As a diploma RN in the late 1970s from a large teaching hospital in the Midwest, education was ingrained throughout my program and practice. Whether we were at a clinic site educating patients and their families or we were a part of a study group supporting the education and progression of each other, the expectation was in supporting the acquisition of the knowledge, skills, and, yes, the behaviors we needed to practice as RNs.

Over the years, I believe there have been several milestones that have greatly contributed to the advancement for, and alignment of, continuing education and professional development. I know they have affected me personally as I’ve moved through the many decisions I’ve made about my career.

**INTERPROFESSIONAL EDUCATION**

I have recollections over the years of working with an interprofessional team, even though the term was not yet recognized. Team members would come together for educational events, during grand rounds, and at other times when the patient’s plan of care needed input from the group. During these times, opportunities existed for collective informal education. During formal continuing education, conventional patterns remained—physicians would educate physicians, and nurses educated nurses. When the Institute of Medicine (Kohn, Corrigan, & Donaldson, 2000) presented their work on patient errors and safety with recommendations to move to patient-centered care, logic followed that we needed to formalize a better way to provide interprofessional education. So, by definition, “Interprofessional education occurs when learners of two or more health or social care professions engage in learning with, from, and about each other to improve collaboration and the delivery of care” (Institute of Medicine, 2015, p. xi).

**SHARED FACULTY: EDUCATION-PRACTICE PARTNERSHIPS**

The concept of shared faculty, or when an RN works in both a clinical practice setting and as an academic nurse educator, was initiated in the 1990s when it became apparent there was a faculty shortage. At that time, I was able to work in both an intensive care setting in a large community hospital and as adjunct faculty for both a 2-year community college and 4-year Bachelor of Science in Nursing program. The advantages for all partners was evident in increasing the ability to provide needed faculty, increase the number of clinical practice sites, and, often, recruiting new graduate RNs from the student pool. It also helped to increase the organization’s research capacity, introduced clinical RNs to the role of adjunct faculty who can maintain clinical competence while teaching others, and provided a closer connection for communication and understanding between clinical practice and academia.

**INDIVIDUAL TO COLLECTIVE COMPETENCE**

Historically speaking, the demonstration of one’s competence has been at the level of individual competence. This is seen during academic education with the completion of National League of Nursing preparation examinations (now HESI testing) and the NCLEX-RN®. For clinical practice, it is demonstrated at the annual skills fair and/or evidence of daily work. An emerging concept, that of collective competence, has been brought forward with the work of Dr. Lorelei Lingard from Western University in Canada. Lingard described health care as a “team sport” and even though individuals who make up the team are competent, the team itself may have issues. Thus, collective competence focuses on a “constantly evolving set of interconnected behaviors” and communications that are enacted within the context of providing health care to

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a specific patient at a specific place in time (Lingard & Hodges, 2012). Collective competence is seen in the work that is being done on teams and collaboration. Although the individual competence of a health care professional is important, the collective competence of the team is critical to the success of caring for a patient.

OUTCOMES-BASED LEARNING

One of the most exciting advances in continuing education has happened in the past 2 years, with the development of American Nurses Credentialing Center’s outcomes-based learning model. With this model, the education process is fully in the hands of the learner with guidance from a nurse planner. Outcomes focus on the learner’s ability to move through knowing to application, demonstration, integration in practice, and, finally, evaluating the impact on practice. The model shows us the importance of moving from seated time to performance and the success of the pilot ensures this opportunity will be expanded to a wider group of learners.

CERTIFICATION OF NURSING PROFESSIONAL DEVELOPMENT PRACTITIONERS

Since 1992, nursing professional development (formerly known as continuing education and staff development) has been recognized as a specialty practice area. RNs can obtain certification in nursing professional development (NPD), and the NPD Practice Model includes a role description of the NPD practitioner as “learning facilitator.” The model also speaks to the NPD’s role in both continuing nursing education and interprofessional education (Harper & Maloney, 2016). Thus, NPD practitioners have found the guidance and resources needed to connect their roles of continuing nurse educator and professional development practitioner.

I strongly believe that these advances have contributed to where I am today—40 years later—working with RNs in transition in a position I find challenging and rewarding. These key milestones have also helped to direct the forward advancement of continuing education and professional development, and over the years I have been happy to see that The Journal of Continuing Education in Nursing has been there to report on the progress!

Note. Readers may access a collection of this and other 50th anniversary guest editorials, along with classic articles and American Nurses Association landmark statements, online for free during our 50th anniversary year, at https://www.healio.com/nursing/journals/jcen/50th-anniversary-collection.

REFERENCES


