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Introduction

It is difficult to counter the view that to maintain standards, provide safe care, protect the public, protect staff, optimise practice and achieve the best outcomes for patients the competence of nurses needs to be continually assessed (Axley 2008). For the majority of nurses providing evidence of competence is a relatively passive process which simply requires a personal declaration that they meet the requirements for continuing registration (e.g. Nursing Council of New Zealand; Nursing and Midwifery Council U.K). Based upon this observation it could be argued that in a number of countries the current processes for reassuring the public are more likely to identify the incompetent minority rather than actively maintain the competence of the majority.

However, what is abundantly clear, is that the notion of competence has greatly influenced pre-registration nurse education and despite the confusion around the actual definition of competence (Cowan et al. 2007), considerable time and effort has been focussed on attempts to assess the competence of student nurses (Butler et al, 2011). We contend that there are strong philosophical and practical reasons why competencies designed for continuing registration should not be used as the basis for undergraduate professional degrees. Bowden and Marton suggested that in the context of higher education competencies: "...described in terms of narrowly defined units of professional behaviour, derived from what professionals are currently believed to be capable of doing, is not appropriate. Education is about the future not the present" (1998, p.11).

More specifically, over 20 years ago in nursing Ashworth and Morrison pointed out the potential that competencies have for educational narrowness. They stated that curricula based around the notion of competencies: "Blinds educators to the real challenges of curriculum design, assessment, and the personal development of students." (1991, p. 257).

In this debate we will argue that it is not possible to assess the clinical readiness of student nurses against competencies designed for the continuing competence of experienced practitioners.

Defining competence

Bowden and Marton (1998) differentiate between five levels of competence. At the lowest level they regard competence as a set of primary skills required in a place of work, which they refer to as the "Behavioral level of competence". Their highest level of competence is that which requires the "Transfer and integration of cognitive structures" or "Holistic competence".

The regulatory bodies for nursing in a number of countries (i.e. Australia, New Zealand, South Africa and the United Kingdom) appear to define competence at the lower end of the levels described by Bowden and Marton.

Not surprisingly, and as a consequence of these operational definitions, many nurses including nurse educators think competence comprises a number of key competencies which can be isolated, accumulated and tallied.

However we argue that competence, as it applies to professionals, should properly be thought of as a generic quality referring to overall capabilities (Ellstrom, 1997; Hager and Beckett, 1990; Beckett, 2004; Cheetham and Chivers, 1996; Axley, 2008; Talbot, 2004; Watson et al. 2002).

This is a conceptualisation that construes competence as a set of global and inseparable characteristics which for humans is the capacity to interact with the environment, or develop competence and is: "... slowly attained through prolonged feats of learning" (White, 1959. p.297).

Occupational competencies and nursing

Although the concept of occupational competence has been around for over 70 years (White, 1959), particular enthusiasm for occupational competencies in nursing peaked during the 1980s and 1990s. This was a time when the pace at which nursing education was moving away from a hospital apprenticeship culture and into universities notably increased.

The apprentice student nurse was based in a hospital; the hospital was the employer of the students, their teachers and also the provider of clinical experience. Furthermore, the actual physical relationship between the centres of theory (the schools of nursing) and the centres of practice (the hospital wards) was very close.

In short the apprenticeship provided the optimal conditions for developing occupational competence through 'on the job' training (Pratt, et al, 2001).

However, nursing patently failed to maximise those conditions and disquiet was regularly expressed the way that student nurses were prepared to enter the workforce and by association the profession (e.g. Briggs, 1972; Workforce Development Group, 1988; UKCC, 1986).

The acquisition of occupational competencies is a quite different matter from the development of competence and to compound matters further in nursing education competence has become entangled with the quite separate notion of 'fitness for practice' (Baillie 2009; Lauder et al 2008).

The fitness for purpose/fitness for practice debate

'Fitness for practice' has evolved from, and at times is interchangeable with, the term 'fitness for purpose' (UKCC, 1999). It, or they, (FFP) usually refer to the skills required by employers of employees so that those employees may function effectively and safely in the workplace.

Although the preparedness for work (FFP) of the newly registered nurse had been an issue for decades, the introduction of Project 2000 in the UK, brought many employers, clinicians and educators to once again seriously question the 'fitness for practice' of newly registered nurses (UKCC, 1999). In part this concern was exacerbated by the increasing physical shift of nursing education from its traditional hospital base to nursing colleges and other tertiary institutions.

This concern was not isolated and health-service managers in a number of countries became increasingly dissatisfied with the skills of new nurses who according to their respective professional bodies were deemed to be "competent" yet apparently did not

have the skills profile expected by employers (Carlisle et al. 1999). Not surprisingly the idea that student nurses could be prepared to meet occupational competencies was to prove an attractive proposition to prospective employers, clinicians and nurse educators (Grundy, 2001; Gill, et al, 2006; Butler et al 2011).

In nursing which was emerging, as it still continues to emerge, from what was termed a "semi-profession" (Etzioni, 1969), it is easy to understand why the competencies approach to learning and assessing skills had widespread appeal.

The assessment of competence: 'I'll know it when I see it'

Multiple definitions of competence amongst educationalists abound. Nonetheless, and in the absence of a clear definition and validated assessment tools, the health professions continue to request that clinicians assess the competence of students (Carraccio et al, 2002). To make the process more complicated in nursing those clinicians who are invited to assess the competence of students are variously referred to as mentors, preceptors, supervisors, and most recently in the United Kingdom the aptly named "Sign Off mentors" (NMC, 2010).

Most often the process for assessing competence requires that the clinician attest to the competence of a student and then has to effectively 'sign off' the competent student nurse (Butler et al, 2011).

The act of 'signing off' the undergraduate over a series of competency-based standards within a clinical placement is now widely accepted practice. It is a form of assessment in which skills are broken down into their subunits and the student is graded according on successful completion (Eraut 1994).

In some educational quarters there is enthusiasm to recreate an era of the skills check list, the schedule of skills acquisition and the end point practical tests (Bradshaw and Merriman, 2008).

However others argue that competence, which is by definition a global capacity, should not be thought of as comprising a series of fragmented albeit related competencies. For however extensive and comprehensive those competencies may be, they do not and

cannot form the whole (White, 1949). In respect of attempts to assess the clinical practice of students across a range of health professions there is a perspective that: "...in the attempt to assess the quality of less tangible qualities, such as professionalism or interpersonal interaction, medical educators should abandon reductionist approaches to assessment as exemplified by standards based approaches to the assessment of competence". (Gallagher, 2010. p.e416)

Time, familiarity and competence

In nursing, there is a perception that at the point of registration nurses must be both competent and 'fit for practice'. This is a chronological approach to knowledge and skill attainment which is common in traditional professional education curricula (Eraut, 1994). However, if students were to meet the goals of 'fitness for practice' and competence they would require a combination of extended periods of clinical exposure and familiarity with the customs and traditions of a specific workplace.

Tanner (2006) described traditional clinical judgment as an amalgamated problem solving activity that involved assessment and nursing diagnosis, planning and implementing nursing interventions focussed toward resolution of the problems, and evaluation of the effectiveness of the interventions.

Benner (1984) made clear the nature of the nurses clinical development from novice to expert and strongly acknowledged that competence development requires significant time. Of competence in patient assessment she stated that: "This intuitive grasp is based on experience and not based on extrasensory powers or wild hunches. It is situated in the clinician's grasp of the situation" (2004, p.191).

Nursing students clearly do not have the prolonged and stable exposure to clinical environments that Benner regarded as central to the development of competence. Indeed, student nurses enter each new clinical area as novices with limited understanding of the contextual meaning of memorised terms.

The registered nurse who is asked to demonstrate competence and thus maintain

registration is most usually based in a single physical location or practises in a defined speciality. Contained in this observation are two very important conditions, one the nurse is familiar with the working environment and two also has the opportunity to demonstrate competence over a prolonged period of time. These conditions are not afforded to student nurses, some of whom may have clinical rotations as brief as three or four weeks duration.

Mandated periods of clinical exposure differ from country to country and even within the same country the actual periods of time spent in a particular clinical placement i.e. medicine, surgery, paediatrics and so also forth vary. What should be of concern to educationalists is that the reasons for these variations are pragmatic or political and bear no relationship to the acquisition of competence (Mallaber and Turner, 2006).

Solutions

We accept that competence based assessment is firmly embedded into nursing education and it we wish to offer some solutions to the problem.

Our ideal solution would be that at the point of registration new graduates are offered provisional registration and thus given time to demonstrate competence in a workplace with which they will become familiar. This we accept will not be a simple matter.

However, our suggested changes to pre-registration nursing courses are contained in the notion of replicating for the student nurse the conditions that apply to the assessment of continuing competence for registered nurses.

Firstly, student nurses should have a prolonged period of internship at the end of their programme. That period should equivalent to one year of practicum experience in no more than two clinical settings.

Secondly, for the duration of each clinical experience the student must be supervised by an experienced nurse, thereby replacing variety of clinical exposure with consistency of support.

Thirdly, in pursuit of their claim to be deemed competent, and in a manner similar to the processes for registered nurses, the student nurse must provide the evidence against

which competence can be inferred and who determines when that evidence is of sufficient volume and quality.

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