COMPETENCY February 24, 2022

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I. PURPOSE

To define the mechanism of establishing and maintaining qualifications and performance expectations of employees providing services and/or patient care at University Hospital. To provide a mechanism at the department level for competency assessment of employees. Physician competency is addressed through the Medical Staff credentialing process.

II. DEFINITIONS

Competency - An observable and measurable attribute (whose source may lie in skills, knowledge, values, traits or perspectives) that contributes to success in performing a task or job. Competence includes four key skill areas for assessment, maintenance, and improvement:

1. Knowledge: That which is learned from books, lectures, videotapes, and other methods.
2. Psychomotor: Using knowledge or those things the individual has learned to do; skills that must be demonstrated; observable.
3. Critical Thinking: Ability to analyze and understand true importance of observations and events.
4. Interpersonal: The skills and ability to work with others.

Competency Assessment - The observation and verification of competency.

Orientation - A formalized process to familiarize a staff member with new circumstances, surroundings, procedures, and expectations.

1. Hospital Orientation - provides information regarding the mission, goals, and expectations of the organization as well as general safety.
2. Department Orientation - provides information and training related to department specific functions as well as a check off of technical expertise and assessment of skills required to meet department needs.

III. POLICY

It is the policy of University Hospital to ensure that staff members are competent to perform the duties required of their position. This is accomplished through proper selection, preparation, competency determination at hire, and annual competency assessment. Processes to be utilized include pre-employment interviews and screening, hospital orientation, department orientations and checklists, in-service training, continuing education programs, and annual performance evaluations.

IV. PROCEDURE

1. Hiring, Employment and Orientation

a. The interview process will include discussion of licensure, certification, or registration, if required, and work experience, as appropriate. Human Resources will verify, upon hire, required licensure, certification or registration and shall make adequate inquiry to determine whether any proposed new hire is listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs. Maintenance of all required licensure, certification, or registration will occur in individual departments.

b. All employees attend Hospital Orientation which familiarizes new staff with the Hospitals' mission and goals, information management, performance improvement principles, general safety and benefits.

c. Each department orientation provides orientation to department specific and position-specific policies and requirements.

   i. During department orientation for direct and indirect patient care staff, competence in all required areas of patient care will be assessed and verified through direct observation of skills indicated on the competence/orientation checklist. Observation will be done by the immediate supervisor, designee or training coordinator for the department, and signed and dated. Any additional training will be completed and required skill levels met before the new employee will be allowed to render patient care.

   ii. Competence will be assessed and documented for support staff during departmental orientation.

d. Prior to assuming full responsibilities, each staff member in all departments will have their initial competency assessment completed by:

   i. Attending Hospital Orientation

   ii. Completing department-specific orientation, which may include competence assessment/orientation checklist(s).

   iii. Satisfactorily completing all learning activities needed to ensure competence.

   iv. Completing Mandatory Training during probationary period.

2. **Assessment Process**
    a. Primary Source Verification of certification, licensure, or registration required for direct patient care positions will be made upon hire by Human Resources.
    b. An initial competence assessment will be done during the interview process by reviewing education, experience, and skills. Further assessment will be completed during the department orientation.
    c. Demonstration of competence to perform skills specific to the area of assignment is required of all direct and indirect patient care staff. Assigned responsibilities will be in accordance with experience, position description, and skill level.
    d. If applicable for the position, completion of a competence assessment checklist/tool will be done during departmental orientation for new staff. Skill requirements on the competence assessment will be reviewed and maintenance of skills considered when completing the annual performance review.
    e. Competence will be maintained through mandatory annual training, attendance and participation at in-services, and attendance at continuing education offerings, academic courses, or other training specific to departmental job requirements.
    f. Competence will be reviewed and documented annually, at a minimum. For non-clinical support staff, competency will be assessed as part of the annual evaluation process.
    g. Corporate compliance confirms no UH employee is on the OIG exclusion list and reports its findings to the Board of Trustees.
    h. Compliance will at least annually make inquiry to determine whether any Hospital employee is listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.
    i. Staff members transferred or reassigned to areas and/or titles requiring new/different skills will have competencies verified by the new supervisor.
    j. The staff member and supervisor will jointly identify staff member training needs during the performance review or at any time during the year as needed.

3. **Responsibility**
    a. Department Directors are responsible for:
        i. Development of department specific procedures to determine how competence assessment will be accomplished.
        ii. Establishing Competency Based Job Descriptions (CBJD) for every position in his/her department.
            1. Define the primary responsibilities of each position; this should include essential and important non-essential duties.
            2. Define required competence, qualifications of staff and populations to whom care is to be delivered (if applicable),
            3. Ensure compliance with licensure regulations for clinical positions.
            4. The CBJD's should be reviewed annually when the performance evaluation is completed for an employee.
        iii. CBJD's must be sent to the HR Compensation Services Office for official approval when changes in the CBJD's are needed. It is mandatory that all job descriptions in each department be reviewed, re-dated and approved by Compensation Services every three years.

iv. Ensuring completion of the division/department orientation plan which includes:
    1. Skills required by the position including those specific to age and other characteristics of the patient population being served.
    2. Skills required for performance of highly technical procedures with knowledge of associated problems.
    3. Ability to operate equipment safely and effectively.
    4. Competence in cardiopulmonary resuscitation and other lifesavinginterventions, as appropriate.
    5. Competence in fire prevention, emergency preparedness, and general safety procedures, infection control procedures, hazard communication, Health Insurance Portability and Accountability Act (HIPAA), patient safety, and compliance.
v. Interviewing applicants for positions to determine basic eligibility and competence level.
vi. Determining competence of all new staff through a competence based assessment conducted as part of department specific orientation.
vii. Assessing on-going competence through a staff development program and completion of annual performance reviews.
    1. Ensuring documentation of the orientation, training, and competency assessment of all staff is organized in a file system approved by the competency committee.

4. Annual Verification of Competence

a. All staff must maintain competence in identified areas of practice and skills, and must participate in all mandatory training required to ensure a safe patient care environment. The mechanism for assuring ongoing competence for direct and indirect patient care staff includes verification of competence in skills specific to assignment. Verification will be accomplished by direct observation, documentation of mandatory training, documentation of critical incidents, quality assurance monitors, skills labs, record review and customer feedback, or other processes providing information related to staff competence. Verification of competence will be reflected in the annual performance evaluation.

5. Competency verification procedure for rehires or staff returning from LOAs

a. All hires returning to the Hospital within 6 months or less after departure will not need to participate in general Hospital Orientation. They will need to be assessed by their department using the department orientation tool and initial competency process to determine any further training needs upon rehire.

6. Reporting Mechanisms

a. Department directors or managers will maintain documentation related to competence and reflect issues in interim and annual performance evaluations.
b. Department directors or managers will submit completed annual performance evaluations to Human Resources within 30 days of their due date.

c. Training and Organizational Development will maintain records of attendance and completion of programs offered through T&OD; department managers will maintain department specific mandatory training and in-services.

7. Staff Development/Continuing Education

a. Programming for staff development to maintain and/or improve competence/clinical skills may occur at the department level, through Training and Organizational Development or from other internal or external resources.
b. In-service programs will be based on staff training needs identified from performance improvement program findings, new or changing technology, new or changing therapeutic or pharmacological interventions, and areas identified for professional growth. Programs will be designed to improve patient outcomes, achieve department and organizational goals, and improve staff performance.
c. Approval to attend workshops, seminars, and academic courses to meet identified training needs during paid work time may be given by the department director.
d. Attendance and participation in continuing education / training programs will be documented at the department level. Attendance at programs held outside the organization should be documented with department directors.
e. Staff members are responsible for meeting their own continuing education needs as may be needed for re-licensure, certification, etc.

8. Compliance

a. All staff will achieve and maintain the skill level to competently perform the duties required by their position. Failure to achieve the required competence during a probationary period may result in termination. Failure to maintain required competence, complete mandatory requirements related to maintenance of competence or achieve competence for new responsibilities, may subject the staff member to the corrective action process.

V. RESPONSIBILITIES

The Chief Human Resources Officer is to ensure compliance with this policy. All University Hospital management is responsible for implementing this policy.