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Rapid Validation of Clinical Competencies in a Time of Crisis

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The coronavirus disease 2019 (COVID-19) pandemic has tasked health care organizations at all levels to respond to critical issues such as procuring personal protective equipment, initiating safety policies and procedures, and rethinking staffing needs. This article describes a program that was designed to focus on rapid competency validation for organizations who had to dial up staffing to meet the immediate demands of the health care crisis.

The warnings of a pending health care disaster reached US shores in January of this year. A severe, acute respiratory syndrome coronavirus (SARS-CoV-2) was rapidly moving across the globe, causing a growing pandemic of novel coronavirus infectious disease (COVID-19). Although the emergence of the coronavirus was taking different pathways, there were similarities noted between severe acute respiratory syndrome (SARS) and the Middle Eastern respiratory syndrome (MERS), with all 3 having their origins in viruses that were transferred among animals and then to humans.1 Unfortunately, the COVID-19 virus was different in its ability to be quickly and easily exported from China to more than 36 countries, resulting in the World Health Organization declaring a “public health emergency of international concern.”2

For the United States, the first case was reported mid-January in Washington State and expanded rapidly from there, impacting all citizens and creating both a health care and economic disaster. One after another, states declared disasters via the Federal Emergency Management Agency, and health care organizations, especially those in high population areas, were feeling the impact. Organizations responsible for directly caring for COVID-19 patients, as well as those anticipating an influx of infected patients, were tasked to rapidly prepare for a pending disaster.

HEALTH CARE REACTION AND THE WORKFORCE

The American Nurses Association defines a disaster as “any event, caused by natural forces, by the physical failure of machinery or infrastructure systems or by the conduct of people that results in a significant disruption to the health and safety of the community or segment thereof, or to the nation,”3(p.1) and COVID-19 meets these criteria. Health care organizations responded rapidly as they reviewed disaster plans and preparedness to provide the equipment needed to safely care for infected patients, create policy to protect staff, and reassess staffing needs. Of particular importance was, and remains, the issue of personal protective equipment (PPE). It was quickly realized that because the United States outsourced much of the PPE production, there was not enough to meet the needs of the most affected organizations, creating a threat to health care workers. COVID-19 planning and obtaining PPE became the immediate priority.

When it came to staffing, nursing leadership responded with a dial-up, dial-down strategy. To ensure available capacity if needed, health care organizations suspended elective procedures and, as a result, dialed down staff in some areas. Nurses affected by the dial-down were moved from their current positions to other areas of practice, were asked to use paid time off, or were furloughed. Along with staff, nursing students were affected as organizations cancelled clinical rotations because of the need for limiting PPE and fearing the threat to students if exposed to the virus. Thus, academic centers were concerned that their students would not obtain the clinical hours required

**KEY POINTS**

- Organizations who have to dial up staffing need to use creative strategies to ensure a competent workforce.
- Programs developed to meet the needs of a migrating staff must continue to focus on competency-based performance to ensure patient safety.
- There is a need for team work and a strong academic-practice partnership to address the challenges presented by the COVID-19 pandemic.
for graduation. In response, nursing leadership in both practice and academic settings including the National Council State Boards of Nursing (NCSBN), the American Organization for Nursing Leadership (AONL), and the National League for Nursing released a policy brief: *U.S. Nursing Leadership Supports Practice/Academic Partnerships to Assist the Nursing Workforce during the COVID-19 Crisis.* The focus of the brief was to identify how nursing students could be utilized as part of the solution to meet critical staffing needs during the pandemic while continuing to obtain clinical hours. Six recommendations were presented for consideration, and recommendation 3 noted “Nursing program leaders/faculty are encouraged to work with health care facility representatives to align clinical skills and competencies with the nursing student-employee work role/responsibilities.” This recommendation closely aligned with, and complimented, Versant’s program for rapid competency validation.

**VERSANT HEALTHCARE COMPETENCY SOLUTIONS RESPONSE**

Versant Healthcare Competency Solutions (VHCS) offers competency-based transition programs and workforce development solutions for nurses across the nation in different stages of their career. The nurse residency program is for new graduate nurses as they transition from academia to practice (acute care, long-term care, and home health settings). The Transition Fellowship targets RNs with more than 1 year of experience transitioning to a new area of practice or returning to work following a leave or retirement (as is the case with the current pandemic). The Case Management Fellowship provides RNs transitioning into the role of a case manager with the knowledge and competencies needed to function in that role and the Advanced Practice RN (APRN) Fellowship is for newly licensed APRNs. All programs are 1 year in length, consisting of a precepted immersion period followed by supportive components (mentoring and debriefing).

Versant also offers a Student Nurse Capstone (SNC) program where students spend their last semester at their chosen organization, on their unit of choice, under a conditional hire agreement for the intention of working there post-graduation. This program provides the students with an opportunity for early competency validation (which is revalidated post-license), socialization, and enculturation into their unit and organization, along with potential cost savings for the organization.

**Versant’s Competency-Based System**

The work of Dr. G. Miller provides a concept of clinical progression that begins with knowledge and culminates in action. Versant’s Competency-Based System (VCBS) focuses on the ability of RN to safely demonstrate competency performance within their specialty area of practice (Figure 1). On the basis of an assigned competency profile, participants complete a competency gap analysis to identify gaps in knowledge, skills, and critical thinking ability. The result is a customized learning plan to direct remediation using current best-practice curriculum. The remediation prepares the individual for competency validation at the point of care via direct observation. Lastly, process and performance outcomes are collected at various points in time during and after the program for up to 5 years.

The VCBS follows Donabedian’s classic model of structure, process, and outcomes to provide a framework to safely transition nurses with the goal of improving the quality of patient care. Versant’s structure remains consistent throughout all programs. This article speaks to using Versant’s model as a framework for collaboration with client and academic partners for student nurses, retired nursing staff, and experienced RNs to quickly move to new areas of practice to rapidly meet the needs of the organization during the time of COVID-19. While retaining Versant’s standardized, structured approach that has proven to be successful in the past, the Versant team customized select processes to focus on rapid competency validation. Versant’s goal is to continue to ensure safe patient care by providing a structure around competency validation during on-boarding, which is much more than simply providing educational resources.

**Customizing Versant’s Program Processes**

Late January, discussions with clients regarding their response to the pandemic threat noted all were hard at work reviewing and revising disaster planning strategies, providing education to staff on management and treatment for both COVID-19 and non-COVID-19 patients, and communicating with community leadership on a multitude of health care issues to address immediate needs.

As noted above, staffing predictions were requiring a dial-up, dial-down approach depending on need and level of COVID-19 activity. Organizations were closing units that supported elective procedures, so nurses in those areas were no longer needed. Conversely, high impact areas were dialing up to quickly ready their workforce to meet both actual and anticipated demands in all areas of care. As expected, critical care and emergency departments were identified as high impact units being challenged to quickly expand their workforce.

As a response to health care staffing demands, Versant designed and deployed the Versant Accelerated Competency Validation (VACV) solution. The VACV provides health care workers and students with limited or noncurrent clinical experience (such as student nurses, nurses transitioning to different areas of practice, travel staff, and retired RNs returning to
work) to be quickly validated and deployed within the health care organization to deliver the appropriate care to an influx of patients.

VHCS nurse-lead teams worked closely with client organizations to identify and prioritize these needs to create the VACV program. Once deployed, and guided by their current disaster plan, participating health care organizations had the option of single-facility participation or the entire health care system. For most, it was a question of which clinical units would have the greatest need. Not all program participants were expected to work in high acuity areas, with many providing backfill in all practice areas. In fact, most clients chose to use existing staff for high acuity units, and those RNs moving from closed units or returning from retirement went to general med-surg units. To ensure these transitioning RNs had the knowledge and skills needed to safely practice in a new unit, it was critical the program was quickly available to them.

Versant’s transition programs (Figure 1) use an evidence-based structure culminating in competency validation with program effects closely monitored via outcomes and evaluations. It was critical to the planning team that the structure of the program remain focused on competency validation. Select processes were revised by a group of experts to allow for rapid competency validation while maintaining the integrity of the program. In most instances, this meant allowing certain components to be optional rather than mandatory. Like all programs, VACV is administered via Versant’s online Versant Voyager platform. A technical administrator was identified by the client organization to manage this work.

The Target Audience

The program was designed to be used with the following participants:

- Students: Although the focus is on nursing students, other health care students could also take advantage of the program (paramedics, emergency medical technicians, and others).
- RN staff who are being transferred to new areas of practice (e.g., ambulatory care to acute care; perioperative RNs to acute care; telemetry nurses to intensive care)
- Retired RNs coming back to care for both COVID-19 and non–COVID-19 patients
- Travel staff or other temporary nursing staff

Creating Competency Profiles

Versant’s competency-based system and the SNC program served as a framework for the identification of 29 foundational competencies and 10 high acuity competencies specific to the VACV program (Table 1). The foundational competencies were originally deemed essential skills in 2015 as a collaboration between a large multisystem client, a university academic center, and VHCS. The high acuity competencies were identified during VACV program development by looking at the results of a job analysis process that identified skills needed to manage the care of the patient with respiratory compromise. Clients can also customize the profile to meet the unique needs of the unit.

Table 1. Foundational and High Acuity Competencies

| Examples of Foundational Competencies                                      | Examples of High Acuity Competencies                          |
|---------------------------------------------------------------------------|----------------------------------------------------------------|
| Activating a medical emergency response                                    | Performs a focused respiratory assessment                      |
| Maintaining a safe environment                                             | Managing the care of the patient in respiratory distress       |
| Practicing infection prevention including isolation precautions            | Managing the care of the patient with acute respiratory failure|
| Performing a physical assessment                                          | Managing an airway; assisting with intubation                  |
| Managing the care of the patient with pain                                 | Managing the care of the patient with assisted mechanical ventilation |
| Utilizing antiseptic techniques                                            | Disaster preparedness and response to mass casualty emergencies|
Competency Gap Analysis
As previously mentioned, the gap assessment and analysis identifies knowledge and practice gaps resulting in a customized and individualized learning plan. Assessment items are based on the competency and its correlating curriculum. Although the gap assessment and analysis are available in the VACV, organizations can opt out of the assessment.

Competency Gap Remediation
For those participants who chose to complete the gap analysis, a learning plan is provided based on the results. The participant then has access to the educational curriculum that aligns with the competency. For example, if an RN working in critical care was identified with a knowledge or practice gap regarding “Managing an Airway: Assisting With Intubation,” they can remediate either independently or in a virtual classroom setting. Because distancing is a concern for classroom activities, all educational modules are available in an online format. The participant can spend as little, or as much, time learning content as needed. Traditionally, when implementing a Versant program, competencies are not ready for validation until remediation is completed. For the VACV program, remediation is optional, and all competencies are ready for immediate validation.

Competency Validation
Versant has been proud to differentiate our programs by requiring directly observed competency validation at the point of care. This has been especially important for New Graduate Nurses (NGNs) as clinical hours for students has been reduced. In fact, the study by Hayden et al. provided “strong evidence supporting the use of simulation as a substitute for up to 50% of traditional clinical time.” Nursing professional development practitioners have voiced concern that NGNs participating in a nurse residency program have never had the actual patient experience prior to competency validation post-graduation. The need for immediate deployment of staff to high impact areas

Table 2. Comparison

| Versant Competency-Based System | Versant Accelerated Competency Validation Program |
|--------------------------------|---------------------------------------------------|
| Competency profile            | An abbreviated, customizable profile (Table 1)    |
| Self-assessment and gap analysis | Optional                                              |
| Gap remediation                | Optional resources                                   |
| Direct competency validation at the point of care and alternatives to direct observation (ADO is used for a small subset of Versant-identified competencies (e.g., Managing Reactions to Blood and Blood Product Administration) | A subset of alternatives to direct observation methods used in this program  |
| • Simulation                   | • Simulation                                         |
| • Case study                   | • Group discussion/reflection                        |
| • Group discussion/reflection  | • Presentation                                       |
| • Presentation                 | • Exemplar                                           |
| Outcomes                       | Limited to 7 demographic questions                  |
| • Versant self-efficacy        | • Birthday                                           |
| • Nurse and work satisfaction  | • Gender                                             |
| • Nursing incivility           | • Race                                               |
| • Group cohesion               | • Current role                                       |
| • Leader empowering behaviors  | • Highest level of education                         |
| • Conditions of work effectiveness | • Previous work experience                           |
| • Program evaluation           | • Program evaluation                                 |
| Supportive components          | Four optional debriefing topics                     |
| • Mentoring sessions addressing 10 topics | • Response to stress                                |
| • Debriefing sessions addressing 26 topics | • Compassion fatigue                                |
|                                 | • Grief management                                   |
|                                 | • Self-care techniques                               |

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prompted a modification in Versant’s competency validation process. Although direct observation at the point of care is the ultimate objective, alternatives to direct observation (ADO) became the primary method of validating performance. Acceptable methods of validation are noted (Table 2).

Social distancing mandates forced organizations to change how validation of performance is managed, putting a strain on resources. As part of the implementation process, competency validators were identified and educated on the use of ADO. An option is to utilize recently retired staff who are willing to return to work during the current crisis, while others identified educators and staff from nonessential units who had been part of the dial-down process and may be available to help with validation. Also, those validating competencies using simulation labs or low fidelity settings did so by appointment for planning purposes and to maintain physical distancing.

Outcomes
Transition program participants complete a menu of assessments, metrics, and evaluations to continuously obtain data. Due to the critical needs of this program only select demographic information and a program evaluation are obtained (Table 2).

Supportive Components
Mentoring and debriefing are important components of a successful transition program. Program designers were challenged to provide a platform for reflection and sharing of experiences while focusing on the need for rapid deployment. Thus, an option is provided for organizations to use debriefing as a strategy to assess staff engagement and stress levels. Although optional, the benefits of using debriefing as a means of support and as a mechanism of communication during trying times was obvious. Staff were being asked to take on new responsibilities in a very unsure and stressful environment, and the need to share these experiences was critical. The recommendation was to include clinical debriefing but conducted in small groups or using other communication-sharing technology. Instead of offering a wide selection of debriefing subjects, 4 main topics were identified (Table 2).

Implementation and Looking to the Future
Although participating clients are ready for implementation when and if needed, as of the publication date, most have been able to manage the workforce needs of the pandemic with creative staffing strategies such as posting open shifts using a central staffing model and reassigning staff between units that share a competency profile. Thus, Versant and collaborating clients must be ready to implement in a moment’s notice depending on how the pandemic continues to impact our clients.

What we do know is that additional research, both quantitative and qualitative, is needed to capture the experiences of health care workers during this time of crisis. Descriptive studies need to be completed to address nurse and work satisfaction, feelings of safety, leadership responses, and a multitude of other critical factors that impacted the caring of patients and their families during this pandemic. Two examples for consideration include: First, Versant uses the Psychological Capital Assessment to look at participant levels of hope, optimism, resilience, and efficacy. We are planning on reviewing data pre- and post-pandemic to identify changes in these areas. Second, there have been reports of traumatic stress for caregivers, and Versant is responding by adding a metric to identify caretaker perceptions of traumatic stress. Eventually, the data obtained and lessons learned from this experience will help to revise and strengthen the program.

CONCLUSION
The COVID-19 pandemic has impacted health care in ways never before imagined. Versant quickly responded to the crisis by revising transition to practice processes to meet escalating staffing needs while maintaining the integrity of a competency-based transition program. Clients have positioned themselves to fully adopt the program when needed as a means of meeting workforce challenges. The Versant Accelerated Competency Validation program is uniquely suited to provide emergent staffing solutions and allows for aggressive deployment of staffing resources necessary to provide safe, consistent patient care while supporting staff during a time of crisis.

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