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An action research study of the development of a Competency Framework in the context of district nursing

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Section 1: Research Design

Introduction

This report presents the results of a collaborative action research study into the development and perceived usefulness of a competency framework in the context of district nursing.

Background to study

There has been considerable structural change in the Community Division of the Trust under study as a result of reconfiguration. There has also been ongoing political, professional, technological and strategic change affecting nursing right across Wales, for example, the NHS Plan recently produced by the Welsh Assembly, the Welsh strategy for primary care, the Welsh strategy for nursing contained in "Realising the potential" (National Assembly for Wales 1999) as well as the national audit report "First Assessment" (Audit Commission 1999). This has all had considerable impact on district nursing services. Against this background, community nurses in the said NHS Trust felt the need to clarify their developing roles, responsibilities and competencies more precisely. The G grade role, in particular, has traditionally centred on caseload management but is becoming much broader. District nursing is not only different from acute nursing, but is also different from the way in which was practised 10 years ago. Staff work in isolation, often making difficult clinical decisions in complex situations. Many staff also find continual change difficult to grasp or accept and need particular support and guidance.

In response to this, a series of away-days were held in the spring of 2001. These were facilitated by the two community services managers for Conwy and Denbighshire and their deputies. G and F grades met together, D and E grades likewise, B grades had their own day. Staff were given appropriate political, professional and strategic orientation and various documentation relating to their posts (e.g. job descriptions, summary of recommendations from "Realising the Potential" & "First Assessment", summaries of skills and demands etc). They were then asked to think about their roles and responsibilities in relation to themselves, to their team and to the service. They then brainstormed the key skills, or competencies, they felt were demanded of community nurses. It was their thinking and understanding which was captured. It was a staff-led, bottom-up process.

Much data were gathered. When collated later, broad performance criteria, key areas of these criteria and details of the content of these key areas, in discrete subsections, clearly emerged. These were written up and sent back to staff for their comment and feedback. Finally they were written into a tabulated format. This incorporated relevant evaluation methods to be used to assess competencies and the methodology for monitoring and recording outcomes as well as relevant remedial or proactive actions taken.

The Competency Frameworks are implemented by line managers. They are administered and discussed at the annual personal development review. They are monitored and actioned within six months of this review. This Framework is our first attempt at formalising the monitoring and evaluation of competencies and remains a live document.

The nursing Competency Framework to be investigated in this research examines the actual performance of the grades of community nurses within each study group. The competencies are set out in terms of managerial and clinical skills specific to each group of community nurses, grades B to G.

Literature Review

Introduction

The literature search parameters were defined as including all literature reviews, discussion papers and empirical studies, with the inclusion of relevant grey literature in terms of reports relating directly to professionalism and to district nursing where competence is addressed. The databases of CINAHL, Medline, ECO, Article First, WorldCat, were consulted using the search terms 'skills' and/or 'competenc*' or 'district' and/or 'nursing'. This returned 15892 results. The search was refined to search for 'skills' and/or 'competenc*' and 'district' and/or 'nurse' returning 237 results between 1998 and 2003. Of these results 62 documents were found to be relevant to the study and informed the review. The search was undertaken again in January 2005 using the same refined search terms. This time dates between 2003 and 2005 were entered, returning seven new articles considered to be appropriate. Other papers have been obtained where necessary where they have been deemed key texts due to their perceived value throughout the literature, as far as 1993. In spite of this, few research papers were found to relate directly to the development of competencies in district nursing (Forbes et al 2001, McIntosh et al 2000, McIntosh 2000, Laux Kaiser & Rudolph 1996). The majority of papers examined competence as applied to the student nurse (Dolan 2003, Watson et al 2002, Bartlett et al 2000, Flanagan et al 2000, Watkins 2000, Carlisle et al 1999, Fearon 1998) or the clinical nurse specialist (Gibson et al 2003, Hicks & Tyler 2002, Dunn et al 2000, Crabtree 2000,

Cattini & Knowles 1999). As the literature was examined, three discrete themes emerged; firstly defining competence, secondly clarity of roles and the developing practitioner, and finally assessment of competence. They are presented below.

Defining Competence

Competence and competency have been described rigorously throughout the nursing press in the last 10 years (Pearson et al 2002, Pearce & Trenerry 2000, Flanagan et al 2000, Nolan 1998, Taylor 1995) with an increase of interest in British literature from around 1997 when Bradshaw (1997a and 1997b) explored the issue; asking what does being competent mean. She, like others (O'Dowd 2003, Cattini & Knowles 1999) discusses the demand from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (now Nursing and Midwifery Council (NMC)) that nurses should be competent practitioners required to maintain their competence. At that time however, the UKCC omitted a clear definition of the concept from its guidelines, giving no clear plan to guide the nurse in achieving and maintaining competent practice (UKCC 1996). Bradshaw (1997a) contests that this is a crucial issue since where there is no basic standard of competence prescribed at each level of practice; the nurse's competence cannot be assessed.

Eight years on the position has changed, as the NMC has published its revised Code of Professional Conduct (2004a). It presents nine key requisites to upholding the Code of Conduct, one of which is a directive to maintain professional knowledge and competence. Nurses, who must be registered with the NMC to practice, are bound to work within NMC regulations, with each practitioner retaining responsibility for their own standard of practice (NMC 2004a).

The issue of competence is addressed further in two linked documents (NMC 2004 b, c) each of which presents the definition of lack of competence;

‘A lack of knowledge, skill or judgement of such a nature that the registrant is unfit to practice safely and effectively in any field in which the registrant claims to be qualified, or seeks to practise.’

(pg 2)

Smith (1997) discusses the interface between maintenance of standards, competence and quality of care discussing implementation of measurement systems to ensure quality is delivered while Tzeng and Ketefian (2003) found during an exploratory study that hospital managers required qualified and competent nurses to deliver high quality care. The link between ensuring competence and ensuring quality is an implicit one, and I could find no evidence that the link had been explored empirically with few studies discussing the link. The quest for a quality service however, entails an expectation that those delivering the service have the expertise to do so (Smith 1997). Ensuring quality is a difficult concept since it varies depending on the perspective from which it is viewed. Patients will look for caring behaviours as indicators of quality nursing (Carey and Posavac 1982) while nursing staff might consider technical ability more important. Cescutti-Butler and Galvin (2003) also identify that competence is defined by patients as demonstration of caring behaviour.

In the United States, statutory body guidelines are much more prescriptive than those currently laid down by the NMC, stating that each organisation must provide training and information and must assess its staff's ability to fulfil specified responsibilities (Boylan & Westra 1998). This approach seems to stress the importance placed on measuring technical ability and specific skills or tasks.

Taylor (1995) rejects the need to focus on specific tasks, stating that competency in four overarching domains will ensure nursing competence. She goes further in her discussion paper, promoting the need for nurses to focus on their interpersonal skills and bemoaning the fact that these have become a neglected part of nursing's basic competencies. In agreement with this, Zhang et al (2001) have suggested that core competencies such as behavioural skills and attributes are more appropriate to test than psychomotor skills. This is refuted by McIntosh et al (1999) who state that interpersonal skills are fundamental to nursing. Such is my personal belief, which concurs with Eraut (1999) who believes that competence in skills performance must exist within a context and purpose, and that possessing a skill is just one facet of knowledge. Eraut (1998) goes further to explain that performance is clearly related to the ability to do something, but whether this demonstrates competence or not and whether performance is necessary to demonstrate competence lacks consensus.

It will become clear as the results are presented that the practitioners interviewed found difficulty with the concept of competence, and as the research shows, the concept is difficult to define operationally. In fact, authors agreed on little regarding the concept of competence. This is evidenced by Girot (1993) who states that competency is over-defined rather than ill-defined. That being the case, I have chosen for the purposes of this study to assign a definition

of competence which 'best fits' the intention of the competency frameworks under investigation. The definition presented was employed by Gibson et al (2003) and adapted by them from Gonczi et al (1993) - "Competence: focussed on performance or a set of tasks" (p593). This is part of a wider definition that includes consideration of the underlying attributes to enable the practitioner to practice safely. As previously stated, my belief is that the professional nurse must possess these attributes to practice as a nurse, irrespective of the ability to engage in the competencies laid out in the framework under study. Gibson et al's (2003) adaptation of Gonczi et al's (1993) full definition can be found at Appendix III.

Currently, the NMC state that in order to be competent the nurse must possess the skills and attributes necessary for carrying out lawful, safe and effective nursing practice, acknowledging any limits of professional practice and undertaking only activities in which he or she is competent (NMC 2004a). The NMC then, appears to focus on the ability to perform a task or skill and appears to ignore the affective domain, and although this is not explicitly stated, it would appear that the organisation subscribe to the school of thought advocated by McIntosh et al (1999) as discussed above.

Historically, nursing competence has been described as being related to the nurse's role as a bedside nurse; including concepts such as caring (Kenny 2003), knowledge and skill, and moral fibre and communication/relationships (Bradshaw 2000) while Norman et al (2002) state that competence in nursing protects patients. Bradshaw (2000) appears to correspond with While's (1994) view which maintains that competence is an interaction between emotional and technical abilities.

The testing of competence in terms of measuring clinical ability has been described positively in many studies (Aggleton et al 1987, Stephens 1999, Andre 2000, Nolan 1998, McIntosh 2000) despite Zhang et al's assertion (2001) that competency frameworks with respect to clinical skills will have to be modified on a continuous basis. Jones and Cheek (2003) also agree that skills should be contemporaneous. This is understood and indeed it could be argued that the dynamic nature of nursing is the reason for developing a baseline of core skills which can be expanded upon as necessary within a live competency document (Percival et al 1994).

The concept of identifying core skills was identified as a positive benefit by Carroll (2004) in the most recent study applicable to this research. Carroll utilised a qualitative methodology with mixed method data collection (Denzin and Lincoln 1994) in order to identify the core skills needed by nurses in a medical assessment unit. The core skills identified were perceived as relevant to the clinical area in which the research was conducted. While Carroll agrees that core competencies can identify the training needs of individuals, the study should be repeated

in the future to ensure the changing nature of nursing skills required in the medical assessment unit is reflected by appropriate core competencies. This study lends weight to the need to identify competencies for practice and to the necessity to maintain the competency document as a live document, developing along with the nursing roles they describe.

Another proponent of the live competency document; Schroeder (1997) states that nursing roles change rapidly and that due to changing expectations of the job a static approach is not suitable. A static document would render the competency frameworks invalid to measure current competence as the competencies required for the job move on but the documentation remains static. This would lead to a lack of clarity regarding current measurement of the practitioner's ability. This concept is addressed within the research presented for this study.

Gonczi (1994) seems to support the concept of generic competencies, conceptualising competence in three ways, two of which are appropriate to examine here. The first of these was that there were a number of general attributes of the practitioner that were essential to effective performance. That is - generic or core competencies are instilled in practitioners. Watson et al (2002) had issue with this concept in that there is no guarantee that generic competencies exist or indeed that they would be sufficient for each group of practitioners to whom they were deemed to be assigned. Gonczi (1994) also considered that competence might be measured on a behaviourist level, in other words by direct observation of performance of tasks. This will be explored in the discussion of the focus group results.

Clarity of roles and the developing practitioner

In literature specific to district nursing, the Royal College of Nursing recently recommended that district nurses should be clear about their skills and expertise (RCN 2002). McIntosh (2000) supports this from the viewpoint that if they can explain what they do in terms of grade mix and skills needed then district nursing work becomes more visible and less likely to suffer from grade dilution. In terms of visibility of work, Chapman (2000) comments that nursing as a profession would benefit from an accurate description of what practitioners do.

While Chapman (2000) considers the need to address clarifying the nursing role from a strategic perspective, Forbes et al (2001) examine the issue of identifying grade related skills from the perspective of the practitioner rather than a strategic one. This research examines the developing skills and autonomy of the community staff nurse. It suggests that clarity in defining the role is important, outlines limitations and establishes clear lines of accountability and support for these practitioners.

The RCN (2002) consider that district nurses should explore lower grade staff potential, and ensure training needs are identified, while Hallett and Pateman (2000) call for clarification of

the community staff nurse's role. With regard to grade-related or level-specific competence, Percival et al (1994) have approached competency development using a framework of grade related skills which require the assessor to be aware of the level of practice the nurse should achieve, while Pearce & Trenerry (2000) approached level specific competency with a rating scale which identifies quality of performance. In addition their competency development took into account the different competencies needed for each field of nursing, developing domain – specific competencies as well as generic core competencies which each nurse would be expected to achieve.

Maretoja and Leino-Kilpi (2001), comment that during their literature review competencies designed to show the developing practitioner were difficult to find. The fact that the competency frameworks in this study make plain the grade differences intends to provide staff with clarity of role expectations as they move along the novice to expert continuum (Benner 1984). Grade differences can be problematic in practice, where the practitioner is unsure of what is expected at each grade (Forbes et al 2001) while Choudhry (1992) comments that uncertainty of expectations leads to role strain. The competency framework presented in this study hopes to achieve standardisation of performance for each grade across the Trust. It can be used as a baseline in much the same way as has been done in a study by Cattini and Knowles (1999) in a framework of core competencies for Clinical Nurse Specialists. The purpose of the framework in this study was to enable staff development, audit and to identify areas for improvement and existing excellence supporting individual and team needs without becoming a management tool. Wider uses of Cattini and Knowles's framework were seen to be providing evidence and justification for the role, which echoes the views of Percival (1994) and Fearon (1997), and interestingly considers that clinical nurse specialists, in common with district nurses, must be clear about their role and purpose.

In terms of ensuring staff development, Gosling (1999) proposed that ensuring competence to practice was linked with continuing professional development (CPD) and that both could be addressed in a way in which supports the development of practitioners and ensures competence is maintained for safe and effective practice. She went further to assert that CPD is a process to ensure competence is achieved and that ensuring competence via CPD can provide a solid structure to support individuals and teams.

While certification for individual nursing tasks would be necessary to determine whether an individual nurse has the skills required for the job to be undertaken, (Bradshaw 1997b) other studies (Boylan & Westra 1998, Forbes et al 2001) have used competency testing to identify training needs stating that this is important as care needs in the community are becoming more diverse.

Assessment of Competence

McMullen et al (2003) argue that observation and assessment of specific tasks is reasonably simple but that using a holistic approach to competency makes testing difficult since competence cannot be observed directly but only inferred from practice. Pearson et al (2002) also note that testing of psychomotor skills is relatively straight-forward but that competence is not directly observable and therefore much more difficult to assess. Bartlett et al (2000) agree adding for this reason that integrated assessment methods should be employed to test knowledge, understanding, attitudes and ethics alongside practice. Percival et al (1994) support this stating that assessors should be trained to examine competence using a framework and multiple other sources which assess more than just clinical skills.

Watson et al (2002) discuss the issue of subjectivity as important where one member of staff is assessing another, so that the tool used to measure the clinical competence should be both reliable and valid, in order that it will measure consistently, and measures the construct it is designed for (Bowling 1997). This is supported by Dolan (2003), who comments that testing clinical competence is fraught with difficulty, since assessors working closely with the nurse to be assessed - often as a mentor or preceptor - may find objectivity is difficult to maintain. Petterson (2000) however states that in her area, assessment of competencies is carried out by managers or expert peers with apparently no concern of any bias there might be as a result of this. Fearon (1997) considered that the main problem of assessment was finding the individual practitioner who would be considered the expert in order to test the competencies of others. In practice, nursing staff may have assessments to carry out on their peers, student nurses, mentees and preceptees, so that they may in reality, pay little attention to the concepts of reliability and validity of the assessment tool in use. This will be investigated as part of the results presented, although it will be seen that much more could have been made of these concepts during the focus groups had the staff attending these been more concerned about the inherent problems associated with assessment issues.

Norman et al (2002) are concerned that there are difficulties with assessing level of practical skills and suggest that multi method testing should be applied during assessment, while Norman et al (2000) suggest the use of self assessment. They state that it is rarely the case that competency tools are tested for validity and reliability. Watson et al (2002) are concerned with testing of levels of competence, debating at what level a practitioner would be deemed to competent or incompetent, but state that competence must be assessed by direct observation. This is the main method currently in use in the research presented here.

Conclusion

This literature review has presented the research studies and literature investigating the concept of 'competence' and associated concepts such as 'Continuing Professional Development', 'quality' and 'assessment issues'. The literature review acknowledged the difficulty of identifying a universal definition of the term competence such that several definitions were presented, depending on the theoretical stance taken by the professional interpreting the term.

The competency framework for which this literature review has been carried out is orientated towards providing a set of generic competencies for each grade of nurse that are skills focussed. Each grade specific competency document consists of descriptions of expected competencies for all grades of community nurse from B to G. In common with most of the above research, the framework provides clarity of role, highlights training needs (supporting CPD) and allows staff who wish to develop to be clear about what might be expected at each grade. It is used across the Trust, creating standardisation of what is expected from each grade of nurse. The assessment aspect is made clear since the nurse in charge of each team carries out the assessment of his/her team. This nurse is always a district nurse who has undertaken the district nursing course after initial registration.

The review has identified several gaps in the research available which include validation of competency tools currently in use (also noted by Wilson et al 2002) and of notable exception was user review and perceptions of the tools. In addition, most competency frameworks in use were developed by management, an important issue.

The concept of maintenance of competence is considered alongside providing training and continual professional development, but notable gap in the literature is the concept of psychological support during development of a practitioner's competence. It will be demonstrated that for some staff, being competent in performing a task is only part of the issue.

The report will now present the research methodology and data collection methods employed beginning by introducing the study aims and research questions.

Study Aims

The study has been undertaken in two cycles in accordance with a contemporary interpretation (Burns 2000) of Lewin's (1947) action research framework. (Please see methodology below for a more detailed discussion of this.)

The aim of the *first* action research cycle was to assess the Competency Framework for validity, usefulness and user-friendliness. It is also intended to assess the impact of the competencies on the functioning of the team and upon patient care, and to identify any discrepancies between grades of staff in terms of the interpretation of the competencies.

The aim of the *second* action research cycle was to amend the Competency Framework in the light of the first cycle, to disseminate the revised tool to staff and to validate it.

Research Questions

The research seeks to investigate staff perception of usefulness of a competency framework. Therefore the following questions are asked of the data gathered.

1. How useful do District Nursing staff perceive the competency framework as a tool to clarify and confirm their ability to perform their role.
2. How valid is the competency framework in determining training needs of different grades of staff
3. What impact has the competency framework had upon the functioning of the team and upon patient care

Methodology

As the purpose of the study was to continue to bring about change in practice, action research (Lewin 1947) was the chosen methodology. Action research is concerned with bringing about action (through change) as a result of the research process. Lewin proposed that action research is a spiral of circular activities with a series of steps, each step influencing the next. Thus an

action research project involves a preparatory stage, followed by a series of steps, each of which is influenced by the one before. The benefits of action research in health care settings include its focus on: context specific problems, bringing about change, improving practice, linking evaluation with action, and involving research participants in the change process (Hart and Bond 1995).

This study is informed by a contemporary interpretation of Lewin's Framework (Burns 2000, p. 444-5), who suggests a model involving the following seven sub-stages:

1. Identification, evaluation and formulation of the problem.
2. Fact finding in order to fully describe the problem.
3. Review of research literature in order to learn from comparable studies.
4. Having generated hypotheses, gather information relevant to testing them.
5. Select research procedures and materials and negotiate proposed actions with stakeholders.
6. Implement action plan, including: methods of data collection and keeping of reports, monitoring of tasks, feedback to research team, classification and analysis of data and evaluation strategy.
7. Interpretation of data and overall evaluation of the project, by production of case study report at the end of each cycle.

(After Burns 2000).

Study Methods

The first three sub-stages of Burns' action cycle were undertaken prior to this study during the preliminary 'awaydays'. The fourth sub-stage - the literature review - commenced during the preparation of this project, but was developed further to take into consideration the findings following the first action research cycle. Sub-stages 5-7 involved collecting and interpreting data, which are outlined below, and presented as a diagram in Appendix II.

The study used two data collection methods during cycle one. The first was an analysis of 18 completed competency frameworks, yielding quantitative data (see appendix I). The second was a series of three focus groups yielding qualitative data from a total of 25 participants graded from D to G. No B grades attended.

During cycle two, a further three focus groups were undertaken. This time the sample was more representative of the population, with all grades of staff represented from grade B to G. The focus groups were less well attended however, with only 12 participants in total.

Interview Schedule

This was designed following interrogation of the data gleaned from the analysis of the completed competency frameworks and was designed to investigate staff perception of the usefulness of the frameworks in line with the aims of the first cycle as stated above in order to answer the research questions.

Cycle One

The interview schedule was semi structured, with prompt questions designed to stimulate discussion and consisted of six questions asked of each focus group as follows:

1. What are your views of the competency framework?
2. Can you tell me about your experience of completing the competency framework?
3. How closely do the competencies reflect actual practice?
4. What, if any affects has the completion of the competency framework on practice?
5. What would you consider a training need?
6. Can you identify any discrepancies between the competency frameworks?

Cycle Two

1. How would you like to see the competencies used in the future?
2. What suggestions do you have in the light of the findings?
3. How should they be used in relation to the PDR?
4. How should they be used in relation to training?
5. How should they be used in relation to other staff tools/ replace/ link?
6. How should they be used to help meet Agenda for Change?
- 7.

Sampling Strategy

The sample was drawn from the whole population under study, that of the district nursing staff of a large NHS Trust. Grades of staff represented therefore range from grade B (Health Care Assistants), to grade G (District Nurses), since all are deemed to possess competencies applicable to their grade. The total population and sample consisted of the following

Grade	Population	Type of staff	Target sample size for cycle one (Quantitative data collection)	Target sample size for cycle one (Qualitative)	Target sample size for cycle two
B	20	Health Care Assistants	20	2	2
D-E	90	Staff Nurses	90	10	10
F	6	Senior Staff Nurses	6	2	2
G	40	District Nurses	40	4	4
TOTAL	156 approx		156	18	18

All 156 participants were invited to submit their completed Competency Frameworks (See Appendix III) for analysis as part of the project. Although the Framework structure remains the same for each grade of staff, the performance criteria differs according to grade.

The second data collection method in cycle one consisted of three focus group semi-structured interviews designed to use the participants as experts in order to establish the content validity of the Competency Framework, that is, the completeness with which items within the Framework cover the important areas of domains of practical competence that they are attempting to represent (Brink 1998). Second, the interview elicited participants' views of the process of completing the Framework including any difficulties experienced. Third, the wider impact of the Framework on practice was determined.

The data collection method in cycle two again utilised focus groups in order to investigate the perceived utility of the framework in relation to existing support and development tools such as the Personal Development Review (PDR) and the yearly mandatory training. It investigated the participants' views over the utility of the frameworks with regard to Agenda for Change. This was a development in practice initiated during the study period, identified by the researchers as having an impact upon the study.

Recruitment of the sample

Staff were invited to send in their completed competency frameworks for qualitative analysis as the first stage of the first cycle. In order to avoid sampling bias and allow staff the opportunity of participating in the study without coercion, recruitment took place by advertising for volunteers using a letter inviting participation, which was sent individually to all staff. The letter briefly explained the project and invited staff to submit their competency frameworks in addition to asking for volunteers for interview. All members of staff from across all grades B to G were invited to participate. As staff had already demonstrated their commitment to the development of competencies at recent study days, it was anticipated that this method of recruitment should produce the required sample. The object was to recruit staff to the project until the target was reached in the order in which they volunteered. As problems with recruitment were foreseen, a second flyer was distributed to promote the project.

This, however, did not elicit the desired response with the researchers receiving three completed frameworks only from a potential total of 156. In addition three staff only volunteered for interview. Discussions with community managers led to the managers asking the staff via G grade meetings to send in their completed (anonymised) frameworks. Further, these discussions allowed the lead researcher to attend two G grade meetings during which there was an opportunity to discuss the project, issues around confidentiality and the wish of the researchers for willing participants. It was mooted that staff might feel less concerned if they could be interviewed as a group. The G grades present agreed to speak to their teams and approval was sought and obtained by the researchers from the LREC to carry out focus group interviews instead of individual interviews. Contact was then made with nursing teams by telephone and mutually convenient appointments were made.

Recruitment of the sample for the second cycle focus groups was made in the same way, by attending the G grade meetings and organising mutually convenient dates.

Quantitative Data Collection

The initial stage involved analysis of the competency frameworks of which (as stated previously) 19 were received. The staff were very slow to respond and the initial collection cut off point was extended by two months to allow staff to continue to send in their completed frameworks. The data yielded has been presented in tabular format in appendix I. A reductionist approach to data analysis was applied (Parahoo 1997) in order to measure the number of competencies completed within the documents. The intention was to gather

quantitative data regarding the use of the frameworks and the extent to which staff had completed the documentation. Analysis of the frameworks was intended to inform (along with the literature review) the construction of the interview schedule for the focus groups undertaken during the first cycle. There was little useful qualitative data obtained since comments were scanty, revealing little of the nature of the process undertaken during completion of the frameworks. Completion of the frameworks varied from a simple tick to denote achievement of a competency, to a signature and suggestions for development or training. On the whole, G grade competencies were completed in a more systematic manner, tending to be completed more fully than those of the lower grades.

Quantitative Data Analysis

The first stage of data collection involved analysis of the competency frameworks for quantitative data which is presented in appendix I. A reductionist approach to data analysis was applied (Parahoo 1997) in order to measure the number of competencies completed within the documents. The intention was to gather quantitative data regarding the use of the frameworks and the extent to which staff had completed the documentation. Analysis of the frameworks was intended to inform (along with the literature review) the construction of the interview schedule for the focus groups undertaken during the first cycle. There was little useful qualitative data obtained since comments were scanty, revealing little of the nature of the process undertaken during completion of the frameworks. Completion of the frameworks varied from a simple tick to denote achievement of a competency, to a signature and suggestions for development or training. On the whole, G grade competencies were completed in a more systematic manner, tending to be completed more fully than those of the lower grades.

Qualitative Data Collection

During the first cycle, a total of three focus group interviews were held by the lead researcher and research assistant from the partner HEI with 25 participants, slightly more than were originally sought. Interviews took place in three sites across the Trust; and were held at lunchtime to encourage participation. There was good representation of staff across the grades D to G, with no B grades were present during cycle one and only one B grade for cycle two. The focus groups were held over a four week period for each cycle and were tape recorded with manual notes made and examined for accuracy with participants immediately following

completion of the focus groups. Transcripts of the tape recordings were sent out no later than three working days following each focus group. These yielded a good response with participants able to verify the text therein. The focus groups were valuable yielding much rich data, with little difference between groups in terms of results. Participants were knowledgeable about the frameworks and eager to share their experiences of using them.

Qualitative Data Analysis

This was carried out following completion of all three focus group interviews. Initially the data were grouped into themes suggested by the questions asked at the interviews. It seemed that the responses were very consistent throughout the focus groups with comments being echoed by each group independently of the questions asked. It appeared that the groups' agendas were similar and that had the interview questions been less structured, comparable results would have been obtained. The initial results were presented in tabular format for each question, then revisited and a thematic analysis undertaken following Colaizzi's phenomenological method (Ryan 1996) so that themes emerged from the transcribed verbatim data. The process was repeated for cycle two but omitting the tabulation according to question since this did not, ultimately, inform the results obtained during cycle one.

Validity of Findings

The validity of these findings may be subject to question since the research was undertaken by a community manager and a lecturer who until recently was a G grade district nurse working in the Trust. This is acknowledged to be a limitation and yet also may have helped to lessen the respondents' anxieties regarding being interviewed, since the researcher was familiar to many of them. Additionally, care has been taken as discussed earlier in this paper, to secure respondents' assurances that the transcripts taken from the taped focus group interviews were truly representative of the respondents' comments. The raw data has been scrutinised independently by two of the researchers with supervision provided by the Research Professor and has been carefully themed, with modifications undertaken as suggested by later emerging data. The participatory nature of this action research study has been emphasised to the participants as the study has progressed. This has advanced the study considerably and may have had a bearing on staff decisions to participate. If this is indeed so, then the moral authority that comes with the results of the focus group interviews lends credence to the

findings and imposes an obligation on the researchers to act appropriately upon them since the participants are telling the researchers what they really want from the competency frameworks (Gaventa and Cornwall 2001).

During the practice of undertaking the first round of focus groups, and subsequent reflection on the process, it appeared that the practitioners held such strongly negative feelings regarding the utility and purpose of the frameworks that the research would need to be altered much more than was actually necessary to take this into account. As the analysis progressed however, the results demonstrated a much fairer representation of the expressions and opinions of the staff. Expression of negativity to the subject of study from participants in focus groups has been found to be an issue where participants were not instructed to express a balanced view (Jackson 1998). As the researchers made no such request, it can be assumed that the negativity expressed was accompanied by a more positive (but hidden) view. The negative aspects to the first cycle focus groups in particular, might have been more balanced and, it could be argued, less biased had the participants been encouraged to take a balanced view. Of course this would have also compromised the validity of the findings by overtly directing the participants to give the results sought.

Rigour is ensured in the research cycles through using both qualitative and quantitative research methodology and by being explicit about the methods undertaken during the analysis of the focus groups.

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Limitations of Study

The sample size was the whole of the district nursing population (n=156) of one NHS Trust with the researchers expecting a very good response rate from the call for completed frameworks. The response rate was in fact 12% which was very poor indeed and calls into question the reliability of the findings. The response rate for the focus group interviews was much better with 25 (16%) respondents when the researchers had hoped for 18 (just over 10%) initially. The sample was unrepresentative of the study population however in that no B grades attended the interviews.

Of the study's weaknesses it could be said to be that the lead researcher was very close to the data so that there are issues around objectivity (Parahoo 1997). There is no claim to be unbiased, and the fact that the lead researcher was close to the participants and to the data has proven useful in engendering trust of the participants, many of whom were mistrustful of not only the competency frameworks but also of the research process itself.

The sample size was the whole of the district nursing population (n=156) of one NHS Trust with the researchers expecting a very good response rate from the call for completed frameworks. The intention to utilise the quantitative data to inform the questions asked of the focus groups was not possible due to the low response rate rendering the sample size unrepresentative of the population. The response rate was in fact 12% which was very poor indeed and so calls into question the validity of the findings. The response rate for the focus group interviews was much better with 25 (16%) respondents when the researchers had hoped for 18 (just over 10%) initially. The sample was unrepresentative of the study population however in that no B grades attended the interviews undertaken for the first cycle.

The second cycle of focus groups was less well attended, although all grades were represented. The response rate for the second cycle was also very poor with 12 staff attending (7.5%). This was concerning since the sisters had again been approached to ask their staff if they would attend. It is reasonable to assume that due to the fluctuating caseloads and busy time of year (during the winter months) would have had an impact on the ability of the staff to attend. Alternatively, it could be considered that the staff did not see the research as priority and hence they would not attend the focus groups.

Another issue that may have caused staff to be reticent to attend may be in relation to the perception of the manager's role in the research project. It has been found (and identified earlier in the report, that the participants may experience a fear of scrutiny (Lee1993), since participating in the research and sharing their perceptions of the competency frameworks had potential for adverse consequences either directly or indirectly (Mason 1997). The final limitation was that the study did not progress the development of the competency frameworks as much as was hoped. This was probably because the second cycle did not advance in real terms from the first. In other words, the second cycle was simply carried out in the same way as the first and as such, led to data saturation and limited the findings. These will be presented in section 2 of the report – following.

Section 2: Research Findings

Presentation of Findings: Cycle 1

Introduction

The findings reported below are taken from the first action research cycle commencing with an interrogation of the quantitative results from the analysis of the competency frameworks. Following the presentation of the results from the both the first and second cycles, the report will present a critical discussion of the results.

The G grade competency frameworks are investigated initially, followed by the D and E grade competency frameworks - representing the largest cohort – and lastly the B grade framework. The competencies are split into a number of categories, ranging from Clinical Skills to Management and Health Promotion. Within each category are a number of outcome statements which must be attained in order to achieve completion of that particular category within the framework. Where an outcome statement has not been achieved within a particular category, that staff member has been deemed for the purposes of this research, not to have achieved that category even when achieving other statements within it.

The analysis of the completed competency frameworks is presented in tabular format to illustrate the quantitative analysis and can be found in Appendix I. The data from these will now be further explored.

Investigation of quantitative data

G Grade staff

Investigating the 6 completed frameworks available from G grade staff, all were able to achieve their competencies relating to Clinical Care, Clinical Governance, Training and Education, Resources, Management of Staff and Leadership. One G grade had not fully completed the competencies relating to Management so was therefore deemed not to have achieved that section. It is useful to note that a detailed plan of action was written against the outcome statement in question. It would have been interesting to obtain the same G grade sister's competency framework to ascertain whether they had achieved their outcomes within the time stated on the action plan, but as the frameworks are anonymised, this is not possible, nor is it within the remit of this research.

Of particular interest is the fact that although all other G grades were deemed to have achieved all their competencies, two staff members had identified training needs. Competencies were Clinical Governance and Management of staff. It can be assumed that although the staff were

obviously competent to undertake their role, that either they or their assessor felt some further development was requested or necessary. The comments were suggestions for further improvement of their ability, or increasing their knowledge. This shows that the frameworks have the facility to be used flexibly and to respond to the needs of those implementing them in practice.

D and E grade Staff

Moving on to the 12 D and E grade competencies, it is possible to see a wide variation in completion both in the way in which the frameworks are used, and in the care taken to provide useful comments to the staff unable to complete a competency statement fully.

Three of the competency documents were unsigned although each of the staff had received ticks alongside each of the outcomes in their document. All staff were able to achieve their competencies linked to Clinical Care, Clinical Governance and Palliative/Terminal Care while 4 staff were not able to achieve Education and Maintenance of Lines. Once again it is possible to see that staff are able to use the frameworks flexibly, with line managers responding to a need to provide (or a wish to have) extra training even when their staff have been able to achieve their competencies. This is an important finding when compared with the participants' feedback from the focus groups which is discussed below. The staff seem to be providing action plans for their team members when needed to achieve a competency statement, although one staff member seems not to have suggestions for achievement of two competencies, Health Promotion and Resources. It is not possible to make an assumption as to why the staff member has no development plan without more detailed information.

One competency framework document had a whole page missing so that there were four competencies omitted from the document. This was recorded as missing data and has been excluded from the study.

B Grade Staff

Only one competency framework was received, and while all competencies had been achieved, none had been signed off by the line manager. The Clinical Care competency had a training need identified, although the competency had been achieved, again it might be assumed that the B grade wished for a deeper understanding of some aspect of clinical care.

Examining the data from all competencies received, an inference might be drawn that the competency document is not viewed as a live document since there has been no future planning in terms of reassessment dates or dates for completion of action plans. This may have been simply because there are other mechanisms already in place, such as the Personal Development Review (PDR) which is carried out annually with a six monthly update as required. This is an

established mechanism which may affect the adoption of the competency framework. The relationship of the competency framework to the PDR will be investigated in some detail during the following analysis of data from the focus groups.

Cycle 1 Focus Groups.

Introduction

The qualitative data from the focus group interviews undertaken during the first cycle was reviewed using a phenomenological method described by Colaizzi (Ryan 1996) during which themes emerged from the verbatim transcripts (Parahoo 1997).

I undertook the data analysis once all focus groups had been carried out in an attempt to reduce subjectivity inevitable from such close involvement and in an attempt to limit early preconceptions about the nature of the results and hence to strengthen validity.

Utilising Colaizzi's phenomenological method, five themes emerged from the interviews:

1. The nature of competence
2. Assessment and resulting training needs
3. Individual responsibility for updating and the relationship between maintaining competence and the professional body (Nursing and Midwifery Council (NMC)).
4. Implementation issues and relationship to existing staff development tools
5. Grade related comments

These themes will be presented individually before conclusions are drawn, while the discussion of the results will take into account the findings from both cycles before drawing conclusions and presenting recommendations.

The Nature of Competence

The first issue arising from the focus groups is of a philosophical nature and concerns a debate around the meaning of competence. This underlies much of what has been discussed in the literature in that the nature of competence has various definitions depending on whether one considers that competence is concerned with the ability to perform psychomotor tasks (Boylan & Westra 1998) or is more concerned with the development of behavioural skills and attributes (Zhang et al 2001).

The competency framework documents under investigation present competence more as a series of tasks in which one has to prove proficiency than a fundamental ability to nurse in a holistic, caring and moral way (Bradshaw 2000). Nursing is of course, far more than the ability to perform tasks and the remit of this study is not to discuss the nature of nursing. It is considered however, that the nurses discussing the nature of competence as part of these focus

groups made some insightful and astute comments which reflected the views of certain authors cited in the literature review.

Discussion within the focus groups centred on the fact that the term competence is open to interpretation and that each nurse will have a different understanding of the term. As one nurse explained:

...being competent is different to feeling comfortable doing something.

(C2)

Being comfortable with undertaking a task was expressed as an emotional response to having been supported through the learning of the task and concerned with having opportunity to undertake the task on a regular basis in order that the nurse remained comfortable undertaking it and therefore competent to undertake it.

From consideration of these concepts the issue of quality of performance and the question of testing quality in practice arose. It was considered difficult to assess quality in any meaningful way, since:

How can you test the quality of someone's performance? (C4)

And:

...who decides who is competent?

(C3)

- the consensus being that the idea of the quality element of performing physical tasks might be difficult to test, although the idea emerged that the ability to test quality might depend on the person undertaking the assessment. There was much attentive listening to these comments emerging as they did from senior staff, although this discussion did not progress further.

Assessment issues and resulting training needs

Since the competency frameworks were completed with the individual staff member's line manager, the staff were able to spend dedicated time discussing and completing them; in most cases this time amounted to over an hour. This was welcomed by D and E grades who stated that they felt valued and supported as a result, stating:

...the framework allows us a chance to speak about practice with the G grade.

(A4)

while a G grade commented on the value of spending time legitimately with the staff member they were assessing.

A more negative aspect regarding assessment concerned differing methods of assessment with some senior staff using questioning techniques to test knowledge prior to signing their staff member as competent. Additionally although there was a simple yes or no answer as to

whether staff were competent it was suggested that there needed to be guidance on their completion or structured guidance on which to base the assessment interviews. There was concern that assessment carried out within teams might cause pressure on the G grade to sign their staff member as competent, and that there should be a choice over who carried out the assessment, rather like the choice over the supervisor/supervisee relationship in clinical supervision.

The G grades commented on the assessment process, identifying that it is easier to assess staff they knew well, but on the other hand there is:

...no objective way of assessing whether you could actually do what you said you could.

(A2)

Interestingly this was refuted by other participants who seemed to think that they would undertake observations of their staff in practice, in order to be sure they were able to carry out the assessed activity, prior to signing the staff member as competent. It was considered their responsibility to manage the care their patients received.

The value of revisiting nursing care, even when staff were experienced, was commented upon, as staff were aware that though they had carried out tasks in a certain way for years, it was useful to be afforded the chance each year to identify any shortfalls in knowledge. An important finding since it underlined the need to discuss practice in a meaningful way in order to develop.

Interestingly, although shortfalls in knowledge and ability were considered to be identified by the competency frameworks, some participants suggested their implementation had not affected patient care at all and had made no difference to practice, although others stated that completion of the frameworks should improve the quality of patient care as they identified learning needs. One participant stated that the framework was beneficial towards patient care since:

...it identifies training needs which will reinforce standards of care.

(A4)

It was universally considered that the competency documents identified training needs, they highlighted these needs in a structured way, and were viewed as a useful checklist against which to measure training needs. The frameworks were considered to be based on practice and on a deeper level made staff think of how they:

...might do something (*carry out practice*) better

(C2)

and in fact one participant suggested that it was useful to go back to basics with the proviso that this was only useful the first time they were completed. This contrasted with the view of another participant who stated that reviewing the competency frameworks gave staff the opportunity to identify any shortfalls in knowledge on a yearly basis.

Once issues around identification of training had been identified, staff began to discuss the practical difficulties inherent in meeting training needs whether theoretical or practical. Many training courses were found to be full on application or staff were not able to be released due to staffing issues, an issue which was deemed to be more problematic in larger teams. If staff were released this had an impact on service provision and hence on patient care, so that where courses were accessed outside the team (i.e. training is not available from other team members), there were resource implications and not all staff could go on the course. One participant commented:

...identified training needs must be met

(A4)

but:

...the G grade must recognise the training needs of the team

(A4)

These comments indicated an awareness of the necessity to address deficits in knowledge or skills but comments were made that it was not always possible to access the courses as frequently they were found to be fully subscribed on application for a place. In addition the comment was made that staff from larger teams felt it was more difficult to access courses since usually only one or two staff could be released at any given time.

Further discussion emerged around the need for prioritising the staffs' training needs so that where several needs are identified within the team, a decision is usually necessary regarding which team member should be released. The comment was made that the G grade would prioritise training need while balancing the need of the individual, the team and the caseload.

Individual responsibility for updating and the relationship between maintaining competence and the NMC

This emergent theme concerns the awareness of the staff regarding the need to keep up to date in order that they did not contravene the Code of Conduct laid down by the NMC (2004a). Staff were definite in their assertions that they were able to maintain their own competence without the need to refer to the competency frameworks; indeed, during the discussion there was heated debate regarding the underlying message perceived to be transmitted from the need

to complete the competency document at all. The verbal expression of discontent varied between focus groups but was evident in all. Participants stated:

...the NMC code of conduct makes plain the qualified nurse's need to maintain their own competence

(B1)

while another stated:

...all staff follow NMC guidelines. So they are aware when they need to state they are not competent to carry out a nursing treatment.

(C4)

Some staff viewed maintenance of competence from a risk management perspective, showing awareness of the necessity of not carrying out tasks unless competent to do so and preferring to address training needs directly rather than waiting to complete the frameworks. One participant commented:

Most training needs would be identified prior to completing the frameworks...

(A2)

This was viewed as a safer approach and was echoed by other focus group participants stating that:

...other skills requiring training, such as supra pubic catheters and ear syringing are highlighted without the need to complete the competency frameworks.

(B4)

while others asserted that training needs would be identified at team level, with staff:

...not doing anything different.

(B4)

than they were before the implementation of the frameworks.

Some participants seemed to be more antagonistic towards the frameworks since they called into question their worth as qualified nurses, thus expressing the view that the frameworks left them feeling they were considered unfit to undertake their roles. The depth of feeling was strong and evident in the language used by some of the focus group participants who suggested that the frameworks were insulting, patronising and intrusive. Moreover, since issues of competence were already addressed at team level and as previously indicated and in most cases, staff expressed very strongly that they did not need the frameworks to tell them whether they were competent or not.

The sense of accountability for one's own practice was clear, it was articulated by some staff that the frameworks must remain the individual staff's responsibility to complete, and could be

used by individuals to assess their own competence. This was echoed by others who were confident in their abilities to identify their own needs with issues of competence already being addressed at team level. Thus was especially relevant to some staff who stated that the person completing the framework with you:

...relied on you saying what you could or could not do
(A2)

and:

...different G's completed the competencies differently.
(A2)

It was considered therefore that assessment of competence was reliant on what you said you could do rather than any objective measurement.

Implementation of the competency framework in relation to existing staff development tools.

This theme emerged as staff described variations in implementation of the frameworks. This appeared to be dependent on their perception of where the frameworks were situated relative to existing staff development tools. There are existing staff development tools including the Personal Development Review (PDR) and mandatory training, both of which occur yearly, with a six monthly review to track progress on the personal development plan decided at the PDR. There was much discussion in the focus groups regarding the perceived purpose of the frameworks, with staff viewing the frameworks as being a management tool or a paper exercise. Several comments were raised over who the tool was for, whom it was there to help and concern regarding whether the tool could be called upon as evidence should a dispute occur over a competence for a particular task. Participants expressed concern about the exact purpose of the frameworks and reported that they were told to use them.

Participants discussed the fact that their caseload holder already knows their abilities since:

...PDRs are done, the caseload holder knows what their staff are able to do...
(B2)

There was a perception, therefore, that they were duplicating what was already done in the PDR process.

Some staff had completed out the competency framework during the PDR and comments were made by staff reflecting positive and negative attitudes towards the frameworks. Some stated that the frameworks were:

...good when done in combination with the PDR.

(C2)

It brings out different issues to the PDR.

(A4)

confirming that the frameworks perform a complementary role in conjunction with the PDR. In fact one participant had utilised the framework to interview a staff member to review their performance. Although the context of this review was not elaborated upon, non verbal indications were that the interview was necessary due to the staff member's poor performance. Staff discussed the issue of frequency of completion and a comment was made that when carried out in conjunction with the PDR, they would not need to be done yearly with one participant commenting:

...once needs have been identified, the frameworks don't need to be completed each year...

(A1)

A further comment indicated that the documentation should be changed if the frameworks are completed each year. Other comments related to the duplication of the competency frameworks with mandatory training, since this is already undertaken to address areas of need, but discussion did not elicit how those needs were identified. It is assumed this will occur during PDR.

The focus groups elicited several positive comments regarding the frameworks themselves; they were simple, offered a structured framework, could be used flexibly and were easy to follow. A comment was made that they were user friendly, although staff were not given guidance on how they should be used. This did not seem to be an important issue, however, since senior staff did not carry out an interview with their team members until they had been through the process with their line managers, so that a precedent for their completion had already been set.

On a more negative note in relation to content and completeness of the frameworks, staff found the D and E grade framework too basic, stating that the frameworks were found to have some gaps and repetition. Although this was not explored in detail, participants were able to reveal that the risk assessment and management aspects were missing from the D and E grade frameworks nor did they take into account prior experience. This seemed to be an issue for some staff. When discussion took place around the G grade frameworks, participants stated that they were management focussed, omitting the practice elements. This could be problematic since:

...the G grade might not be up to date.

(A3)

Some staff found the frameworks time consuming with discussion being necessary for each competency before having it signed off but time spent on discussion seemed to vary between staff. It appeared to depend on the way the G grade approached the process and on the nursing experience of the staff member under review.

During consideration of the purpose of the frameworks, some participants were unsure what completing them would change and discussed the fact that;

...the mandatory training is already in place to address areas of need.

(C4)

so that they were questioning whether the frameworks were duplicating the mandatory training which was already carried out on a yearly basis.

Others stated that that the frameworks themselves would need to change as the clinical area, and policies and procedures changed. If the frameworks did not change then staff stated that that they did not need to be repeated every year; in fact staff asserted that it was insulting to have them repeated each year.

The next issue centred on the utility of the frameworks for new staff, and that they were:

...more useful for new staff.

(A2)

inferring that they were less beneficial for existing staff, an assumption backed up by comments such as:

...frameworks are an introductory thing when someone is new to the job.

(A2)

and

...useful for new staff or bank staff.

(C1)

The frameworks were considered to be good as an induction by some respondents. However others stated that it tended to duplicate the induction process and that it might be used after the induction had been completed, perhaps after six months in a new role.

It was stated that the frameworks basically covered the role of the community staff nurse and what might be expected of district nursing staff, but that they were very task orientated, not reflecting the holistic nature of district nursing work, although

It included everything you needed to be competent in terms of skills.

(A1)

Grade Related Comments

Once again, the idea emerged that the G grade competency frameworks do not cover clinical roles and are very management orientated; this was considered important in most of the focus groups, with the issue raised by the G grades present.

In terms of usefulness of the frameworks, there was parity between all focus groups in that they found the frameworks highlighted what staff had not done or had forgotten, they acted as a reminder of areas where training might be necessary, were useful for identifying problems and for re-evaluating training needs and significantly:

the frameworks might help to make the role more similar across teams.

(A3)

There was a rousing call from all the focus groups that D and E grade competencies should be separate since there is a difference in pay and responsibility:

Separate competencies might enable a clearer distinction between grades and justify salaries.

(A3)

The implication of the Government's forthcoming pay structure 'Agenda for Change' on the grading structure of teams was noted and as such staff wished the frameworks should be separate to reflect the fact that E grades did more in terms of their role when the G grade was not present. This was not presently reflected in the framework. One respondent noted that completion of the frameworks:

...might have an impact on pay since the improvement in skill and ability could go towards gaining extra pay points at the roll out of Agenda for Change.

(A4)

Participants suggested that the current combined framework reflected the D grade competencies more accurately than those of the E grade; and a comment was made that the document might be less static if it gave room for the respective grades to develop. Staff highlighted that presently where a training need was identified, it was likely to be task oriented for D and E grades, but that the nature of their work extended to far more than tasks as has already been highlighted. Indeed they indicated that the frameworks were only a minimum requirement and that for the E grades competencies should include aspects such as decision making, team management, risk assessment and patient assessment. This was considered to be a neglected issue since;

...some E grades may have competencies at G grade and may perform some of the G grade role.

(C1)

The final issue in relation to grading was discovered when one respondent noted that they thought they would be able to check the competencies of the higher grade prior to applying for that grade, but since the D and E grade competencies were the same, this was not possible:

...if a chance of promotion came I would be able to check the competencies then show I had performed at a higher grade.

(C1)

This seemed to cause some disappointment. The comments were validated by other staff during the focus groups so that the wish for separate frameworks was clearly stated.

Conclusion

To conclude this presentation of results then, the nature of competence in terms of the frameworks under study is deemed to be concerned with the ability to perform psychomotor tasks. Participants found this difficult to reconcile with their concept of the nature of nursing which was seen to be bound up with the ideals of holism and the caring nature of nursing. Participants were able to communicate their nursing principles such as the need to deliver high quality nursing care which was not assessed as part of the competency document.

The term 'competence' was considered as a concept by the participants in relation to the awareness that an emotional need 'feeling comfortable doing something' must be fulfilled before staff considered themselves competent to undertake a task. This was an aspect participants were unable to take forward during the first cycle of focus groups.

Assessment issues were raised in relation to opportunities to discuss practice and the value placed by the staff on opportunity to spend time doing that. The same was true even for those participants who considered themselves experienced. Concerns arising from the testing of competence were related to the responsibility of assessing staff. Discussion ranged around the accessibility of training courses and ability to allow staff time away from the clinical area in order to attend the courses.

The relationship between maintenance of competence and the NMC was an issue regarding the individual responsibility of staff to keep up to date. Staff considered the frameworks were useful in terms of reminding them what they needed to know, but were concerned that the need to complete the frameworks carried an underlying message regarding their ability to maintain their competence and thus be able to practice under NMC legislation.

The place of the competency framework in relation to existing tools was discussed as participants described how the procedure had been implemented. It appeared that the framework had been introduced to be utilised alongside the annual Professional Development Review, the results of which belong to the staff themselves. The respondents were unsure as to

whom the competency framework was intended for with several respondents expressing an element of suspicion, although there was a consensus of opinion that the frameworks were a useful, structured instrument when undertaken in conjunction with the PDR process. Similarly a consensus was identified in relation to the utility of the tool for new staff members.

A prominent issue was elicited in relation to D and E grade staff. The respondents considered that the fact that D and E grade competencies were presented as a single document within the competency framework reinforced the consideration that D and E grade staff had similar roles. This was an issue since this perceived similarity was not reflected in their grading and pay. Finally, the framework was perceived to be more representative of D grade responsibility than E grade, since skills such as risk management and patient assessment were missed from the E grade document.

Presentation of Findings: Cycle 2

Introduction

The report will now present the findings from the second cycle of focus groups. It will present the themes emerging from the data and will summarise the findings. These will be discussed in Section 3 in relation to the findings from the first cycle and in relation to the literature.

The second round of three focus groups was initially arranged for September 2004. However, due to the need to change the format of data collection from a quantitative measurement (questionnaires to ascertain staff perceptions of the revised framework) to a qualitative data collection method (focus group interviews), the researchers were required to obtain ethical permission from the LREC. This was sought in August and was not granted until the end of October. The focus groups were designed to take place shortly after this, but permission had not been sought from the Trust - due to my inexperience as a researcher and lack of understanding that it would be necessary. Permission took some time to come through and written confirmation that we could proceed was not received until January 2005. This put the whole cycle back by at least six months and meant that the first focus group of the second cycle did not take place until mid January 2005.

The first focus group had been organised with full agreement of the sisters involved, but only one participant arrived, meaning that the focus group could not be undertaken. This was disappointing.

As a result the manager was approached and the next sisters' meeting was attended with the aim of explaining the importance of the data collection for the second cycle. The sisters' meeting duly attended and the focus group rescheduled, the attendance rate for this focus group doubled to two staff. The focus group went ahead in order to avoid wasting any further time by rescheduling another group in an attempt to increase attendance.

The second focus group was also poorly attended with only three staff attending, although both of the initial groups yielded much data. The final focus group was by far the best attended, with seven staff from the local area becoming involved so that the total attendance for the second round of focus groups was 12 or 7.5% of the population.

The participants in each of the three focus groups seemed far more relaxed and participative than they had on previous occasions despite the fact that several of the respondents had not been involved with the first cycle. I am unsure why this should be so, although I can surmise that the staff had more pressing concerns in the shape of Agenda for Change. In addition, the

majority of the staff had participated in the first round, so perhaps were able to reassure the remainder of the group by their relaxed attitude.

Analysis of the focus groups was undertaken using the same data analysis method as employed during the first action research cycle, although the thematic analysis of the data was a lengthy process as themes were slow to emerge. This could well have been because initial reading of the transcripts seemed to indicate data saturation in that many of the comments appeared similar to those expressed in the first cycle of focus groups. An additional factor was the fact that Agenda for Change had confounded the issue of grade related competencies. D and E grade staff are likely to be graded on the same pay band, but the staff are still facing tremendous uncertainty regarding the effect Agenda for Change will have on their roles.

As a result of this uncertainty, the staff interviewed could not discuss Agenda for Change in great detail, but the interesting aspects of their discussion regarded how the staff perceived the competency frameworks in terms of usefulness during the first stages of Agenda for Change.

Four themes arising from the data are presented.

1. The nature of competence
2. Assessment issues and resulting training needs
3. Grade related comments
4. Agenda for Change

The Nature of Competence

The first theme emerging concerned competence and demonstrated staff understanding of the concept. This discussion also arose in the first cycle of focus groups and seems to be crucial in appreciating the understanding of the staff regarding their own competence. Staff were aware of the need to be competent as stated in the Code of Conduct (NMC 2004a) and referred to the responsibility of each individual to maintain their own competence. They were grateful that the frameworks allowed them to demonstrate their competence:

I think for your own self to know that you're doing something right, I like that part. (A1)

There was a struggle to identify the separate nature of the concepts of competence and confidence, but as the discussion is presented, it is possible to identify how staff made the distinction between the two.

Concern was raised about how long staff could be deemed to remain competent after being assessed, one participant commenting:

I have been in place for five years in my present job, so am I still competent?

(A1)

while another stated:

...you might have had that piece of paper signed to say you were competent, but what I'm saying is that you might not be in six or twelve months' time.

(B4)

A participant considered the concept of being competent:

Not being competent doesn't mean that you can't do it, does it, it just means that you need to know how to do it. It's not a problem as such unless you're sending that person off to do something that they shouldn't be doing. It's just a way of flagging up something that needs addressing.

(B3)

Another perspective was suggested. Competence was concerned with more than skills, staff were aware that when a complex skill was learned, along with the psychomotor skill, there were cognitive aspects to be learned. This was especially so where care pathways had been implemented. This meant that the staff member needed to demonstrate that they knew about these as well as understanding the skill.

Other focus group members discussed competence in terms of being a skill that staff have learned and been deemed competent to carry out, but considered the possibility that when staff have not had the opportunity to practice that skill, there may be a lack of confidence. This would affect their feeling competent to perform the skill. Staff were still able to carry out the skill or task but perhaps needed a reminder. This was corroborated by another member of staff:

...if you don't feel confident with something, or you haven't done something for a while like a PICC line, you might not be happy about doing that.

(A6)

Another commented that a staff member had said they needed to observe another staff member carrying out the task as a reminder of how to undertake it before they performed the task themselves. This was identified as important, as a participant noted:

... you said to me last week, I haven't done it – I need to go with someone else to get my skills up again

And another responded:

And that's what we all do

(B4)

Other issues were discussed in relation to maintaining competence. It was of concern to some participants that when assessing staff as competent, there should be some understanding of the legal aspects involved. It was a worry to some that a member of staff would be signed as being competent by their line manager assessing their performance on a good day when the staff member was generally unable to undertake the task that was being assessed. But it was considered that the person signing to say that the staff member was competent could not be legally held responsible if there were problems in two or three years' time. Confounding issues were discussed:

...but then you can also be competent but have no professional pride, you can do it beautifully in front of somebody and then as soon as they are out of the way... (B3)

There was some discussion about whether there were staff who considered they were competent or who said they were competent but were not. This was a worry to some staff but another member of staff considered that it is not easy for management to decide who is competent and who is not. This leads on to the next theme, that of assessment of competency and the training needs arising.

Assessment issues and resulting training needs

Staff had a very positive perspective on this. They considered the framework a useful basis from which to examine the job as it describes the skills needed. G grades valued the frameworks using them when assessing new staff and perhaps when flagging up a particular problem. Many of the staff commencing work as a community staff nurse would already possess many skills but may need to adapt these for use in the community. Hence the ability to utilise these skills in the community would have to be assessed. The G grade commented that she would use the frameworks to help her carry out this assessment. Another G grade qualified this by stating:

The frameworks are useful for new staff, but I think you've got to ask the member of staff what they need haven't you? I will say what do you think you need, but we have to go by the competencies because that's what we're meant to use. (C1)

Some G grades would use the framework for new team members (those with community experience) as well as for those new to the community. Assessing staff in practice was a useful way of assessing ability:

I might come round with you, I would have to be sure that you were up to standard, you wouldn't go round on your own until I was sure and I might go around again with you afterwards (*after the induction period*) to make sure that I am happy with your work, as I might get the flack afterwards!

(A1)

This was confirmed by another G grade who indicated that at her level of experience, she would be able to examine the care given to her patients and critically assess whether it had been carried out to her satisfaction. Deficits in care might indicate a lack of competence. If the frameworks had been completed in spite of this, she would be concerned to investigate why this had happened.

Some G grades were less sure about continuing to use the frameworks after the initial assessment period:

They are good for new staff, initially finding out what everyone's skills are, but once you know your team, you know your team don't you?

(B5)

The statement was supported by another G grade who commented that she would refer to the frameworks during Personal Development Reviews (PDRs) or when assessing new members of staff, but stated that they were under-utilised. It was discussed that the frameworks could be used during periods of high staff turnover, or with a staff member who had little insight into a problem in practice, in order to help them see the problem objectively.

Comments were made regarding transferability of the document when working with another team but a G grade stated she would probably reassess that staff member:

I would go through them again with you, you see because I don't know you and I'm not signing anything to say you're competent if I haven't seen you doing it..... a new person, I would expect to go out with them to see what their skills were.

That's because you are responsible as well aren't you, as team leader?

(B3 – dialogue between two participants)

Another participant stated similarly:

...if you move somewhere else to work you would probably have to do another set of competencies, they would probably want to know what you were competent at, and obviously they don't know you, they would need

to go with you, you could say, oh yes I can do that, that and that but you might not be able to. (B3)

This was confirmed by other participants who stated that the issue of being a new staff member in a team meant that the G grade would not know them well and would want to reassess them, as they are responsible for the team. In addition, the managers have to be sure they know at what level their staff are working to ensure a quality care.

The D and E grade staff were mainly concerned to verbalise that the frameworks were useful when assessing what the job entails and what the staff member would need to achieve within the job. Further, the frameworks were seen as being a useful checklist, and a tool against which their practice could be benchmarked. Their utility for introducing new staff to the role was discussed several times and qualified by a comment indicating that it was considered once abilities were assessed, there may not be a need to reassess them again, particularly when staff were encouraged to self assess and when utilised alongside the PDR process. One participant commented:

I think it goes hand in hand, it's all focussed, it's part of your personal learning objectives and allows you to discuss your competencies.

(A3)

However there were concerns that staff using the framework to self assess might be able to over estimate their abilities so that they consider themselves capable when they may not be. This was refuted by other staff commenting that the induction pack was available and very comprehensive, so that completion of both that and the competency framework would be comprehensive enough to identify any problems. One member of staff commented that a staff member new to the community setting might not actually be aware of what they need to know, but this was countered by a comment that the induction pack includes the competency framework and the induction document which identifies all the basic skills necessary to undertake the job.

Comments such as:

It is useful for people who are new to the job and people who don't know the job (A4)

were backed up by:

...the frameworks could be used as proof of what you do. (B1)

There was a consensus that the frameworks should be used as a tool to support staff, either to access training or to identify areas of need, but that it should not be used against them if an issue occurred in practice since the work of the district nurse is so unpredictable.

Although in direct opposition to this opinion, another member of staff raised the issue:

a lot of what we do is like bread and butter, we do it day in, day out, it's all part of the job so I don't think we need to be reminded every year.

(B2)

This feeling was confirmed by some staff who considered the frameworks were not necessary as a reminder of their responsibilities as qualified nurses. As professionals they were aware of their skills deficits and were able to speak with their team about the issues. Some staff expressed the view that the frameworks were a paper exercise, especially since the staff using them were for the most part very experienced nurses, but others indicated they were a useful tool. Other staff were hesitant about this, commenting that the competencies were guidelines for the staff, but were unsure of their value. For another, the frameworks were a paper exercise confirming her grade, but that due to the changes in nursing practice, the frameworks would have to change to reflect this. One member of staff suggested a space for updating the frameworks as she was aware of the legal aspects of maintaining current documentation although another stated that she would not like to have to complete the whole document each year as it was so large and time consuming. Another participant replied stating that she felt the frameworks did not need to be completed each year, while a G grade commented that as team leader she was meant to monitor her staff development consistently.

In terms of utilising the frameworks with the induction programme, staff were using the frameworks differently, in a way which best suited their needs. For one member of staff, this meant the induction pack was started immediately they started the job, with the competency frameworks and the PDR carried out six months after their start date. In other teams, the frameworks had been implemented immediately, any deficits identified, and training accessed. The framework was used to identify current skills and skills deficits and many of the competence statements were completed immediately. Training issues were deemed to be easy to identify from the frameworks but staff also identified their needs as they arose without referring to the frameworks. Some staff recognised training needs during the PDR process, which then informed the caseload reviews undertaken with the line manager.

An issue was raised regarding the action plan which is completed following assessment of staff competence. Staff considered that the action plan should stay with the team at team level and should not be sent to the line manager:

...it's your team leader that needs to know, if you need to be sent off on study leave for training needs, not higher up really, because at the end of the day it's the team leader that's arranging the study days for you...

(B4)

Some staff stated they discussed their training needs as a team, without referring to the competency frameworks, identifying that the mandatory training covered most of their training needs. It was noted, however, that sometimes accessing all the required training could be difficult. This was important to the staff since they were aware of the need to access the training required in order to allow them to carry out their roles. Some training is more difficult to access and leads to restrictions in care provision, particularly in relation to ear syringing training, as numbers are restricted. In addition to the limitations on numbers accessing courses, staff found difficulty being released from the team since the staffing numbers did not generally allow it:

It might be an excellent study day, and you allocate two staff and you come to the day and one doesn't go because you're too short staffed. That happens all the time doesn't it?

(C4)

Staff had found other ways of accessing training in house to help with this problem. They asked specialist nurses to come to see the whole team in practice or would access the specialist nurse at their base where there was need for training for only one or two nurses.

In conjunction with the PDR process, staff have found the frameworks an excellent tool which has identified staff training needs adequately. Most staff identified that they used the frameworks alongside the PDR process, but some staff were quick to point out that if there was a training need, they would not wait until the PDR process to identify that need to their line manager. Some staff will revisit the framework document before undertaking a PDR with their manager because they are useful as a reminder, but as for revisiting the framework after the initial completion, staff thought they did not need to do so:

We use it for our professional profile along with the PDR. But there is no space to update the competency framework once all the competencies are achieved. I used it to go back to until I had completed the competencies that were highlighted from the initial assessment, but have not revisited it since it has been achieved.

(A6)

Another participant stated she had not reviewed her framework since all aspects had been completed, but suggested that the annual mandatory training was a good reminder of what she needed to achieve on a regular basis. A G grade added to that, saying that she did forget about the frameworks, except for new starters and during the PDR. Again the notion of the frameworks as a reference document arose from the data, with participants confirming their usefulness during the PDR process. If staff lacked direction, the frameworks could provide a focus.

Grade Related Comments

The next emergent theme related to roles staff undertake within their grade job description. D and E grade staff appeared to perform different roles depending on the team they work with. Discourse began between four participants regarding assessment during one focus group demonstrating this:

Because a D wouldn't or not many of them anyway would do a full assessment, short term and things yes...

I've done a lot of that though, myself.

I've done them too but very rarely. I do a lot of short term assessments though.

I've done them when the G grade was off and they would do the next visit.

(A6)

Discussion ranged around this fact with one respondent asking how D and E grades can work at different levels in the community. She went on to clarify her question by stating:

...I don't see how you can work at a lower level once you have worked as E grades. I would still think at the higher grade, even though I was paid at the lower grade.

(B1)

One respondent considered that every D grade on the community does more than their job description requires:

I think that there shouldn't be such a grade as a D grade - perhaps for the first six months, but...

(B1)

This aspect was addressed by other staff who were concerned to support their D grades by considering how they often worked beyond their grade requirements. The statement was made that it was not only the G grade staff who considered this, but that it was well known that some more senior managers were supportive in this issue with a comment made:

I know that (name) doesn't agree, she thinks that the community staff nurses should be on the same grade. (B1)

It is apparent that most D grades do more than they are expected to, with the main difference between D and E grade activity emerging around assessment. Most E grades undertake patient assessments, but the D grades were doing some assessments even though they were of limited number due to an awareness of differences in pay and responsibility. Issues of fairness were discussed. One G grade commented that she tried to avoid giving D grade first visits because she considered it was wrong that the D grades should be put upon when they were earning less. In addition, she considered that when all the staff were on duty, then there would be an expectation for all staff to work to grade. The support for the D grade staff was evident in all focus groups so that one member of staff was able to comment (in response to a previous comment regarding unfairness that D grades tend to do more than their role description demands):

It's interesting that it's not only the D grades that say that, but to hear the G grades say that... (B1)

Her body language suggested that she felt supported by her colleagues.

The focus groups discussed how standards varied across teams with some D and E grades undertaking more initial patient assessments than those in other teams. A comment made by one participant pointed out that the frameworks and job descriptions were now separate for D and E grades but the indications were that Agenda for Change, despite creating one scale for qualified staff, would still create division among the community staff nurses. Staff spoke of the concern they had presently about the changes their jobs were undergoing and an awareness that the new system was likely create division among staff:

...so we're waiting for Agenda for Change to tell us that we'll still all be different! (B1)

Agenda for Change

The implication of Agenda for Change was discussed to varying degrees within the focus groups. The feeling was similar between all groups that the staff remained unsure how Agenda

for Change would affect them. General comments regarding the proposed changes to pay structure indicated that despite a level of information and education regarding the implementation of Agenda for Change, staff were concerned that they still lacked an understanding regarding the implications for pay banding and its effect on the structure of the teams. Despite reading about it in the nursing press, the uncertainty remains. The complication of pay banding and the grading system meant that staff were unsure how it would work in practice:

It looks as though the D and E grades will be amalgamated, and they will both be on the same grade. The two grades, if you compare them, there won't be a difference, but maybe in the spine points, or gates to go through depending on your skills and abilities. (A6)

The staff were aware of the need to know about their skills and abilities, particularly since they would be required to match their job description to the skills they were using in practice. Interestingly, staff did not use the frameworks to help to write their new job descriptions. The reason for this was not explored, but will be considered during the discussion of the results. The level of uncertainty regarding the future meant that comments about the framework in relation to Agenda for Change were inconclusive; staff simply did not know how their frameworks would be affected.

Some staff suggested that despite the changes there would be very little effect on their roles, but that those staff with the district nursing qualification, currently working as E grades would benefit from the changes in pay scale. Discussion ranged around the issues that the sample job descriptions appeared to omit. An E grade was concerned that the managerial aspects such as managing the caseload in the absence of the sister was missing, while the G grade was concerned that budgetary issues were omitted. The staff were supportive of one another during the discussion of the uncertainties that Agenda for Change was causing, but were unable to take the discussion forward beyond eliciting that they actually knew very little of what it would mean to them as a team in the future.

Conclusion

The focus groups undertaken during the second cycle elicited some very interesting data that added to the data gathered during the first cycle, despite initial concerns regarding potential data saturation.

The first theme concerned role performance dependent on grade. It could be expected that staff would perform similar roles within defined grades. It appeared that staff undertook varying roles dependent largely on the structure of the team to which they belonged and the abilities of

the individual staff. This was an issue for D grade staff mainly, who indicated that Agenda for Change would address this, despite some cynicism among staff of the efficacy of the changes in staff grading structure imposed by its implementation. The uncertainty regarding the implications of Agenda for Change was widespread and the participants were unable to see how its implementation might affect individual staff and team dynamics. This is important since the roll-out of Agenda for Change will undoubtedly create change.

The concept of competence was raised once again in this cycle demonstrating the ability of the staff to recognise what the concept means to them as practitioners. They understood the nature of competence meant that they not only had to be able to perform a set of skills to a required standard, but also had to be able to be confident in their ability to perform those skills.

The competency framework documentation was viewed positively, particularly by G grade staff who considered their utility in terms of identifying skills deficits and during induction of new staff. It was interesting to note that the attitude towards the document was observed to be much more positive than during the first cycle of focus groups. Possible reasons for this will be explored during the discussion which follows.

Section 3: Discussion

Introduction

The discussion will bring together the results from the first and second cycles, analysing the qualitative and quantitative findings in relation to the literature. This will follow the themes emerging from the focus groups so that parallels can be seen between the research findings and the literature. For some of these themes evidence is presented from both qualitative and quantitative data to correspond to the literature, but this is always so. Where there is no corresponding evidence, this will be stated.

The nature of competence

Issues regarding the nature of competence are the first to be considered. These arise from the focus groups but were not available from the quantitative data.

The primary issue concerns the meaning of competence. As can be expected by the multitude of definitions presented in the literature review, practitioners were equally unsure about the concept of competency and competence despite being aware of the need to maintain their competence in order to fulfil NMC requirements. Discussions about what competence really signified were unresolved by the focus groups, but tended to focus on the ability to perform a task rather than on behavioural skills and attributes, thus reflecting the nature of the competency frameworks. This is in opposition to Taylor (1995), who preferred to ensure competency in over-arching domains.

Participants showed awareness that competence concerned more than a level of skill, but in terms of assessing competence, during the first cycle of focus groups this was equated with the testing of skills. During the second cycle staff were aware of a construct of the concept involving not just the ability to practice the skill, (psychomotor aspect) but also the knowledge (cognitive aspect) required to underpin the action of performing the skill. This is essential according to the NMC (2004a) who identify that a lack of skill or knowledge or indeed judgement rendering the nurse unfit to practice is deemed lack of competence. So it can be seen that the NMC and the participants of the focus groups were broadly in agreement about the nature of competence, despite being unable to define competency during the focus groups. The focus groups brought a new concept into the discussions of competence, and that was a consideration of an emotional response in terms of the individual practitioner's evaluation of their competence. There was a discussion around the concept of being comfortable in undertaking a task, so that if the practitioner had not carried out a procedure for some time,

although they might have been assessed as competent in carrying out that task, they would not necessarily feel comfortable undertaking it. So that in order to be competent from their own point of view; the practitioner also had to be *confident* in their own ability. This concept has not so far been identified in the literature.

It can be concluded therefore, that competence and confidence can be linked but are not directly proportional to each other, thus it is not necessary that someone assessed as being highly competent would automatically be confident in their ability. But this was expressed by individuals and seemed to be dependent (at least in part) on the frequency of undertaking the task or practising the skill in question.

When undertaking tasks staff were already assessed as competent to carry out, confidence was gained through the support of peers. The staff who had not undertaken a certain task for some time accompanied other staff members for a 'refresher'. I consider this a useful coping strategy aimed to increase confidence in order to prove to themselves their continuing competence, and does not appear to be utilised (and rightly so) when learning a new task and demonstrating initial competence.

There was discussion about staff who might consider themselves competent but who are not. This of course would be addressed during assessment of demonstration of the task (Schroeder 1997) providing it is agreed that competence can be broken down into 'testable' and demonstrable tasks. Also raised, was the issue that during assessment of competency, the staff member might perform the skill extremely well during assessment, but not undertake that skill in a proper manner once deemed competent. A staff member performing in this way was deemed by the focus groups to have a lack of professional pride. There does not seem to be any way of controlling this since once deemed competent, district nursing staff tend to work alone, and the competency frameworks do not address this issue. It would appear that this is concerned with professionalism and maintenance of registration with the NMC. Since this research has been underway, the NMC have published documentation to support the reporting of staff who demonstrate a lack of competence (NMC 2004c), but have published no guidelines published regarding assessment of competence. This consideration will be addressed in the following theme.

Assessment and resulting training needs

Assessment issues were bound up with the testing of competence being dependent on the assessor. They participants were concerned that differing methods of assessment were being utilised depending on the assessor, with some staff being assessed in practice, the simplest method of assessing competence (McMullen et al 2003), and some employing additional

questioning techniques. There was an obvious difference in the way in which the assessment was documented when the competency frameworks were quantitatively analysed, but there were few comments on the documents to assist with understanding why this might occur and comparison between assessors was not possible due to the anonymity of the submitted documents. Investigating the published literature it is clear that there are difficulties with assessment of practice, since many authors propose a means to address these. Proposals include self assessment (Norman et al 2000) which was backed up by participants in the second cycle of focus groups, and the use of an expert practitioner (Fearon 1997). Participants revealed that at present, the line manager carried out the assessments of their own staff, an issue for Percival et al (1994) who consider that assessors should be trained before assessing competence. Participants were aware of the practicalities of this approach, but were concerned that there might be pressure on the manager to sign their staff as competent. Watson et al (2002) and Dolan et al (2003) express concern that an assessor is likely to be prone to subjectivity when they already know the staff member they are assessing. Conversely, Petterson (2000) notes that the testing of psychomotor skills is straightforward and is undertaken in her clinical area by expert peers or managers and shows no concern about potential bias. It is clear that participants had issue with the fact that there was no choice in assessor, and considered that they should be allowed to choose their assessor, much as an individual would choose a clinical supervisor in order to feel confident that there was no bias. These issues might be addressed by training of assessors to limit subjectivity, to look beyond the task being undertaken at the affective and cognitive components of competence.

On the whole, the G grade seemed to derive most benefits from the framework, since they had a baseline from which to measure individual performance and could utilise them if there was a problem. This perception seems to back up the general feeling that the documents are a management tool, since the G grades are team managers responsible for identifying their team members' deficits and abilities.

The assessment of practice brought some interesting side effects: the staff were spending at least an hour discussing practice. This was thought to be very useful, with staff welcoming the chance to spend time legitimately with their own line managers. This could be an indication that the staff do not have another opportunity to discuss practice in a structured way as they would be able to if practicing clinical supervision.

Tied up with the issue of assessment are the issues of quality and standards, since delivery of a quality service requires those delivering the service to possess the skills to do so (Smith 1997). While focus group participants discussed that the implementation of the competency frameworks had not made a difference to the quality of care they delivered, some were

concerned to explore how the frameworks had made them consider how they might improve their practice, and believed that because they identified training needs, this fact had affected the quality of patient care.

Where assessment of competence identified a training need, participants were keen to assert that they would not rely totally on the competency framework to identify these, since a shortfall in competence was potentially serious and could affect their registration if not acted upon. Other studies have identified the utility of a competency framework in identifying training needs (Carroll 2004) and in enabling staff development (Cattini and Knowles 1999). The quantitative data taken from the analysis of the frameworks themselves indicated that they are used to enable staff development, even when the competencies are achieved since the comments found for all grades of staff related to further development considered necessary. It was not clear, however, whether these needs had been identified by the staff member themselves or by the assessor. In terms of data from the focus groups on this issue, staff considered in common with Cattini and Knowles (1999) that the frameworks were a tool to support staff in terms of identifying training needs, but further they should not be used against staff if a deficit in training was identified.

Accessing courses was difficult at times due to staffing levels, but this issue has not been explored in literature investigating competence and may warrant further study.

Individual responsibility for updating and the relationship between maintaining competence and the professional body (Nursing and Midwifery Council (NMC)).

Focus group participants were very concerned with their professional need to prove they were up to date and competent to carry out skills. They were all aware that they would not undertake a task they were not competent in, due to their professional code – showing an implicit awareness of potential sanctions were they to do so. This was recognised within the literature review by inclusion of the NMC professional guidelines fundamental to the practice of nursing (NMC 2004 a). Data from the focus groups showed how acutely aware the staff were of the need to maintain their own competence, in fact there had been some heated debate regarding the underlying message of having a competency framework document at all. The participants were at pains to point out that they were all professionals adhering to the code of conduct, and as such were aware of their own accountability. The strength of feeling regarding the implication that the competency frameworks called into question their professionalism has not been identified in the literature, but this is because there have been no previous studies

describing practitioners' evaluation of frameworks. This is another new finding that adds to what is already known about competency framework documentation.

Implementation issues and relationship to existing staff development tools

The quantitative data collected, although limited in utility and application to the furthering of this research project, never-the-less highlighted issues that were reflected by the qualitative data. One of these was the recognition that the frameworks could be utilised in a flexible manner since staff had completed them in many different ways. It was noted that despite practitioners being assessed as competent, some frameworks had been annotated with an action plan for further development. This indicated the utility and flexibility of use, since staff were adapting them for their own purposes. The focus groups confirmed the perception gained from the quantitative analysis, with comments regarding the frameworks' simplicity, structure and flexibility, further that they were user friendly. I was unable to locate literature that provided any empirically derived evidence to support the findings (in common with Wilson et al (2002)). The literature review identified several gaps in the research available which include validation, user review and perception of competency tools currently in use. Although this finding is not generalisable to the entire nursing population it is able to inform about user perception of the tool; empirical evidence such as this has been unavailable until this study was carried out.

The quantitative data also identified that the competency framework was not a live document. This finding was reinforced by data from the second cycle. The practitioners had completed it initially, but had not set dates for achievement of incomplete sections of the document nor for reassessment of these. The most recent study carried out on competency in practice (Carroll 2004) advocates the maintenance of the competency document as a live document, due to the changing nature of nursing skills. It might well be that the skills in use have developed since the framework was first constructed in 2001, and hence the practitioners find the document redundant. There is contradictory evidence for this assumption however, since some practitioners posed questions about the ability to class themselves as competent after some time has passed, having stated that even though they had been assessed as competent, they might not be in six months' time, while another practitioner postulated a period of 2 or 3 years. A further comment indicated that the documentation should be changed if the frameworks are completed each year. Jones and Cheek (2003) and Percival (1994) all support the need for any competency document to remain live while Schroeder (1997) states that static documentation is bound to lead to a lack of clarity regarding the practitioner's current level of ability.

The relationship to other staff development tools is evidenced in focus group data in both the first and second cycles, since the participants discussed how there was considerable overlap between the induction pack for new community staff and the PDR. Together with the yearly programme of mandatory training, some participants considered that the frameworks duplicated what was already done to keep their skills updated and stated that there was no space to update the frameworks after the first year. Others contributed that the frameworks were helpful when completed during the PDR process as a reminder of specific tasks required in their roles but no more than that. This has been found in the literature (Boylan and Westrs 1998, Forbes et al 2001), but I could find no evidence that the literature reviewed identified the relationship of competency frameworks to existing staff development tools such as the PDR although links have been made between Continuing Professional Development and the competency framework.

Grade related comments

Although the competency frameworks are intended to be clear for each grade of staff and as such should show how staff development can take place, the study has found evidence to refute this. Participants felt let down when attempting to utilise the frameworks as a means of identifying their development needs to move up to a higher grade, since they have not identified the difference between grades D and E. Choudhry (1992) found that role strain can occur where staff are unsure of their responsibilities while Forbes et al (2001) identified that clarity in defining the community staff nurse's role is important. Findings from the focus groups indicated that the research was correct, and that participants noted the D and E combined frameworks were not accurate in describing the respective roles thus not exploring the community staff nurse's potential. This is seen by the RCN (2002) as important alongside Hallett and Pateman (2000) who call for clarification the roles of this group of nurses. While there was some lack of clarity for staff in defining their roles, there was no lack of clarity regarding responsibilities for maintaining competence.

In relation to Agenda for Change (DoH 2005) the impending changes of grade and pay related to the skills necessary to undertake their current post had the potential effect of prompting staff to investigate their competency frameworks to clarify their roles. Most staff did not use the frameworks for reference. This indicates that the staff perceived their relative value as low or that their understanding of either Agenda for Change; or their competency frameworks did not allow staff to consider the problem properly. The data would support both the fact that staff perceive the frameworks as having low value (ie a paper exercise) and that they had a poor

understanding of the implications of Agenda for Change since comments from several participants bear that out.

Conclusion

This report has discussed the findings from the research in relation to the literature review to show how the emergent themes had previously been dealt with by other researchers. It has elicited several important concerns regarding practitioners' perceptions of the competency framework, an aspect that has not been previously investigated. It has also investigated the practitioners' views of the meaning of competence and their perceptions of the assessment of competence and discussed these in the context of the literature. The final section will present the conclusion and recommendations of the study.

Section 4: Conclusion and Recommendations

Introduction

This report has presented an action research project, undertaken over two cycles according to Lewin (1947). The purpose of this research was to investigate perceptions of staff of the frameworks while aiming at improvement of service and involvement of staff in the process. Action research was employed as the method of choice as it has a practical, problem solving emphasis. It employs a reflective approach, reflecting on action. Its particular strength lies in the involvement of users, in this case the district nursing staff and in the ability to link research to action and to change. It is problem focussed and promotes partnership between researchers and participants all of whom are involved in the change process. Action research marries theory and practice. It is theory generated in and by practice (Costello 2003).

The aim of the first cycle was to assess the competency frameworks for validity, usefulness and user friendliness. It also aimed to assess the impact of the competency frameworks on the functioning of the team and upon patient care and to identify discrepancies between grades of staff in terms of the interpretation of the competencies.

The aim of the second research cycle was to amend the framework in the light of the findings and to disseminate the revised tool. The staff would then have been requested to complete a questionnaire in order to validate the tool. This was not possible, however, due to the reflections on the first cycle and three further focus groups were carried out.

Reflection on the study

At the outset, the research seemed to require two action research cycles, since it was considered that the tool (the competency framework) under study, was acceptable to the practitioners as it had been developed using a bottom up approach and was therefore owned by them. The findings following the first research cycle seem to indicate that the tool is useful to the practitioners, but not in the way envisaged. If the research had undertaken to examine the perception of usefulness of the tool while controlling the extraneous variables, the investigation might well have missed the rich data actually collected that indicated a need to amend the study.

The animosity towards the frameworks experienced by the researcher during the first cycle coloured reflections on the first cycle since this was an issue not considered prior to the initial design of the study. This meant that the frameworks were not altered and so the proposed data collection method (a questionnaire to evaluate the revised frameworks to the whole

population) could not go ahead. A second cycle was required however, in the light of the structural changes underway caused by the implementation of Agenda for Change.

There was a poor response at the start of cycle one. Staff were reticent to participate, and only a handful of completed frameworks were received following the letter sent to staff. This was puzzling by this since it was considered the staff had ownership of the process since they were instrumental in designing it. The lead researcher attended the G grade meetings in the Trust to answer questions from the staff and to ascertain why there was such a reticence to send in the completed frameworks. It was noted that the letter inviting participation had been misunderstood and that sending the completed competencies to a manager was quite off-putting for the potential participants. This appears to have limited the response to the research, and also may have affected the results.

Due to the reluctance of staff to volunteer for interview, it was necessary to seek an amendment to the data collection method. The decision to allow the research to proceed using focus groups was granted and each team was contacted both individually and during the sister's meeting, with the aim of eliciting a greater response. The focus groups were held, but there was a real animosity towards the frameworks which could be considered to have coloured the perception of the frameworks' utility in practice. It was not until the data analysis was undertaken that a more balanced view was gained.

Key Issues Arising

From the results of both cycles emerged five key issues.

These are:

1. The competency framework documents are user friendly, flexible and simple, but static and not greatly valued since they have not been utilised consistently.
2. Staff are unsure as to whether the implementation of the frameworks had made a difference to practice and to their patients
3. There is an issue of confidence bound up with the concept of competence which has not been taken into account by other researchers
4. The strength of feeling among participants that the documents call into question their worth as practitioners, questioning their professionalism and ability to identify shortfalls in their competence
5. Participants have a perception that there is overlap between the existing staff development tools (PDR, mandatory training and induction) but actively value the opportunity to discuss practice in a way that none of these tools allow, but which would be possible in clinical supervision.

Recommendations for practice.

These arise from the data and are related to the way in which the frameworks are utilised, and to the support necessary for staff.

The first recommendation concerns the perceived utility of the frameworks. They do not appear to have a central role in identifying the training needs of the staff nor a defined place alongside existing structures such as the PDR and the mandatory training. The utility of the frameworks would be increased if they were maintained as current documents, allowing changes to the document as the district nursing team roles change. While the contemporaneous nature of the document (the living document) would be enhanced by a simple insertion of further dates so that it is not just a one off assessment.

The second recommendation concerns the fact that the D and E grade competency document is combined. This must change since the findings clearly indicate this as an important issue. This is lent credence by the literature, which asks staff nurses in the community to be clear about their roles, and allows staff to explore the areas of responsibility of the grade above in order to develop. In addition, the frameworks should be linked to the job descriptions recently designed for Agenda for Change.

The third recommendation regards support for the developing practitioner. The findings strongly suggested that staff members welcomed the chance to discuss their practice in order to reflect on it in a meaningful way, to enhance practice. This does not appear to be possible among the existing structures currently in use. However, given the high value placed upon it by practitioners a system of support which allows practitioners to discuss their own practice should be implemented. This system is known as Clinical Supervision and has been in existence in the Trust under study for at least six years, but has been very slow to be taken up by the practitioners as a form of practice development and support.

The fourth recommendation regards the issue of assessment. In order that the assessment of competencies is unified across the Trust, a typology of assessment should be attached to the document enabling each staff member to understand how an individual competency might be achieved.

The penultimate recommendation regards the need to update the frameworks regularly, so that they remain a living document, truly reflecting the practitioners' roles.

The final recommendation concerns an area for further study. This concerns the need to probe further into the connection between confidence and competence, and the ways in which confidence is regained in the ability to perform a previously learned skill. This might involve an experimental approach utilising 'actors' to avoid the ethical issues of undertaking experimental research involving patients.

Conclusion

This report has presented an action research study investigating staff perceptions of a competency framework. It has elicited straight-forward findings regarding staff perceptions of the framework, and has offered common sense recommendations for practice. The most important aspect of this research is that the real world of nursing and relationships between perceptions of the framework and reactions to the research are explored.

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APPENDIX I

**Data from analysis of the completed competency frameworks
D and E Grade (combined) competency: 12 frameworks received.**

	ACHIEVED	NOT ACHIEVED	TRAINING NEEDS IDENTIFIED /PLANNED	REASSESS DATE	SIGNED	BLANK
CLINICAL CARE	12		1		9	3
CLINICAL GOVERNANCE	12				9	3
TRAINING + EDUCATION	11	1	2		9	3
RESOURCES	10	1			8	4
SELF	11		1		8	4
HEALTH PROMOTION	11	1			9	3
RESPIRATORY CARE	10		1		7	5
UROLOGICAL CARE	9	2	5		8	3
IMMUNISATION	11		5		8	3
WOUND MANAGEMENT	11		2		8	3
DIABETES MANAGEMENT	11		2		8	3
MAINTENANCE OF LINES	8	3	3		7	5
BOWEL CARE	10	1	2		6	5
EYE CARE	11				8	4

PALLIATIVE/ TERMINAL CARE	12		3		9	3
NETWORKING	11	1	1		9	3
EDUCATION	8	4	3		7	3

B Grade Competency 1 framework received

	ACHIEVED	NOT ACHIEVED	TRAINING NEEDS IDENTIFIED /PLANNED	REASSESS DATE	SIGNED	BLANK
CLINICAL CARE	1		1			1
CLINICAL GOVERNANCE	1					1
TRAINING + EDUCATION	1					1
RESOURCES	1					1
SELF	1					1

G Grade Competency 6 frameworks received

	ACHIEVED	NOT ACHIEVED	TRAINING NEEDS IDENTIFIED /PLANNED	REASSESS DATE	SIGNED	BLANK
CLINICAL CARE	6				5	1
CLINICAL GOVERNANCE	6		1		5	1
TRAINING + EDUCATION	6				5	1
RESOURCES	6				5	1
MANAGEMENT	5	1	1		5	1
MANAGEMENT OF STAFF	6		1		5	1
LEADERSHIP	6				5	1

APPENDIX II

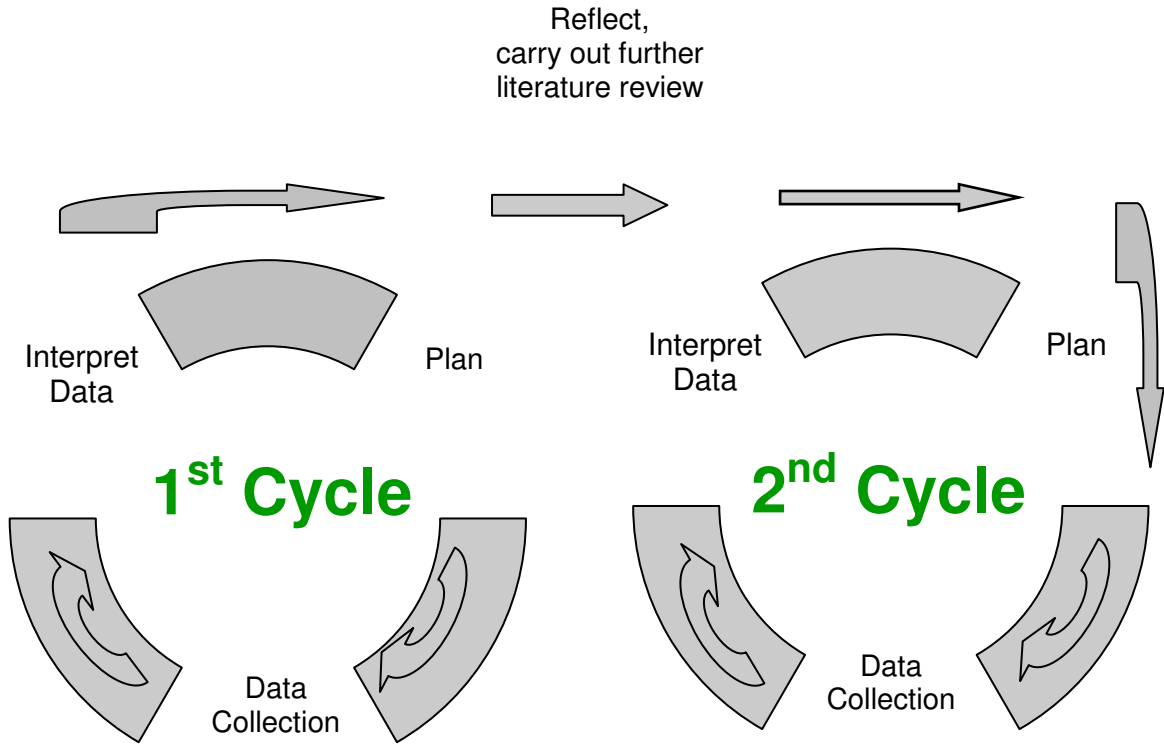


Figure 1: Two Action Research Cycles.

APPENDIX III

Clinical Competency for B Grade Community Staff (District Nurses)

Name:.....

Title:.....

Clinic / Dept:.....

Competency Statement: Participant will demonstrate, in depth, practical knowledge, theory of operation and clinical application.

PERFORMANCE CRITERIA	EVALUATION METHOD	ACHIEVED	NOT ACHIEVED	TRAINING NEEDS	REASSESS -MENT DATE	ASSESSOR SIGNATURE / DATE
Clinical Care: 1. Be responsible for giving personal care to patients in their own homes 2. To work in partnership with patients and carers 3. Carry out care tasks as delegated by the caseload holder within personal assessed competencies i.e. pressure area care, simple dressings, Venepuncture, Lofric catheter, PV creams, eye care, change of catheter bags, PEG feeding, MSU collection 4. To assist District Nurses in patient care at home visits and clinical settings 5. Work collaboratively with the nursing team 6. Abide by the standards of record keeping as stated by the NMC 7. Perform Venepuncture in clinic settings	1. Demonstrate skills in personal care 2. Evidence in case notes. Documentation audit. 3 Training needs evaluated at annual PDR. NVQ programme / trainers 4. Evidence of competency available via NVQ assessments 5. Team meeting attendance lists. 6. Audit of case notes, desk diary 7. Clinic audit					

PERFORMANCE CRITERIA	EVALUATION METHOD	ACHIEVED	NOT ACHIEVED	TRAINING NEEDS	REASSESS -MENT DATE	ASSESSORS SIGNATURE / DATE
Clinical Governance 1.Participate in clinical audits 2.Participate in reflective practice in self and with team	1.Monitor audit outcomes. 2.Evidence of clinical supervision					

<p>Resources</p> <p>1.Ensure efficient use of resources 2. Order stores Office support for trained staff</p>	<p>1. Team meetings / discussion 3. PDR review</p>					
<p>Training and Education</p> <p>1. Participate in NVQ programmes stated in Trust Policy Green 09 2.Participate in PDR process and identify aim development needs 3.Ensure attendance to all mandatory training sessions 4.Follow study leave guidelines re learning outcomes, appropriateness to role.</p>	<p>1.NVQ assessor evidence of participation in programme 2.Audit of PDR forms 3.Attendance lists 4.Audit study leave forms</p>					
<p>Self</p> <p>1.Foster a culture of mutual respect and trust within team 2.Take responsibility for personal management</p>	<p>1.Team meetings / discussion 2.Demonstrate good attendance and timekeeping</p>					