Competency Assessment Plan
Lancaster General Hospital (LGH)

PURPOSE

The purpose of this plan is to provide guidance for the development and management of competency assessments within LGH.

DEFINITIONS

DCE	Division of Corporate Education
LMS	Learning Management System (MyLearning)
Preceptor	Designated staff member, who by virtue of experience or training, participates in orientation of newly hired staff
Validator	Designated staff member, who by virtue of experience or training, participates in assessment and documentation of competency of fellow staff members.

OVERSIGHT

The LGH **Competency Management Team** will maintain oversight for the competency assessment process. This includes, but is not limited to the following duties:

- Develop, review and update the LGH **Competency Assessment Policy**
- Annually review, inventory and update **Competency Assessment Plan**
- Review **content and menu of annual mandatory OLT modules**
- Provide final **approval for all organization-wide mandatory competencies**
- Determine the **appropriate target audience** for mandatory organization-wide or role-based competencies, including the definition of 'staff' for TJC, OSHA or DOH required competencies/training
- Determine the **schedule (timing)** for disseminating mandatory organization-wide or role-based competencies
    - July 1 – Mandatory annual OLTs and unit/department competencies
    - January 1 – All others
- **D**etermine **method for documentation** of compliance
    - Standardized competency forms
    - Develop specific LMS curriculum for house-wide mandatory training for ease of record retrieval
    - Set standard naming criteria of mandatory training and competencies within the LMS for ease of record retrieval
- Facilitate incorporation of competencies into **non-patient care areas** *(financial, IT, leadership, transcription, telecommunications, quality & decision support, materials management, risk management, HR, etc.)*

PROCEDURES

New-Hire/Orientation

1. During the new-staff orientation period, a competency-based orientation plan is initiated and used to document the completion of the orientation process. This plan serves as a guide through the orientation process, outlining the progression of knowledge and skills development and assessment required for the new position. The unit/department orientation plan contains core and unit/department-specific competencies and must be completed prior to the end of the orientation period. The orientation plan will serve as validation of initial competencies for the first year of employment until July 1st of the following year.

2. Competencies are chosen by the unit/department manager along with any Professional Development leaders, and with consultation as needed from the Division of Corporate Education (DCE) consultants.

3. Competency validators for new staff will be provided by unit/department-based preceptors assigned by the manager.

4. Plans will be updated when new knowledge, skills, equipment and practices are implemented, performance issues identified, or quality outcomes identified that could be improved with a focused intervention.

5. The Unit/Department Orientation Plan is the property of LGH. This document must remain on the premises at all times and be available for review by assigned preceptors, unit manager and DCE educational consultants.

6. Unit/Department Orientation Plans that are lost or misplaced must be reported to the manager and the DCE educational consultant immediately. This situation will require the staff to begin the competency assessment documentation process again.

7. Unit/Department Orientation Plans will be reviewed and staff will be deemed "competent for independent practice" prior to the end of the orientation period. In some situations, the orientation period may be extended at the discretion of the manager, in collaboration with the DCE educational consultant.

8. Any staff failing to demonstrate required knowledge/skills will be required to meet with the manager, preceptor and DCE educational consultant to outline and begin the remediation process.

9. Any staff failing to complete the Unit/Department Orientation Plan within a scheduled orientation period or orientation extension period, and failing to complete the remediation plan will be required to relinquish their current position. The staff may be

offered and accept another position within the organization, or will necessitate termination (see LG Corrective Action and Discipline Policy).

Organization-Wide Competency

1. All LG Health staff is required to complete mandated online training modules (OLT's) to assess continual readiness on a yearly basis from July 1st to April 1st.

2. OLT's will be assigned by a committee that identifies internal and external regulatory requirements, as well as reviewing PI and quality data, performance measures, and new initiatives throughout the system or within departments. These OLT's will be reviewed annually for continued appropriateness.

3. Staff will be designated into three categories based on their job responsibilities and duties: (1) direct clinical, (2) indirect clinical, and (3) non-clinical. OLT's will be assigned to employees based on these categories.

4. Staff hired between April 1st and July 1st will be assigned OLT's that must be completed during their orientation period.

5. Staff failing to complete assigned OLT's will be subject to disciplinary actions in accordance with standing Human Resource policies.

6. Staff needing remediation for behaviors or actions not meeting acceptable standards may be required to review OLT's or assigned additional OLT's to become compliant with standards and regulations of the organization.

7. Required OLT's for Department of Nursing staff will be determined and mandated by the Nursing Operations Council. These modules will be in addition to the 'direct clinical' modules.

8. Required OLT's may also be assigned to other specific job roles throughout LG Health. (Example: Radiation Safety)

Unit/Department Specific Competency

1. Annual unit/department-specific competencies are evaluated and assessed for all personnel between July 1 and April 1 of each year. Staff hired between April 1st and July 1st will complete the Unit/Department Orientation Plan unless the manager mandates that selected annual competencies are appropriate and required based on observation, assessment, and documentation at time of hire.

2. Annual competencies may be established through a cooperative effort between the managers and unit/department-based councils based on new regulatory standards or goals, hospital goals or initiatives and performance improvement (PI) data.

3. Core competencies are established for all units/departments. These competencies include the domains of critical thinking, technical, and inter-personal skills; and are designed to meet the needs of the populations served. They are determined annually by a variety of methods which include:
    a. Risk-volume analysis (specifically high risk/low volume skills)
    b. Special policies or procedures involving high-risk medications or equipment
    c. Adverse event reports/quality Indicators/PI data/RRT reports
    d. Communication with the managers and staff regarding recognized areas of concern or need
    e. Communication from patients, families, and physicians
    f. New initiatives, procedures, equipment, policies or practices
    g. Changes in procedures, equipment, policies or practices
    h. Trends in healthcare.
    i. Regulatory Standards

4. Each competency will be identified with the related domain, rationale, and evaluation methods for verification.

5. Competency validators will be identified based on criteria established by the manager. These criteria should be listed on a "**Recommended Criteria for Competency Validator**" form, (See attachment A) which is to be completed on each validator and filed in the validator's employee file. Validators will be identified on each shift

6. All new competency validators will be educated to their role by attending the DCE Validator training class **or** by completing the online Validator Training module. It is highly recommended that they also attend the Preceptor Course.

7. Satisfactory completion of competencies is defined according to each competency, and could range from 80% or greater on all skills or written exams. Some competency skills will require a 100% pass rate. In the event an acceptable pass rate is not achieved on any component, it is the staff's responsibility to notify the manager. The manager and staff member will determine additional remediation to be received prior to retesting. It is the staff's responsibility to arrange for a retest within two weeks after the first test. Failure to pass the second test will necessitate meeting with the manager and DCE educational consultant to identify an action plan and time line for the successful completion of identified competencies. Unsuccessful resolution of competency issues may necessitate termination or an offer of another position, if available, that requires a different skill set for which the staff member may qualify (LG Corrective Action and Discipline Policy).

8. Upon staff completion of annual competency assessment, the manager will enter the information into the staff's computer-based educational record.

Remediation

1. Typically the remediation is planned by the manager with input from the DCE educational consultant as needed. When remediation occurs, it is documented on the validation sheet as being successful or unsuccessful. The type of remediation at the discretion of the manager with the input of the DCE educational consultant as appropriate.

2. Each staff member will complete competency testing/validation on an annual basis in the time period between July 1 and April 1st of each year. Between April 1 and June 30, managers and designated unit staff will plan and develop new competencies for the following fiscal year.

3. Upon staff completion of annual competency assessment, the manager or their designee will enter the information into the employee's computer-based educational record.

Disciplinary Action

1. On April 1st of each year, any staff who have not yet successfully completed competencies will have an action plan developed collaboratively between the manager and the staff member. The manager may consult with the DCE educational consultant prior to this process. At the discretion of the manager, the staff member may be prohibited from performing the skill until competencies are completed.
    a. A written action plan will be coordinated and approved by the manager with a successful completion date to be within 14 days. This plan will include critical events that need to occur and time frames.
    b. The manager will give a written warning to the staff member and a copy will be sent to Human Resources. It will specify the need for successful completion within 2 weeks.
    c. If, during the 2-week period, the staff member has shown progress and initiative, but requires more time to achieve competence, it will be granted on an individual basis after consultation between the manager and the DCE educational consultant. The time for extension will not exceed an additional 30 days. The manager will notify Human Resources of the extension.

2. Upon staff completion of annual competency assessment, the manager will enter the information into the employee's computer-based educational record.

Documentation

1. Competency verification by the validators may initially be captured on the **Competency Assessment Form** (Attachment B).

2. Upon completion of all competencies, the information is entered into the employee's (LMS) computer-based educational record.

3. Supporting documents such as written tests, skills checklists, etc. will be developed as needed for each competency listed.

4. Supporting documents specific to each staff member do not need to be saved UNLESS the staff member initially failed a competency or remediation has occurred.

5. Blank copies of the supporting documents should be available upon request by Human Resources or regulatory agencies such as the Department of Health, OSHA or The Joint Commission.

6. All documents associated with a remediation must be saved in the staff's personnel file or other secure location on the assigned unit. This includes the original skills checklists, tests, action plan, etc.

Record Retention

1. The manager is responsibility for maintaining all competency records for staff assigned to the unit. All competency documents are filed in the staff's personnel file or other secure location on the assigned unit. These include the Unit/Department Orientation Plan and yearly competency completion documents.

2. Competency documents are kept on the unit/department during employment. If staff transfers to another unit, the file is transferred to the new manager.

3. Upon termination from the organization, the file is forwarded to the Human Resources Department for storage following hospital record retention policies.

4. Orientation, competency and validator records will be maintained for a period of no less than 25 years.

Rev. May, 1998
Rev. July, 2000
Rev. December, 2000
Rev. June, 2001
Rev. June, 2002
Rev. April, 2003
Rev. April, 2004
Rev. April, 2005
Rev. August, 2007
Rev July 2008
Revised December 2008
Revised August, 2010
Revised April, 2011
Revised October, 2011

ATTACHMENT A - SAMPLE

Employee Name___________________________________

Lancaster General Hospital
Recommended Criteria for Competency Validator

Check All That Apply	√
One year experience in specialty area	
PMP (Performance Appraisal) score that is satisfactory to the manager	
Clinically competent as documented by Staff Educator	
Clinical ladder III or IV	
Serve as expert in a specific clinical competency as documented by additional training or experience: (Please specify)	
Current BCLS/ACLS/PALS	
Not currently participating in a performance improvement plan	
Specialty area certification: (Please specify)	
Current or previous experience as a preceptor/mentor	
Current or previous experience in leadership role or advanced practice role: (Please specify)	
Other: (Please specify)	

- Above criteria is not an exhaustive list and should be used as a guide for choosing competency validators
- Additional criteria may apply to different specialty areas
- Each unit/department manager is responsible for determining the competency validator requirements

I agree that all information on this form is accurate _____________________________
Employee Signature/Date

☐ **Competency validator training completed** _____________________________
Date

____ _____________________________
Manager Signature **Date**

ATTACHMENT B – SAMPLE COMPETENCY ASSESSMENT FORM
Used by Validators.

Competency Assessment Form (JOB TITLE) (FY)

Employee #:_______________ NAME: ________________________________

This form is to be completed by April 1, (enter year).

Competency Description Statement	Methods of Validation	Domain/ Rationale	Date Completed - Validator Signature
1.			
2.			
3.			
4.			

Domain Key: CT – Critical Thinking T – Technical IP - Interpersonal

Rationale Key: New procedures, policies, equipment, initiatives, etc. that affect this job class; Changes in procedures, policies, equipment, initiatives, etc. that affect this job class; High Risk aspects of this job class; Problematic aspects of this job; Regulatory agency required

Goals Key: Joint Commission National Patient Safety Goals (NPSG)