintenance of a safe environment). The format places the adapt-

ed institution-wide competency statements in a column on the left and the PNDS interventions as behavioral criteria in a column on the right.

Perioperative Nurse Survey

In our efforts to validate this approach and framework, a draft competency tool was distributed to a convenience sample of 15 perioperative practitioners and clinical specialists. Participants were asked to rate the degree to which the behavioral criteria accurately reflected the competency of a perioperative nurse. A one to four (ie, completely disagree to completely agree) Likert-type scale was used. The intent of this evaluation was to determine content validity, clarity, and the fit of the individual PNDS intervention criteria to the general competency statements.

Results

The return rate was 66%, and the level of agreement was reported as percentages of the scale rating. The labels "completely agree" had the following ratings: pain-82%, safety-92%, patient education-77%, and nursing process-89%. The label "slightly agree" showed agreements at the following ratings: pain-17%, safety-6.7%, patient-20%, and nursing process-10%. These high levels of agreement suggest that these PNDS interventions could serve behavioral criteria within our facility's competency statements.

Conclusion

This data from this small scale testing can only be applied to our facility. However, we achieved more than 90% agreement for all four competency categories. The language is clearly understood by our staff and can be a reference point for perioperative nursing practice. Our nursing process competency statement, "Demonstrates use of the nursing process in the delivery of care to the patients," was found to be too encompassing and general. Many areas of specific focus could be identified with more discrete statements. For example, these statements could segregate physiologic criteria from psychosocial criteria providing more specific categories for skill delineation.

Most importantly, this project has started a dialogue among our staff members and it has generated interest in the use of the PNDS language in our daily work. This has even influenced staff members

to recommend review and revision of our clinical records to reflect the vocabulary. Such a positive outcome is most welcomed in today's health care environment. We look forward to building on the synergy of the process. This affirms another beginning step in the constant change process.