A GLOBAL VIEW OF COMPETENCY IN NEONATAL CARE

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Abstract

Neonatal Care is one specialty within nursing as a whole where the repertoire of skills and knowledge for practice is broad. Competence in skills, an important component of today's nursing agenda, must extend to any post-basic specialty a nurse opts to work within. To become 'qualified in specialty' (QIS) is an aim of nurses who work within the neonatal area of practice following qualification, a term that pertains to the competencies required to learn to progress in their career in a chosen field. In addition, to be deemed clinically competent should apply to all neonatal nurses across the world caring for neonates and their families in any setting. This paper focuses on a global perspective in relation to the area of neonatal nursing care and a discussion around the question of future global standardisation of competency. The neonatal discipline is discussed as one example within nursing to raise issues for further discussion on an international level.

Introduction

Specialised nursing requires knowledge and competency in skills that have not yet been developed in full by newly qualified nurses. Neonatal care is one specialty that qualified nurses can choose to work and specialise in, where the acquisition of a broad range of skills and knowledge is essential for the safe and effective care of the neonate and family (Hancock, 2003). Competence is deemed to be of utmost important in order to be 'qualified in specialty' (QIS) in the neonatal nursing field following post-registration nurse training. Neonates and their families have a right to receive competent care and the public has a right to expect neonatal nurses to demonstrate professional competence (WSNA), 2010). Moreover, to ensure equitable practice and assessment, agreed standards are necessary. Within the United Kingdom (UK), a previous lack of such agreement in relation to competency standards for neonatal nurses has meant there has not been, until recently, a standardised approach to defining QIS. This has made it difficult to ascertain whether consistent education has been delivered to and received by all within this field (Turrill, 2011). However, a recent and much needed core syllabus for clinical competency in QIS that matches key knowledge to essential skills has been published that gives educators a valuable opportunity to standardise education for QIS practice (BAPM/ NNA / SNNG, 2012). Internationally, as well as various definitions of competence, there are generic and neonatal specific competency frameworks. This paper therefore presents a global view of competency

drawing together some selected specific frameworks and definitions and considers neonatal competency within a global perspective.

What is competence in nursing?

Many definitions of competency exist. Within the UK, the Nursing and Midwifery Council (NMC, 2010) use this term to describe skills and abilities to practice safely and effectively without the need for supervision. The National Occupational Standards from the Skills for Health (2011) also focus on skills but also see the importance of knowledge and understanding necessary to undertake a task or role to a nationally recognized standard of competency. The term therefore involves both skills and knowledge in order to work effectively. Brady and Smith (2011) take this even further and state that competence includes training, critical analysis and learning with the application of that learning into practice, the ultimate aim of any nurse education. Similarly, in the United States, the National Council of State Boards of Nursing (NCSBN, 2005) along with the American Nurses Credentialing Center (ANCC, 2012) refer to the ability of the nurse to integrate knowledge, skills, judgment and personal attributes to practice safely and ethically in a designated role and setting in accordance with their scope of professional practice. The Australian College of Neonatal Nurses (ACNN, 2010) believes that competence also incorporates decision-making both clinical and ethical along with critical thinking and importantly recognizes cultural awareness, an element of utmost importance in line with global relevance. Sloand et al (2004) speak of the necessity to include 'cultural

competency' within nursing education curricula, a term they believe is ethically correct showing a keen understanding of diversity among people across the world . Finally, the World Health Organisation Global Standards for Education in Nursing and Midwifery (2009) present a broad composite statement describing competency as a set of skills which reflect knowledge and attitudes having both psychosocial and psychomotor elements.

Several competency *frameworks* also exist. In the UK, the Skills for Health (2011) offers a framework for training and development with clear goals for structured learning with defined outcomes, all mapped against and indicatively linked with NHS Knowledge and Skills Framework (KSF) Dimensions (DoH, 2004) to provide a fair and objective framework on which to base review and development for all staff. Within nursing, many countries have clear national standards that provide a set of competency standards to cover pre-registration training for nursing and midwifery (NMC, 2010, Canadian Nurses Association, (CNA) 2010, United States Credentialing Centre, (ANCC) 2012). This is placed into context by Arcand and Neumann (2005) who state 'establishing a thorough and effective competency assessment program is essential to meeting standards of regulatory bodies and providing quality care. (p S34)'. Similarly, the WHO (2009) Global Standards for the initial education of profession nurses and midwives base their framework on establishing competencies to provide a basis for curriculum development. Here, an important link is highlighted between guidance for competency within the

nursing profession and the development of an education syllabus that is aligned with this.

Overall, it is clear that competence is multi-faceted. As NNRU (2009) states, there is no agreed consensus of a definition and this extends internationally. Standardisation in line with statutory requirements within pre-registration education though is a key thread though all said countries' programmes. However, this has not been the case for post-registration nurse training since the disbanding of the English National Board in 2001 which is why debate around this topic is welcome for future educational practice.

Competency in Neonatal Nursing

In line with this, the discussion turns to 'competencies' in the post-basic specialty of *neonatal care*. The overall aim is for a neonatal nurse to demonstrate competency in all dependency levels (Department of Health (DoH), 2009; British Association of Perinatal Medicine (BAPM), 2010) to be deemed QIS with respect to knowledge, skills and attitudes. As the ACNN (2010) state; 'if neonatal nurses are to be prepared as professionals for the health care needs of the future as well as today's reality', then an agreed competency standard in this specialty is necessary. This is perhaps best conceptualised within a comprehensive evidence based set of competencies in the form of the aforementioned UK framework (BAPM/ NNA / SNNG, 2012) which serves as a guide to the range of

knowledge and skills required to deliver safe and professional care to neonates and families.

This competency syllabus, as for the WHO Standards outlined above, links competencies with curriculum development for QIS status in neonatal nurses. The document was developed from an original framework comprising seven grouped elements of competencies and eight core skills sets matched to four levels of experience and educational requirements leading up to QIS and beyond (new entrants, neonatal nurse QIS, experienced neonatal nurse and expert). The development of this work was based on, and incorporated the valuable work of Grieg at al (2006) and the Scottish Neonatal Nurses Group (SNNG) who formulated their own competence framework and core skill sets for neonatal nursing in Scotland to align with the potential career pathways in this field for all levels of practice. These two frameworks give neonatal educators a key opportunity to work towards standardising neonatal clinical based competencies so that there is equity between all neonatal nurses who undergo formal post-registration training.

Considering international comparisons, a recent publication by Sundquist Beauman and MacKenna (2011) outline a set of evidence based competencies for neonatal nursing in conjunction with the National Association of Neonatal Nurses (NANN) in the United States. Assessment of competency is included for areas of care such as Respiratory compromise, cardiac, delivery room, breast

feeding, high risk neonate, screening, temperature control, physical examination along with very specific skills including arterial puncture, ostomy care and sedation. The Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), the March of Dimes Perinatal Nursing Certification (2011), the Canadian Nurses Association (CNA, 2012) and the Australian College of Neonatal Nurses (ACNN, 2011) have written competency frameworks for all levels of nurse in the clinical area. The Australian model (ACNN) serves as a sound example of competency standards that are utilised for the advancement of clinical practice based assessment, as well as for self reflection. Their competencies are organised into domains that represent the components of the specialty and are similar to the above UK and US models in relation to core content. Each domain has descriptors as key performance elements and each element has a number of cues and through direct observation or questioning, the outcome of the nurses' behaviours and actions can be identified. Like the RCN and SNNG documents within the UK, the standards can be used for nurses beginning their careers as a novice, through to QIS and thereafter to expert level. They can also be used, as stated previously, as a framework for curriculum development and assessment of post-graduate specialty programmes. In addition, the WHO not only have global generic standards as already highlighted (WHO, 2009) but also have an agreed consensus on essential competencies for skilled attendants in the African region which outlines standards for all health professionals working in postnatal care specifically (WHO, 2006a).

It is clear that many competency frameworks exist with some key differences in terminology and core definitions. But there is also much content that is common between them or certainly elements that overlap. These common elements pertain to the *broade*r domains of care required to be competent anywhere in the world rather than the more specific skills that are not practiced or permitted in some countries such as those identified in the US document. The broad domains however include; Respiratory and cardiovascular care, feeding and fluid management, developmental care, infection prevention, thermal care and the psycho-social / ethical care of the family. Also commonly identified are the importance of communication skills, personal development and valuing culture, equality and diversity. The named frameworks also have integrated means of assessing neonatal nurses according to performance criteria which can be applied to varying levels along with identified expected knowledge for the relevant skill areas.

A Global view of health care

The importance of standardisation for equity in education has been acknowledged previously. The question now arises as to whether standardisation can work *globally*, bearing in mind the many different frameworks of competency in existence? To place this issue into context, one must first consider the differences in models of health care that exist between high and low resource settings.

Across the globe, universal health care is achieved in different ways as described by Shah (2011). In wealthy nations, these include: government, tax funded systems such as the NHS, those that are privately run but the government contributes a majority, (e.g. Canada and France) and by private insurance companies (United States). Health care in developing countries however differs in that while many also strive to provide universal health care, most struggle to achieve this due to lack of sufficient resources, or inappropriate use of existing funds leading to health inequality. Poverty is also a major problem. In many parts of the world such as rural India, central Africa and Pakistan, many people are without access to health. Shah also summarises such an unfortunate paradox; ''poverty exacerbates poor health while poor health makes it harder to get out of poverty''. Corruption can also present as a problem which not only makes the problem worse but exacerbates the lack of health resources.

Availability of health workers is also an issue. Many developing countries suffer from significant staff shortages that limit the capability of health systems to deliver even basic level healthcare. The number of doctors and nurses in proportion to the population can be small particularly in rural settings. In addition, it can be very difficult for people to access services. Coombes (2005) also talks about this issue being exacerbated by the "brain drain" within poor countries where those educated in vital jobs within health are then employed by rich countries.

Many reports have identified critical shortages of health workers (Kerry, 2012); for example, a global deficit of 2.4 million physicians, nurses, and midwives has been highlighted (WHO, 2006b) as well as an unacceptably low health worker to population ration (WHO, 2011) in such countries as India and sub-Saharan Africa. Another report has found that for nurses/midwives, several countries on the subcontinent have as few as 20 nurses or midwives per 100,000 people compared to the United States which has in contrast approximately 980 per 100,000 US citizens (WHO, 2010). Kerry (2012) also highlights that staff shortages are most dire where the global burden of disease is highest. It has been found that sub-Saharan Africa has 24% of the global burden of disease, but only 3% of the world's workforce and only 1% of the world's health expenditure (WHO, 2004) Although significant aid has been directed towards global health goals over the past several decades, there is still some way to go. As acknowledged in a recent United Nations (2013) report; ''despite the increased political leadership, partnership and progress in maternal and child health'', women, children and babies ''are still suffering and dying disproportionately – and many of these deaths are from preventable conditions. An example is given of some African countries where access to critical life-saving, affordable medicines is compromised by poor supply and distribution systems, insufficient health facilities and staff, low investment in health and high cost of medicines'' (pg. 19).

A Global view of neonatal care

There are about an equal number of neonatal deaths (3.6 million) and stillbirths (3.3 million) in the world each year with a remarkable 98% occurring in the less-resourced and developing world (Carlo et al, 2010). Monitoring of Millenium Development Goal 4 (United Nations, 2011) progress has revealed that although both the under-5 mortality rate and the neonatal mortality rate are slowly decreasing, an increasing proportion of under-5 deaths occur in the neonatal period or the first 28 days after birth (Lawn et al, 2010). Overall, there exists significant differences in neonatal mortality (Wall et al, 2009, 2010) between high and low resource countries with alarming gaps in neonatal healthcare and education provision globally (Uxaa et al, 2006; Oulton, 2006; Lawn et al, 2009). It is also well documented the stark differences in levels of practitioner competence, resources, available equipment, technological advances and drug therapies between continents in maternal and infant health care provision (Bhutta et al, 2009; Darmstadt et al, 2009). Woeful understaffing is reported in many developing countries across the globe (Little et al, 2011); for example, in rural India, Pakistan, central Africa and some countries within the Far East Asia; for example, Indonesia.

It can clearly be seen how different healthcare is across the globe and the underlying reasons. In relation to neonatal care then, we can view this from two ends of the spectrum: Firstly, the sophisticated western world perspective, that comprises technological advancements supported by funding and resources in

key areas of care (e.g. thermal care and ventilation) and education. Secondly, the resource limited model from developing countries where often basic care provision is limited or unavailable and where health care education particularly in specialties such as neonatal care is either under-resourced at best or not in existence.

So, considering the different models of healthcare provision between high and low resource settings, is it really possible to achieve global standardisation in competency for neonatal nursing? Until the stark inequalities have improved significantly, this is not feasible.

However, there *are* common elements *of practice* which can be applied to the nursing care of any neonate *anywhere* in the world. One could argue that a neonatal nurse has the same ultimate goal in relation to the holistic and safe care of neonate, mother and family regardless of where she/he works. In addition, a newborn baby and family born in any country has the same basic needs; to be kept safe, warm and fed within a protective and supportive family centered care setting. Therefore, they deserve the same fundamental care whether equipment is available to assist this or not. All neonates ''need simple things done well'' in relation to the approach to resuscitation at birth; for example, positioning, assessment and simple airway maneuvers (Resuscitation Council UK, 2010) and again, this should be whether they are born in high or low resource settings. Singhal and Bhutta (2008) support this claim and state the

need for staff training for competence in simple resuscitation techniques in resource limited settings. Another example can be seen in relation to the prevention of hypothermia where simple, feasible and cost-effective interventions are required (Kumar et al, 2009) such as drying, wrapping, skin to skin contact at birth in any country of birth. In other words, the essence of what newborn babies, neonates and families need along with why is the same, regardless of *where* they are born and *how* this is achieved. Inequalities in provision and resources in fact support the vital need for equity in competency and skills across the global workforce in neonatal and maternal based care. Overall, in the same way that all neonates and their families deserve the same standard of care; as long as this care is culturally appropriate and the resource limitations are acknowledged and/or managed as much as possible, the aims of any educated and competent neonatal nurse should also be the same.

In addition, the *underlying aim* to strive for global standardisation of both care and competence is certainly well documented. The WHO (2009) goal for a global standard is to establish educational outcomes that are based on competency, promote the progressive nature of education and ensure employment of practitioners who are competent and so provide quality care. This aim surely applies to anyone working anywhere in the world. Ehnfors and Grobe (2004) believe a global strategy is necessary using core competencies as central to any basic or continuing education in health to prepare a faculty for the future. Such core competencies at a global level include knowledge and

use of evidence based principles, ability to collaborate and integrate care using interdisciplinary teams and a common value for respecting patients' differences, values, preferences and needs. This final point re-iterates the concept of cultural competency described earlier by Sloand et al (2004). During continual global migration, this term is essential in all aspects of care and is particularly significant in the field of maternal and neonatal nursing since, as stated by Ottani (2006) childbirth anywhere in the world is a major life event that is 'culturally shaped and socially constructed'. This author proposes a framework for globally relevant care that is culturally sensitive and *competent* within any country with the suggestion that this should be incorporated into nursing curricula for all which concurs with the central massage of this current paper.

The Council of International Neonatal Nurses (COINN) in it's position statement on neonatal nurse education supports the development of a set of competencies which provide a basis for positive neonatal and maternal outcomes. Again outcome, as for the WHO belief, is best quality care. COINN also states that competencies are essential for well-educated specialty trained nurses. Their mission statement also incorporates the development of neonatal nursing on a global level as a recognised specialty dedicated to neonates and families. Moreover, one of their core values is to promote standards of both practice and education (COINN, 2011). The International Council of Nurses (ICH) re-iterate this who work on a worldwide scale to ensure quality care for all, global polices, advanced nursing knowledge and the international presence of

a competent professional workforce (Oulton, 2006). This principle should also be applied to the neonatal workforce across the world allowing cross-cultural care (Ottani, 2006).

The way forward for neonatal education

In relation to the UK perspective, the new BAPM/NNA/SNNG Framework should now lead educators both University and clinically based, to implement the guidance laid out in the key areas in order to achieve standardisation and consistency for all neonatal nurses becoming QIS. A valuable opportunity lies here to ensure equity for all. Once UK standardisation is achieved, there are key areas to address to work towards this happening on a global level. These areas are as follows…..

- Firstly, all neonatal nurses should be aware of the different models of neonatal healthcare discussed previously and the current inequalities in the context of the global picture, the Millennium Development Goals (United Nations, 2011) and the ultimate aim to close the gaps in healthcare and education provision between countries. Discussing and dissemination of these issues could be done via various means; on an international platform at conferences and meetings, via membership of COINN and/or Neonatal Nurse Association correspondence / newsletters, through relevant and topical journals or web-sites and through the media.
- Collaborate and network at a global level with key players within the education systems in neonatal care to allow international scoping,

pooling of frameworks and agreement in relation to standardisation of QIS status and education. International conferences should be utilised as a platform to network and form alliances between countries. As above, individuals with the drive to work towards this goal could take advantage of the vast array of technology enabled tools designed to facilitate ease of international communication namely; email groups, social networking and teleconferencing.

- Critical debate is needed on the overall goals of neonatal nurse education for QIS globally in relation to the overarching common elements for content of an appropriate framework that can be applied globally. These were identified earlier in this discussion in relation to both clinical practice as well as the psycho-social, ethical and culturally sensitive areas of care. Specific performance criteria may need varying depending on the individual country and resource barriers would need to be addressed but overall, the main areas for competency can be agreed.
- Collaboration and partnership working between education providers is essential to promote an integrated approach to assessment and curriculum development with contingent alignment of outcomes to the agreed framework.
- Finally, International bodies such as COINN need to work towards endorsement of a global framework for neonatal and maternal care and training including dissemination and ongoing evaluation. This needs to

acknowledge the key differences in resources and cultural background worldwide as discussed but still promoting a core set of skills and knowledge for the care of the neonate and family in any setting.

Conclusion: Developing and assessing competence is of vital importance in today's healthcare and nursing agendas including that within the neonatal specialty following pre-registration training and qualification. The development of agreed competencies is valuable to promote neonatal nurse career development through the many levels of experience and practice. The aim of this paper has been to raise issues for future debate at international level in the neonatal nursing specialty. Ultimately, to achieve the end result of neonatal nursing as a global specialty as stated by COINN (2011), should be the central focus for future internationally based discussions that address how to achieve standardised competencies and QIS status in neonatal nurses on a global level, if atall possible.

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