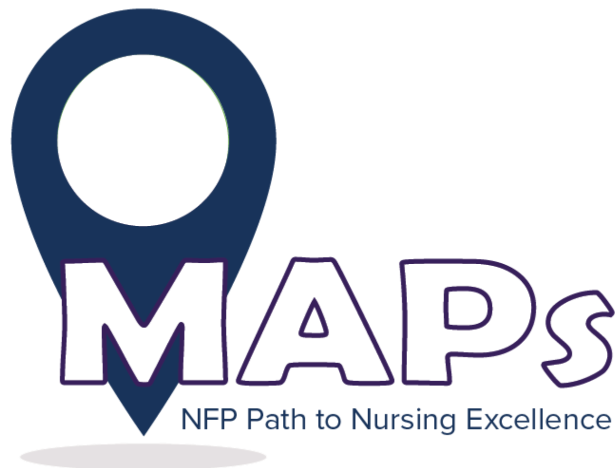
Mastery Assessment and Plan (MAP) Guidance

June 2018



Nurse-Family Partnership
National Service Office
1900 Grant Street, Suite 400
Denver, CO. 80203-4304
Phone: 866.864.5226, 303.327.4240
Fax: 303.327.4260
www.nursefamilypartnership.org

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Instructions for the Mastery Assessment and Plan (MAPs)

The Mastery Assessment and Plan (MAP) forms are used by the nurse home visitor and supervisor to assess and reflect on the nurse home visitor's knowledge and skills in implementing the Nurse-Family Partnership (NFP) model with a client. NFP is a top-tiered evidence-based program and the MAPs provide guidance for the nurse home visitor's journey in acquiring specialized knowledge, skills, and expertise to effectively deliver NFP. The **majority** of information for MAP assessment is gathered during a joint visit. The supervisor may also include observations and insights from her/his experience of the nurse home visitor during case conferences and other interactions. The supervisor provides feedback and support including affirmation of the nurse home visitor's strengths. In addition, the supervisor and nurse home visitor collaborate to determine levels of skill and knowledge, to identify areas for growth, and to develop a plan for professional growth in the NFP model. These are an essential component of an NFP career development ladder.

Content of the Mastery Assessment and Plan (MAP)

The MAPs reflect the NFP Standards and Proficiencies. The NFP Standards align with the American Nurses Association and American Public Health Association Standards. There are 6 NFP Standards:

1. Applies theories and principles integral to implementation of the NFP model.
2. Uses research, ongoing quality improvement and reports from data systems to guide and improve practice.
3. Uses the Nursing Process to deliver individualized client care and set goals across the six domains.
4. Establishes therapeutic relationships with clients.
5. Utilizes reflective processes to improve practice.
6. Adheres to Standards of Nursing Practice.

Each NFP Standard includes multiple Proficiencies representing knowledge and skills nurse home visitors employ to successfully move clients towards the desired outcomes of the program. Each Proficiency includes specific examples of how the Proficiency may be demonstrated.

MAPs establish a Career Development Ladder

There are sequential MAPs (MAP 1, 2, 3, etc.). The MAPs build on each other. While they are coded in the same way, the items are different since they reflect increasing skill, knowledge and integration into nursing practice. MAP 1 focuses on foundational knowledge and skill. These are the items that are essential to engaging, enrolling, and retaining clients and include knowledge and skills that are essential to making a difference that will improve client outcomes. Subsequent MAPs build on these skills. As nurses progress through the program and the MAPs, they are supported in developing a more nuanced practice and managing more

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complex applications. Regardless of the nurse's prior experience, in each standard the nurse will experience varied levels of mastery for some of the proficiencies and will most likely find some areas to challenge himself/herself to grow. The MAPs are entered into the data collection system and achievements and growth plans will be reflected in the NFP learning management system. This will clearly demonstrate ongoing growth and greater mastery over time.

Preparing for a Joint Visit and MAP:

Supervisor Preparation for the Joint Visit:

- Depending on the size of your team, schedule 1-2 joint visits per month so each nurse home visitor has a joint visit with you every 4 months.
- Notify each nurse home visitor several weeks in advance that it is time for her/him to schedule a joint visit with a client.
- Ensure the nurse home visitor has a copy of the appropriate MAP (4 mo., 8 mo., 12 mo., etc.). Review the purpose of the observation: acknowledging the nurse's strengths, knowledge, skills and learning about the nurse's needs for professional growth and support.
- Prior to the visit, familiarize yourself with the MAP you will be completing.

Nurse Home Visitor Preparation for the Visit:

- Prepare your client for the joint visit. Consider what this client needs in order to normalize the presence of the supervisor and ease any discomfort/awkwardness that either you and/or the client might feel.
- Consider a statement of this nature, "My supervisor likes to get to know my clients in case I am ill or on vacation. She/he also helps me keep growing as a nurse by observing how I work and giving me feedback. She/he would like to come on a visit next time I see you. May I bring her/him?"

Supervisor and Nurse Home Visitor Collaboration:

- Create a plan for how the nurse home visitor will introduce the supervisor at the beginning of the visit and plan the logistics of the visit. (e.g. Will you drive separately or together? Will you enter the home together? Will the supervisor play a small role in the visit?)
- Prior to the visit, discuss the plans for the visit, the client strengths, risks and needs and any challenges the nurse home visitor is experiencing in working with the client.
- Over time with different MAPs, the nurse home visitor should select different clients representing various phases of the program (pregnancy, infancy, or toddler) and personal/situational factors for your joint visits.
- If the nurse is working on time management or documentation, some supervisor/nurse home visitor dyads have found it helpful to spend ½ to a full day visiting together to establish a system that works better as they go through the day.

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Completing a Joint Visit and MAP:

Observation during the Joint Visit:
- The supervisor observes objectively.
- The supervisor attends to the neighborhood and home environment, dynamics of the relationship between the nurse home visitor and this family, as well as visit content and fidelity to the NFP model.
- The supervisor focuses on the strengths of this nurse home visitor, the client and family while also observing for challenges and vulnerabilities.
- The supervisor seeks to blend into the environment unless the supervisor and the nurse home visitor have planned for the supervisor to conduct a small portion of the visit.
- If any unusual or challenging circumstances occur in the visit that require intervention, the supervisor role models the spirit and principles of the NFP program.
- The supervisor takes notes that include examples of strengths, knowledge, skills, integration of concepts and areas for growth. (See optional sample *Joint Visit Observation Notes* pages in Appendix. You may choose between the simple notes pages that include Standards only or the more detailed version that includes the Standards and Proficiencies for MAP 1 or use your own note taking method.)

Completion of Documentation and Reflection after Joint Visit
- The supervisor may want to reflect with the nurse immediately after the joint visit or s/he and the nurse home visitor may decide to wait until the next 1:1 clinical supervision session.
- Sample reflective questions to consider:
    - Was this a typical visit with this client? And if not – what was different?
    - How did your plans for the visit need to be changed or adjusted?
    - How is the therapeutic relationship with the client evolving?
    - What challenges do you experience with boundaries: any over- or under-involvement?
    - Which of the domains is your strongest? Which is your weakest?
    - How did you apply NFP theories in this visit?
    - How did this visit reflect your values and skills in nursing?
- Together, describe the nurse home visitor's strengths, vulnerabilities, needs, challenges, and areas for growth that surfaced during this visit.
- Discuss the home visitor's observations.
- Explore any differences in perspective, potential nurse home visitor blind spots, identified challenges, etc.
- Collaborate in coding each proficiency item. Description of Coding follows this section.
- Discuss nurse home visitor's plans for professional development and record them on the last page of the MAP in the professional development box.
- Offer support and resources as part of the development plan.
- Discuss logistics of follow-up; the professional development plan may include a SMART goal.

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Coding the MAP

It is important to affirm good performance regardless of which stage the nurse home visitor is in developmentally. Highly experienced and relatively inexperienced nurses may look quite different, yet each has areas of mastery and areas for growth. When coding the MAPs it is anticipated that nurses will have a variety of skill and knowledge levels regardless of their level of experience.

Definitions for Coding:

- **Emerging level** describes the nurse home visitor that can define the concepts and principles, can perform the tasks and complete basic functions related to this proficiency, but is not yet "fluid" and confident with this proficiency.   The nurse may need support, modeling, or role play from colleagues to be successful in delivering this proficiency.
- **Integration level** describes the nurse home visitor that has surpassed the emerging level for the proficiency and is starting to integrate theories and principles. The nurse home visitor can use concepts related to this proficiency in new situations and can modify approaches appropriately when needed. The nurse can generally perform these skills with confidence and efficiency.
- **Complex Application level** describes the nurse home visitor that has surpassed the integration level for this proficiency. The nurse can synthesize multiple factors and adapt care or strategies in complex situations and for complex clients. The nurse home visitor feels this proficiency is very important and has high level of knowledge and skill in this area. Generally, nurse home visitors do not reach this level until they have had a few years of experience and focused learning on the specific proficiency.
- **Review level** describes different conditions. 1) The supervisor has determined that the nurse is not yet able to define the concepts and principles related to the particular proficiency or is not yet able to perform the tasks or basic functions related to the proficiency. 2) The nurse has requested a review and support, resources, knowledge or skill to address a gap or lack of confidence in meeting this particular proficiency. 3) The nurse is not now able to perform the proficiency after previously being able to.
- **Not Assessed:** There may be some proficiencies that the supervisor is not able yet to assess. Skip the proficiency and address it later when the next MAP is due or in between the usual time frames.

Options for "Review" level:

If the nurse or the supervisor choose to code a particular proficiency as "Review", further indicate the type of gap to address. Identifying the specific type of need is likely to prove useful in determining a successful professional development plan. Additionally, the type of gap the nurse is experiencing is helpful information to the NFP NSO education team. For example, if the education team sees that many nurses experience a challenge on a particular proficiency due to knowledge, the team knows improvement to this content is needed.

- add "Knowledge" if the nurse home visitor has a knowledge gap.

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- add “Skill” if the nurse home visitor has a skill gap.
- add “Importance” if the nurse home visitor does not see the importance.

Goal of Observing Home Visits and Coding MAPs: The goal is NOT to have all items at “Complex Applications” level, but instead to acknowledge successes, to increase awareness about needs for support or professional development, and to provide opportunities to challenge oneself in one’s career development.

Example of Coding Proficiencies

Proficiency 3.1: *Uses the Nursing Process including the Strengths and Risk (STAR) Framework to assess client strengths and risks in all domains and plans intervention accordingly including use of family, community and personal resources.*

Emerging level: The nurse can code the STAR Coding form to accurately reflect strengths and risks in each measurement category. The nurse may need assistance from the supervisor or colleagues to be accurate and complete. The nurse uses the STAR Coding to set priorities and plan interventions.

Integration level: The nurse is quite skilled and comfortable with STAR coding, regularly using it to assess each measurement category and develop interventions based on stages of change. The nurse notes and supports changes in client health behaviors. The nurse uses STAR coding to communicate client needs to others who may care for the client.

Complex Application level: The nurse is highly skilled at using STAR coding and the nursing process to improve client outcomes. The nurse is highly effective at adapting the plan of care for clients with complex challenges and at managing a complex and dynamic caseload based on thorough assessment of needs, clients’ readiness for change, and clients’ needs for frequency and intensity of the intervention.

Review level, *Knowledge* gap: The nurse does not yet know the rationale or fully understand the coding levels for the different measurement categories and/or stage of change.

Review level, *Skill* gap: The nurse has insufficient skill to code correctly, or fails to use the coding or readiness to change to inform nursing process, establish priorities, or document client status and change.

Review level, *Importance* gap: The nurse does not value the STAR Framework or how it supports the nursing process. The STAR coding may be seen as one more thing to do vs. a way to fully understand and meet client needs while building on the client’s strengths.

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Completing the MAP Form for data collection

The MAP data collection forms are designed with a check boxes for each proficiency to be assessed. Since there are 4 levels (Emerging, Integrating, Complex Applications and Review) and 3 options for Review (Knowledge, Skill, and Importance), each item has 7 boxes. This makes the form easy to complete although long when printed on paper. Notes may be taken on an observation sheet during the joint visit and the data collection form may be completed collaboratively between the supervisor and nurse home visitor during 1:1 reflection time(s).

Timeline for Completion of the MAP:

- Required: Once every 4 months after a nurse home visitor begins enrolling clients.
- Recommended: Begin within 3-4 months of the nurse home visitor enrolling clients. This provides an opportunity for the supervisor to assess a new nurse home visitor early in his/her implementation of the NFP model and an opportunity to provide support early in their development process.
- Recommended: Complete additional MAPs on an "as needed" basis. This may be: 1) at the request for additional support by the nurse home visitor; 2) or when the supervisor identifies concerns or wishes to document exceptional growth and achievement; 3) or to document proficiencies that were not assessed during the usual time frame. Choose the MAP that best meets your needs.

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Optional: Joint Visit Observation Notes

Nurse Name________________________ Date___________

Standard 1: Applies theories and principles integral to implementation of the NFP model

Standard 2: Uses research, ongoing quality improvement and reports from data systems to guide and improve practice.

Standard 3: Uses the Nursing Process to deliver individualized client care and set goals across the six domains.

Standard 4: Establishes therapeutic relationships with client.

Standard 5: Utilizes reflective processes to improve practice.

Standard 6: Adheres to Standards of Nursing Practice.

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Optional: Joint Visit Observation Notes – MAP 1

Nurse Name________________________ Date___________

Standard 1: Applies theories and principles integral to implementation of the NFP model.

- Proficiency 1.1 Applies Self-Efficacy Theory to promote client empowerment and growth.
- Proficiency 1.2 Uses client-centered principles to engage, retain and empower client
- Proficiency 1.3 Applies knowledge of Attachment Theory to establish and maintain relationships with clients
- Proficiency 1.4 Applies Attachment Theory to help client demonstrate consistent, responsive and nurturing caregiving.
- Proficiency 1.5 Applies Human Ecology Theory to strengthen client social network and support systems.

Comments about Standard 1 ____

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Standard 2: Uses research, ongoing quality improvement and reports from data systems to guide and improve practice.

- Proficiency 2.1 Uses appropriate therapeutic communication in gathering information to complete data collection forms.
- Proficiency 2.2 Uses clinical judgment and engagement strategies about timing of questions around sensitive issues.
- Proficiency 2.3 Uses data to inform nursing assessment and improve client outcomes.

Comments about Standard 2 ____

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Standard 3: Uses the Nursing Process to deliver individualized client care and set goals across the six domains.

- Proficiency 3.1 Applies critical thinking skills when using the nursing process within the six domains
- Proficiency 3.2 Applies professional clinical nursing judgment and collaborates with the client to individualize the intervention to meet the specific needs of the client and infant.
- Proficiency 3.3 Implements the program in a manner that is safe for the client and the child

Comments about Standard 3 ____

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Standard 4: Establishes therapeutic relationships with client.

- Proficiency 4.1 Demonstrates therapeutic qualities and characteristics. (e.g.: dependability, empathy, trust, respect, professional intimacy and awareness of power differentials).
- Proficiency 4.2 Applies the spirit, principles and strategies of therapeutic communication to build relationship with client and promote healthy change.
- Proficiency 4.4 Understands and respects client/family culture, as a foundational element of therapeutic relationship.

Comments about Standard 4 ____

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Standard 5: Utilizes reflective processes to improve practice.

- Proficiency 5.1. Understands and applies reflective process to improve practice

Comments about Standard 5 ____

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Standard 6: Adheres to Standards of Nursing Practice

- Proficiency 6.1 Pursues knowledge in maternal-child health and nurse home visitation that reflects most current nursing practice.
- Proficiency 6.2 Engages in ethical practice.
- Proficiency 6.6 Complies with state and agency nursing legal requirements

Comments about Standard 6 ____

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