Part 3

Future QA Report

Literature Review

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Future QA Report, Literature Review

First published March 2017. Updated June 2017.

Additional copies of this booklet may be obtained at **www.cno.org**, or by contacting the College's Customer Service Centre at 416 928-0900 or toll-free in Canada at 1 800 387-5526.

College of Nurses of Ontario
101 Davenport Rd.
Toronto ON M5R 3P1

www.cno.org

Background

Statement of purpose

The College's Quality Assurance (QA) Program supports its important commitment to the public – that nurses are engaged in continuing competence and quality improvement.

In March 2016, Council reviewed the College's current QA Program and its purpose. During the meeting, Council identified a number of areas including risks and challenges, key principles, nurse and public engagement, and use of technology.

The purpose of this March 2017 discussion is to provide a clear direction about what Council could consider as it embarks on a review toward a future vision and model for QA.

Council has identified the need to enhance the program as a major priority. It will be addressed at every Council meeting in 2017 (see Attachment 1 on page 16).

This report has been prepared to support Council's ongoing discussions. It summarizes the evidence gathered from a systematic review of peer-reviewed, academic literature.

Questions for Council members

As you review this report, please keep in mind the following questions:

- What main areas in the literature do you consider important to the College's future QA Program?
- In light of the evidence, what are the gaps or areas for further consideration?

The current state of the College's QA Program

The purpose of the QA Program is to assure the public that nurses demonstrate their commitment to continuing competence and quality improvement.

Under the *Regulated Health Professions Act, 1991* (RHPA), all regulatory colleges are expected to establish QA Programs to promote continuing competence and quality improvement among members.

Section 80.1 (b) and (c) of the *Health Professions Procedural Code* (the Code) clearly articulates that a QA Program must include: self, peer and practice assessment, as well as a mechanism for monitoring members' participation in, and compliance with, the program. Find the legislation that is related to the QA Program in the online Council portal.

Currently, the College's QA Program reflects the expectations in the RHPA and *Nursing Act*. All members registered in the General and Extended classes are expected to participate in Self-Assessment. To do this, members reflect on their practice, identify learning needs and develop a Learning Plan to promote their continued competence.

Key questions guiding the literature review

Council's discussions in December 2016 and input from meetings with the QA Committee informed the following questions:

1. What are the primary components of QA Programs for regulated health professionals?
- Definitions and purpose
- Approaches and components, including best practices
- Recommended assessment types, sample sizes and criteria for selection

2. What does the literature indicate about the following components of QA, as specified in the RHPA?
- Continuing education
- Professional development
- Continuing competence
- Standards of practice
- Quality improvement
- Advances in technology
- Self, peer and practice assessments
- Interprofessional collaboration

3. To what extent do regulatory frameworks affect QA Programs?

For more information about methodology used for the literature search, selection and analysis, refer to the *Future QA: Annotated Bibliography*.

Themes

The purpose of this literature review is to explore the existing evidence related to QA Programs for regulated health professions.

The review identified four emerging themes:

- "Competence" and "continuing competence" as key concepts in defining QA and its purpose
- Foundational elements and primary components of QA Programs
- Risk-based regulatory frameworks as an emerging approach to regulation and implications for QA
- Regulatory responsibility: QA as part of a broader collaborative system

Competence and continuing competence

There are different terms in the literature, used to describe a broad range of QA activities for regulated health professionals. The range of activities associated with QA start with the education and registration requirements, and continue throughout a health professional's career. Literature identifies a variety of terms used to describe QA Programs as listed below:

- Maintenance of Certification (MOC)[1, 2]
- Maintenance of Licensure (MOL)[3]
- Continuous Professional Development (CPD)[4]
- Continuing Professional Competence (CPC)[5]
- Revalidation[6]
- Recertification[7]
- Fitness to Practise[8]

In addition, some particularly important terms have emerged in the literature as key concepts of QA, namely:

- competence and competency
- continuing competence

The term competence was absent from discussion within regulatory frameworks until the 1970s[9]. Terms like "fitness" and "properness" were previously used and mostly associated with the notion of suitability to practise. More recently, "competence" has become a key concept that has shaped the meaning of QA.

"Competence" as a concept takes into account the necessary knowledge, skill and judgment a health professional requires. The themes as identified in the literature have shaped some of the definitions of "competence" and take into account concepts like:

- patient safety
- higher standard of care
- quality of care
- improved performance[10]

These themes are also reflected in the College's definition of competence: "the capability for consistently integrating the required knowledge, skill and judgment for safe, ethical and effective nursing care practice."

By extension, "continuing competence," is defined as the ongoing commitment to integrate and apply a professional's knowledge, skill and judgment with the attitudes, values and beliefs required to practise safely, effectively and ethically in a designated role and setting[11].

To achieve ongoing commitment to continuing competence, the literature also illustrates the need for continuous professional development through which nurses acquire a higher level of competence throughout their career pathways[12].

While terms such as suitability to practise, competence, competency and continuing competence have emerged as key concepts related to QA, they are inconsistently defined and used in the literature. These inconsistencies add complexity to the discussion of QA. Some of the reasons include:

- ongoing debate about the meaning of competence and its assessment[13]
- inconsistent interpretation of competence by different stakeholders (i.e., patients, practitioners, employers and regulators)
- the need for the meaning of competence to be flexible, given the multifaceted nature of practice settings[14]

Despite the different terms and concepts associated with QA, and the complexities in defining them, the literature consistently points out that QA as a regulatory function has a clear purpose: to assure the public that health care professionals are competent and fit to practise throughout their professional careers. To fulfill this purpose, the dimensions of "knowledge, skill and judgment," as included in the definition of "competence" becomes central to QA in any of its forms.

QA regulatory processes and public protection: The link

It is important to note that the research reveals difficulties in establishing a clear "causal" link, rather than an "implied" link, between any QA Program and increased public protection[15]. Evaluating whether a regulatory system increases public protection might rely on assumptions rather than evidence[16]. In addition, the lack of evidence about whether public protection has been enhanced after QA activities may also be due to the difficulties associated with measuring public protection.

There are some ways that regulators can measure public protection. For example, regulatory bodies can measure whether there are links between QA and disciplinary procedures[17]. However, findings from the literature indicate that health regulatory bodies in Ontario have not yet measured whether their QA processes directly result in increased public protection. This is likely related to the fact that QA Programs in Ontario are designed to improve the practice of health professionals, and not to identify and remove unsafe practitioners[18]. Thus, regulators have focused their evaluations on how members feel they have benefited through the program, rather than how public protection has increased.

The extent to which regulatory processes for QA are directly linked to public protection and quality of care outcomes, is still unknown. Further research is required to demonstrate a causal link between QA requirements and public protection.

QA Programs: Foundational elements and primary components

The literature analysis identified two foundational elements for QA Programs:

- underlying philosophies
- components of programs (including assessment types)

Underlying philosophies

In 2011, the Health Professions Council in the U.K. conducted a comprehensive review of QA Programs among health regulated professions in Ontario including dietitians, medical laboratory technologists, occupational therapists, pharmacists and physiotherapists[19].

Physicians, nurses, social workers and dentists were also consulted[20]. The report compared the QA model in Ontario with that of the U.K.

The report revealed that Ontario's QA Programs focus primarily on "quality improvement," which aims to improve the service that practitioners deliver at every level. Conversely, the U.K. model is based on "quality control," which focuses on the minority of practitioners who do not meet the standards.

This demonstrates a broader theme within the literature about shifts in regulatory models that may implicate QA Programs. Specifically, this refers to the emergence of risk-based regulatory approaches for QA, discussed in more detail below.

Components

The literature suggests that QA Programs should include: professional standards of practice; self, peer and practice assessment; continuing education or professional development; a mechanism to monitor participation and compliance.

Professional standards of practice

- One of the roles of professional regulators is to articulate to their registrants the standards, responsibilities and behaviours that constitute safe practice[21].

Self, peer and practice assessment, including approaches and tools such as:

- professional development portfolio
- learning and professional development plan
- self-directed learning modules
- peer feedback techniques (e.g., providing feedback on several occasions is generally more effective than presenting it once[22])
- multi-source feedback (e.g., it strengthens reliability of assessment by including multiple perspectives[23])
- directly tracking assessment and feedback to the individual's practice[24]
- simulation (e.g., a preferred assessment technique[25])

Continuing education or professional development

- Promoting ongoing learning across the continuum of training and practice is considered a best practice for continued QA[26].
- However, literature suggests that continuing education is not sufficient on its own[27, 28].

A mechanism to monitor participation and compliance with the program

- When considering the overall QA monitoring mechanism, it is important to look at a mixed-model approach, and sample sizes and criteria for selection.

Mixed-model approach:

- Literature has identified integrative approaches or triangulation between QA components to increase reliability of QA processes[29].
- It is necessary to use a minimum of two instruments to measure a member's competence (e.g., combining a Self-Assessment tool with patient feedback will likely improve accuracy of measurement mechanisms, and result in a more reliable assessment[30]).

Sample sizes and criteria for selection:

- The existing literature about QA did not directly address how regulators should select their members for Practice Assessment to ensure safety.

- Ontario QA Programs showed sample sizes varied between 2 and 5 per cent of members, depending on the size of the membership[31].
- Common approaches to sampling are addressed in the literature on risk-based regulation, as discussed below.

Risk-based regulatory frameworks

The underlying philosophy or focus of the regulatory framework has significant effects on the design of a particular QA Program. QA Programs that focus on quality improvement have different implications than those that are based on quality control.

A focus on quality control or risk-based approaches to regulation was a strong theme in the literature. Key findings include:

- Regulatory interventions should focus on controlling the greatest potential threats to achieving regulatory objectives. This is done by using pre-determined probability and consequences of risk[32].

- Developing QA processes that are proportionate and effective at mitigating risk within a risk-based regulatory approach requires a clear understanding of practice settings and professional tasks[33].

- This approach commonly fails due to two types of errors[34]:
  - **False alarms or false negatives:** When assessments incorrectly identify a professional as unfit. This can result in cost implications and present difficulties for health professionals and their employers.
  - **False positives:** When the system fails to identify someone who is not fit to practise. These present greater risk than false negatives.

- Challenges to implementing risk-based regulatory approaches[35] include:
  - **Defining risk-based quality standards or thresholds:** Given that the concept of quality is ambiguous and contested, there is a struggle to pre-determine acceptable risk.
  - **Assessing care quality "risks":** While Peer Assessments were traditionally key to addressing quality, the objectivity and credibility of this approach is questioned. However, when assessments are not conducted by peers, it is challenging to match expertise to the assessment.
  - **Enforcing quality:** It is difficult to use a pre-determined tool (i.e., risk matrix that assesses the probability and consequence of regulatory breaches) to select appropriate enforcement when adverse events occur.

- Four pre-conditions that need to exist for risk-based regulatory approaches to work, include[36]:
  - Regulatory goals must be clear and it should be possible to pre-determine and agree on acceptable risk.
  - Regulators must be able to reliably assess the probability and consequences of adverse outcomes that are unacceptable.
  - Regulators must have a range of enforcement tools to use effectively in response to increasing risk.
  - There must be tolerance for adverse outcomes that have been pre-defined as acceptable risks.

Using elements of risk-based approach to sampling

Some elements of a risk-based approach can successfully combine with a mixed-model

approach to select members for Practice Assessment. The most common approach to sampling appears to be combination of stratified random sampling with targeted elements (i.e., in which practitioners undergo self, peer and/or practice)[37].

Some regulators have implemented risk-based approaches to selecting members for Practice Assessment. For instance, the College of Occupational Therapists of Ontario has implemented a two-stage assessment[38]. A random sample selection requires members to complete multi-source feedback and submit their Learning Plan to the college. Assessment results for all members are then compiled. Members in the tenth percentile who scored the lowest, are required to participate in the Peer Assessment. This approach targets professionals who pose the greatest risk to the public and has proven to be successful.

Other health professional regulators in Ontario use different strategies for selecting practitioners for Peer Assessment. Some colleges target individuals who have been in practice for a longer period of time, as they represent a higher risk group[39].

The literature about risk-based regulation illustrates how risk-based approaches can integrate into existing QA Programs, such as in the examples above. In the literature, the concept of risk is discussed in the context of mixed-model approaches to sampling, and choosing the appropriate regulatory mechanisms for different types of practitioners. However, regulators views differ when it comes to ideal sampling size and selection criteria.

QA: Part of a broader collaborative system

Professional collaboration in a QA Program should include three key concepts:

System of shared responsibility

- Competence is a shared responsibility between the profession, individual practitioners, professional organizations, credentialing and certification entities, regulatory agencies and employers[40].
- A cohesive system of shared responsibility should be created[41].
- Existing QA systems are generally coordinated by the regulator. If regulators were to use a more collaborative approach, engagement with employers and organizations would be required[42].

Member engagement and collaboration with employers and regulators

- Engaging members to participate in QA Programs is essential. Literature reported opportunities for additional education programs and workplace learning to influence nurse participation and engagement in continuous professional development[43].
- There is a need for collaboration among employers, managers, education, institutions and professional associations to create a conducive learning climate for nurses.
- The future of regulation may not lie in more regulation, but rather in ensuring that existing regulatory systems speak to each other, and various regulators work more closely together[44].

Interprofessional collaboration

In recent years, there has been public concern about the lack of communication between health professionals. As a result, "interprofessional collaboration" has emerged in the literature. It is described as: shared responsibility by both team and individual for client care[45].

To align with this new phenomenon, the government recently revised the RHPA to address and promote this concept in QA requirements. The amendments state that QA Programs must promote interprofessional collaboration[46].

Despite efforts to emphasize the importance of interprofessional collaboration in QA Programs, the literature reported:

- challenges in understanding legal, professional, and regulatory guidelines and standards of different professions, which were considered to be barriers to interprofessional practice[47]
- Ontario colleges had unclear expectations about the intent of the amendments[48]
- broader collaboration among regulatory bodies in Ontario is required[49].

The literature revealed that implementing interprofessional collaboration in QA Programs requires commitment from a range of stakeholders including regulatory bodies, professional organizations, educators and patient or consumer groups[50]. These findings are consistent and linked with the concept of QA as part of a broader collaborative system.

Gaps in the literature

The literature provided substantive information about:

- definitions and purpose of QA Programs
- different components that regulators use to implement QA
- regulatory approaches including best practices, assessment types and strategies for sample selection
- regulatory responsibility for QA, as part of a broader collaborative system.

However, the findings indicated that the following themes require further investigation:

Effect of QA on increased public protection and quality of care

The literature does not fully address the link between regulatory activities related to QA and their effect on public protection and quality of care (e.g., patient safety, outcomes and engagement).

Public engagement

Given the limitation discussed above, more information is needed about the public's understanding of QA, and their perceived needs from regulatory QA Programs.

Recommended sample size and selection criteria

There is no recommended one-size-fits-all sample size for QA. Risk-based approaches continue to be integrated into the ways regulators select and target practitioners for assessment. The environmental scan should provide us with additional information about the ways other regulators approach sampling and selection.

Alternative regulatory frameworks other than risk-based approach

While the risk-based approach was a strong trend in the literature, other regulatory frameworks were not explored. It is possible that risk-based approach emerged because of a lack of well-defined regulatory frameworks to date. However, further research is required to determine whether there are well-defined, alternative frameworks to the risk-based approach, and if those frameworks could affect the way QA Programs are developed and implemented.

Next steps

At the next Council meeting in June, Council members will review and discuss an environmental scan of national and international QA practices and programs. Council members will have an opportunity to compare them to the College's current QA Program.

References

[1] Boulet, J., & Zanten, M. (2014). Ensuring high-quality patient care: the role of accreditation, licensure, specialty certification and revalidation in medicine. Medical Education, 48(1), 75-86. http://doi.org/10.1111/medu.12286

[2] Horsley, Tanya, Moreau, Katherine, Lockyer, Jocelyn, Zeiter, Jeanie, Varpio, Lara, Campbell, Craig, et al. (2016). More Than Reducing Complexity: Canadian Specialists' Views of the Royal College's Maintenance of Certification Framework and Program. Journal of Continuing Education in the Health Professions, 36, 157-163. http://doi.org/10.1097/CEH.0000000000000099

[3] Boulet, J., & Zanten, M. (2014). Ensuring high-quality patient care: the role of accreditation, licensure, specialty certification and revalidation in medicine. Medical Education, 48(1), 75-86. http://doi.org/10.1111/medu.12286

[4] Plaus, K., Muckle, T. J., & Henderson, J. P. (2011). Advancing Recertification for Nurse Anesthetists in an Environment of Increased Accountability. *AANA Journal, 79*(5), 413-418. http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=104605453&site=ehost-live

[5] Ibid.

[6] Council for Healthcare Regulatory Excellence (Now the Professional Standards Authority for Health and Social Care) (2012.) An approach to assuring continuing fitness to practise based on right-touch regulation principles. http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf

[7] Ibid.

[8] Ibid.

[9] Vernon, R., Chiarella, M., & Papps, E. (2011). Confidence in competence: legislation and nursing in New Zealand. *International Nursing Review, 58*(1), 103-108. http://doi.org/10.1111/j.1466-7657.2010.00853.x

[10] Church, Cory & MSN, RN-BC. (2016). Defining Competence in Nursing and Its Relevance to Quality Care. Journal for Nurses in Professional Development, 32, E9-E14. http://doi.org/10.1097/NND.0000000000000289

[11] Case Di Leonardi B. & Biel M. (2012). Moving forward with a clear definition of continuing competence. Journal of continuing education in nursing, 43(8), 346-351; quiz 352-353. http://doi.org/10.3928/00220124-20120116-18

[12] Takase M. (2013). The relationship between the levels of nurses' competence and the length of their clinical experience: A tentative model for nursing competence development. Journal of Clinical Nursing, 22, 1400-1410. http://doi.org/10.1111/j.1365-2702.2012.04239.x

[13] Vernon, R., Chiarella, M., & Papps, E. (2011). Confidence in competence: legislation and nursing in New Zealand. *International Nursing Review, 58*(1), 103-108. http://doi.org/10.1111/j.1466-7657.2010.00853.x

[14] Ibid.

[15] Health Professions Council. (2011). An exploration of quality assurance programs in professional regulators in Ontario, Canada. Retrieved from http://www.hcpcuk.org/assets/documents/1000361CReportofinternationalrevalidationstudy-FINAL.pdf

[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] Health Professions Council. (2011). An exploration of quality assurance programs in professional regulators in Ontario, Canada. Retrieved from http://www.hcpcuk.org/assets/documents/1000361CReportofinternationalrevalidationstudy-FINAL.pdf

[20] Ibid.

[21] Council for Healthcare Regulatory Excellence (Now the Professional Standards Authority for Health and Social Care) (2012.) An approach to assuring continuing fitness to practise based on right-touch regulation principles. http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf

[22] Brehaut, J. C., Colquhoun, H. L., Eva, K. W., Carroll, K., Sales, A., Michie, S., . . . Grimshaw, J. M. (2016). Practice Feedback Interventions: 15 Suggestions for Optimizing Effectiveness. Annals of Internal Medicine, 164(6), 435-441. http://doi.org/10.7326/M15-2248

[23] Health Professions Council. (2011). An exploration of quality assurance programs in professional regulators in Ontario, Canada. Retrieved from http://www.hcpcuk.org/assets/documents/1000361CReportofinternatio

nalrevalidationstudy-FINAL.pdf

[24] Eva, K. W., Bordage, G., Campbell, C., Galbraith, R., Ginsburg, S., Holmboe, E., & Regehr, G. (2016). Towards a program of assessment for health professionals: From training into practice. Advances in Health Sciences Education, 21(4), 897-913. http://doi.org/10.1007/s10459-015-9653-6

[25] Bluestone, J., Johnson, P., Fullerton, J., Carr, C., Alderman, J., & BonTempo, J. (2013). Effective in-service training design and delivery: evidence from an integrative literature review. Human Resources for Health, 11, 26. http://doi.org/10.1186/1478-4491-11-51

[26] Eva, K. W., Bordage, G., Campbell, C., Galbraith, R., Ginsburg, S., Holmboe, E., & Regehr, G. (2015). Towards a program of assessment for health professionals: from training into practice. Advances in Health Sciences Education, 21(4), 897-913. http://doi.org/10.1007/s10459-015-9653-6

[27] Plaus, K., Muckle, T. J., & Henderson, J. P. (2011). Advancing Recertification for Nurse Anesthetists in an Environment of Increased Accountability. *AANA Journal, 79*(5), 413-418. http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=104605453&site=ehost-live

[28] Bluestone, J., Johnson, P., Fullerton, J., Carr, C., Alderman, J., & BonTempo, J. (2013). Effective in-service training design and delivery: evidence from an integrative literature review. Human Resources for Health, 11, 26. http://doi.org/10.1186/1478-4491-11-51

[29] Eva, K. W., Bordage, G., Campbell, C., Galbraith, R., Ginsburg, S., Holmboe, E., & Regehr, G. (2016). Towards a program of assessment for health professionals: From training into practice. Advances in Health Sciences Education, 21(4), 897-913. http://doi.org/10.1007/s10459-015-9653-6

[30] Council for Healthcare Regulatory Excellence (Now the Professional Standards Authority for Health and Social Care) (2012.) An approach to assuring continuing fitness to practise based on right-touch regulation principles.

[31] Ibid.

[32] Beaussier, A.-L., Demeritt, D., Griffiths, A., & Rothstein, H. (2016). Accounting for failure: risk-based regulation and the problems of ensuring healthcare quality in the NHS. Health, Risk & Society, 1-20. http://doi.org/10.1080/13698575.2016.1192585

[33] Council for Healthcare Regulatory Excellence (Now the Professional Standards Authority for Health and Social Care) (2012.) An approach to assuring continuing fitness to practise based on right-touch regulation principles.

[34] Ibid.

[35] Beaussier, A.-L., Demeritt, D., Griffiths, A., & Rothstein, H. (2016). Accounting for failure: risk-based regulation and the problems of ensuring healthcare quality in the NHS. Health, Risk & Society, 1-20. http://doi.org/10.1080/13698575.2016.1192585

[36] Beaussier, A.-L., Demeritt, D., Griffiths, A., & Rothstein, H. (2016). Accounting for failure: risk-based regulation and the problems of ensuring healthcare quality in the NHS. Health, Risk & Society, 1-20. http://doi.org/10.1080/13698575.2016.1192585

[37] Ibid.

[38] Health Professions Council. (2011). An exploration of quality assurance programs in professional regulators in Ontario, Canada. Retrieved from http://www.hcpcuk.org/assets/documents/1000361CReportofinternationalrevalidationstudy-FINAL.pdf

[39] Ibid.

[40] Levine, J., & Johnson, J. (2014). An organizational competency validation strategy for registered nurses. Journal for nurses in professsional development, 30(2), 58-65. http://doi.org/10.1097/NND.0000000000000041

[41] Eva, K. W., Bordage, G., Campbell, C., Galbraith, R., Ginsburg, S., Holmboe, E., & Regehr, G. (2015). Towards a program of assessment for health professionals: from training into practice. Advances in Health Sciences Education, 21(4), 897-913. http://doi.org/10.1007/s10459-015-9653-6

[42] Schafheutle, E. I., Hassell, K., & Noyce, P. R. (2013). Ensuring continuing fitness to practice in the pharmacy workforce: understanding the challenges of revalidation. Research in Social and Administrative Pharmacy, 9(2), 199-214. http://doi.org/10.1016/j.sapharm.2012.08.007

[43] Brekelmans, G., Poell, R. F., & Kees, v. W. (2013). Factors influencing continuing professional development. European Journal of Training and Development, 37(3), 313-325. http://dx.doi.org/10.1108/03090591311312769

[44] Spencer-Lane, T. (2014). Safeguarding the public by regulating health and social care professionals: lessons from Mid-Staffordshire and the Law Commission review. The Journal of Adult Protection, 16(1), 52-59. http://dx.doi.org/10.1108/JAP-06-2013-0024

[45] Ries, N. M. (2016). Innovation in Healthcare, Innovation in Law: Does the Law Support Interprofessional Collaboration in Canadian Health Systems? Osgoode Legal Studies Research Paper No. 64/2016. http://dx.doi.org/10.2139/ssrn.2820057

[46] Health Professions Council. (2011). An exploration of quality assurance programs in professional regulators in Ontario, Canada. Retrieved from http://www.hcpcuk.org/assets/documents/1000361CReportofinternationalrevalidationstudy-FINAL.pdf

[47] Ries, N. M. (2016). Innovation in Healthcare, Innovation in Law: Does the Law Support Interprofessional Collaboration in Canadian Health Systems? Osgoode Legal Studies Research Paper No. 64/2016.

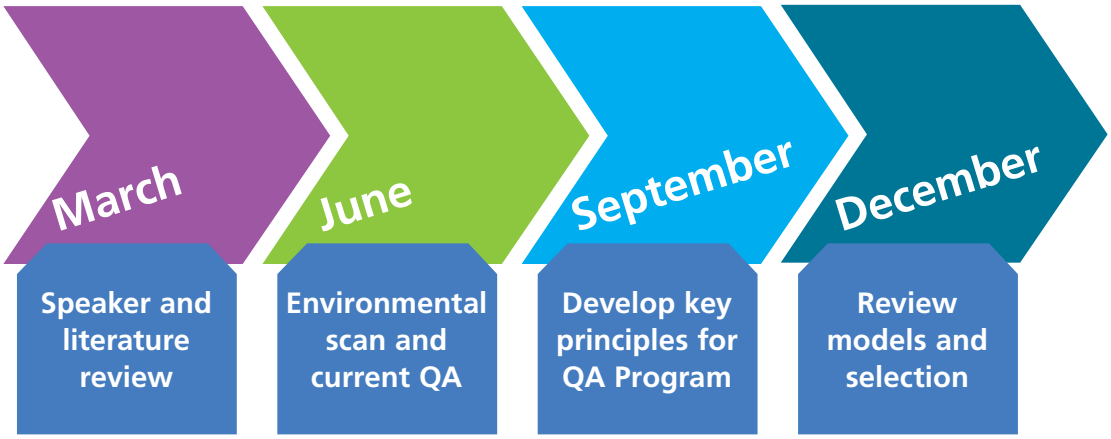
[48] Regan, S., Orchard, C., Khalili, H., Brunton, L., & Leslie, K. (2015). Legislating interprofessional collaboration: A policy analysis of health professions regulatory legislation in Ontario, Canada. Journal of interprofessional care, 29(4), 359-364. http://dx.doi.org/10.3109/13561820.2014.1002907

[49] Ibid.

[50] Helfawi, M. (2015). Patient involvement in Interprofessional Collaboration, a catalyst to the delivery of patient-centered care at community-based mental health settings. Master of Health Sciences (Doctoral dissertation, University of Ontario Institute of Technology). https://ir.library.dcuoit.ca/xmlui/bitstream/handle/10155/508/Helfawi_May.pdf?sequence=1

Attachment 1: Future QA Project Plan

The Plan for 2017



Future QA Report

Literature Review

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

101 Davenport Rd.
Toronto, ON
M5R 3P1
www.cno.org

Tel.: 416 928-0900
Toll-free in Canada: 1 800 387-5526
Fax: 416 928-6507

June 2017
2017-82