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Examining Doctor of Nursing Practice Clinical Competency

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ABSTRACT

An assessment of post-master's Doctor of Nurse Practice (DNP) education on clinical practice outcomes for master's-prepared advanced practice registered nurses (APRNs) may inform DNP program development and practice. Electronic survey assessment of DNP-APRN perceptions of clinical competency after completion of post-master's DNP education indicated engagement in DNP Essentials. Overall, DNP-APRNs report consistently engaging in competencies associated with Essentials I, II, III, VI, VII, and VIII, and to a lesser extent, competencies for Essential IV. These findings indicate DNP-APRNs function as change agents, patient advocates, and proponents of improved patient and community outcomes. Comparisons before and after DNP-APRN education are indicated for assessment of practice and program development.

Keywords: clinical practice, DNP competencies, DNP education, DNP role, DNP-prepared APRN

INTRODUCTION

Conceptualization of the Doctor of Nursing Practice (DNP) role addresses health care systems clinical leadership and practice specialization needs.[1] The Institute of Medicine (IOM)[2] released a report in 2001 calling for improvement in safe practices and new competency standards to meet patient care quality and safety criteria. The American Association of Colleges of Nursing (AACN) subsequently created a task force clarifying the DNP role and recommending advanced practice registered nurses (APRN) doctoral level education.[3] Recommendations from the IOM report[4] and AACN[3] prompted expansion of DNP educational programs in the United States and identification of DNP Essentials for APRN clinical competence.

This study assessed perceptions of clinical competency, as measured by the DNP Essentials, among APRNs after completion of a post-master's DNP education program and focused specifically on APRNs who initially completed a master's program and subsequently completed a post-master's DNP program (DNP-APRNs). This study focused only on perceptions of DNP-APRNs practicing in direct patient care settings within the US. The term "APRN" is inclusive of the advanced practice roles of Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), and Nurse Midwife. These findings may inform APRN and DNP program development and assessment of clinical competence.

REVIEW OF LITERATURE

The 2003 IOM publication, *Health Professions Education: A Bridge to Quality,* outlined critical competencies necessary to provide safe and quality care for patients in the 21st century.[4] Competencies identified included practicing evidence-based medicine, interprofessional collaboration and teamwork, focusing on patient-centered care, prioritizing quality improvement, and incorporating information technology.[5] The AACN DNP Essentials[3] reflect these competencies. Walker and Polancich[1] stated that doctoral-prepared advanced practice nurses are integral to the future of health care as "change agents" conceiving new practice models for efficiency and delivery of quality care in complex environments.

Contemporary literature supports the need for DNP-APRNs in today's complex health care environment. DNP-APRNs are expected to develop unique patient care models and provide leadership in collaborative environments to effect change.[1,6] Purdue and Roberts[7] describe doctoral-prepared

nurses as having an increased aptitude and obligation to improve nursing practice beyond the capacity existent in previous advanced practice nursing roles.

Few studies describe perceptions of clinical competency, as measured by DNP Essentials, for DNP-APRNs in clinical settings.[6,8–12] This study assessed perceptions of clinical competency as measured by the DNP Essentials among APRNs after completion of a post-master's DNP education program.

METHODS

Design

This study used a cross-sectional design. Study instrumentation included a self-report survey designed specifically for this study. The survey, designed to measure DNP-APRN perceptions of clinical competency in practice after completion of post-master's DNP education, focused on the AACN DNP Essentials. The survey included the AACN Eight Essentials for DNP education as they translate to clinical practice and the core competencies for DNP-APRNs in clinical practice. The study received approval from the University of Texas at Austin Institutional Board Review before implementation.

Inclusion and Exclusion Criteria

Sociodemographic questions included on the survey addressed DNP-APRN nursing education and clinical practice. Responses to these demographic questions were used to identify potential participants meeting the inclusion criteria for this study. Inclusion criteria consisted of DNP-APRNs who completed a DNP educational program after initial APRN preparation via a master's program. A DNP-APRN met the inclusion criteria if currently practicing primarily in a direct patient care role. Exclusion criteria included omission of current DNP students, master's-prepared APRNs, BSN-to-DNP graduates, PhD-prepared APRNs, and non—APRN-DNP graduates.

Instrument Development

DNP-APRN clinical competencies were initially identified in the literature and incorporated into the survey.[3,9,13–17] Expert panels of master's-prepared APRNs with a post-master's-DNP reviewed the instrument to assess content validity. Members of the expert panel were recruited from DNP and APRN faculty and DNPs working in community health settings. Expert panel members represented direct patient care providers, nursing educators, and administrators. Qualtrics Survey Software (Qualtrics, Provo, UT) programming formatted the anonymous survey with separate links for distribution to the membership of the individual APRN organizations.

The survey consisted of demographic questions and background questions pertaining to the level of advanced practice education, pathway to DNP, clinical practice site and specialty, change in practice site or salary after DNP education, years since DNP completion, roles outside of patient care, and state level of practice authority. Respondents were asked to self-identify the length of time since completion of post-masters DNP programs using categorizations of "less than 1 year," "1 to 5 years," "6 to 10 years," or "more than 10 years,"

Respondents were asked to describe the environment in which they practiced as *full, reduced,* or *restricted*. A full-practice environment includes evaluation, diagnosis, and treatment of patients under the singular authority of the state nursing board.[18] Reduced-practice environments require a collaborative agreement with a health discipline outside of nursing and limit the ability for the APRN to participate in at least one aspect of APRN practice.[18] Restricted-practice environments specify supervision, delegation, or team-management by a health discipline outside of nursing and limit the ability for the APRN to participate in at least one aspect of APRN practice.[18]

The survey included 48 items concerning DNP-APRN clinical competencies. Participants meeting eligibility criteria described how frequently they engaged in each DNP-APRN competency item during 1 week. Responses were obtained on a 5-point Likert scale, with 5 indicating "all the time," 4 indicating "frequently," 3 indicating "sometimes," 2 indicating "rarely," and 1 indicating "never."