Future QA PROGRAM

Jurisdictional Review Report

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

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Jurisdictional Review Report: Future QA Report,

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Background

This report explores trends and current practices in Quality Assurance (QA) programs among other health regulatory bodies in Ontario, Canada and internationally. Council can consider the report's findings and lessons learned from other jurisdictions as other pieces of evidence in the development of the College's Future QA Program.

Objectives

The purpose of this report is to identify approaches taken by other jurisdictions in relation to QA programs. The following areas were explored in the review:

- QA legislation, regulations and by-laws
- QA components (including continuing education, self, peer and practice assessment)
- QA frameworks and processes
- Assessment methods and tools for assessing competence
- Compliance mechanisms (including approaches to sampling and selection)
- Stakeholder engagement (including the public, health care professionals and employers).

Scope of the review

The scope of this review is broad. It explores:

- 24 regulated health professions in Ontario, Canada[a]
- 12 Registered Nurse and/or Nurse Practitioner regulatory bodies in Canada
- 12 Licensed Practical Nurse regulatory bodies in Canada
- Select international health regulated professions, including:
  - Nursing, Medicine, and Pharmacy in the United Kingdom, Australia and New Zealand[b]
  - Three state boards of nursing in the United States – California, Texas and Massachusetts.[c]

This review only includes examples from nursing and other health regulated professions. Non-health professions were excluded from this review. A recent jurisdictional review of quality assurance programs for both health and non-health professions found that health professions have more uniform and robust QA programs than non-health professions.[1] This may stem from the fact that there is no over-arching legislation defining the requirement for, and structure of, a quality assurance program.[2]

Methodology

Information on other health regulators' QA programs was gathered from a thorough review of their websites related to:

- Specific sections of regulations and/or by-laws on QA requirements
- Relevant QA content on web pages
- Statements of purpose on QA programs
- Assessment methods and frameworks
- QA data from annual reports
- Position statements
- QA publications and other relevant resources.

[a] 24 out of the 26 health professions were reviewed. Two recently regulated professions, Homeopathy and Psychotherapy, are still in the process of developing their QA programs.

[b] These professions were selected because they represent the largest groups of allied professions, and the geographical regions have a long history of regulating the professions in the public interest.

[c] The College consulted with the National Council of State Board of Nursing (NCSBN) regarding continuing competence. Given the lack of resources by NCSBN in this area, the College explored, as case studies, how three state boards of nursing regulate continuing competence programs.

In cases where recent changes to QA programs were noted or where there was insufficient information on the websites, College staff contacted the regulators by telephone and/or email.[d] The grey literature, which includes a number of publications, reports and papers published by some organizations, is also integrated in the review.

Guiding questions

The following guiding questions were used when reviewing QA programs:

- What are the main QA components most commonly used by regulators?
- What types of assessment methods and tools do they use?
- What types of methods do they use to select members to participate in their QA programs?
- How do regulators ensure members' compliance of QA requirements?
- To what extent do regulators engage with stakeholders, including the public, health care professionals and employers?
- What are the most recent trends and best practices in QA programs across all jurisdictions?

Emerging themes from the review

The review revealed the following themes emerging from recent changes made by nursing and health regulatory bodies' in relation to QA programs.

Ontario

In Ontario, there are a number of factors influencing regulators to enhance their QA programs and processes. These factors include:

- A shift in culture in terms of looking at continuing competency throughout health professionals' careers as opposed to entry-to-practice competencies
- A need for stronger assessment methods and tools (for example, implementation of multiple assessment tools, including multisource feedback)
- A need to encourage the professions to advance their skills through ongoing professional development
- A need to leverage technology to enhance functionality of QA processes
- A need for revising assessment tools that no longer reflect best practices.

Canada

The review highlighted that nursing regulatory bodies in the rest of Canada have different legislative frameworks than in Ontario with respect to their QA programs. The most distinct feature of their legislative frameworks is a lack of a practice assessment component. Recent trends show that nursing regulators in Canada are also beginning to introduce multiple assessment methods, namely multisource feedback in terms of enhancing their continuing competence program.[e]

International

The review of nursing and other health care profession regulators in the United States, the United Kingdom, Australia and New Zealand revealed the following emerging themes:

- Strong collaboration between regulators, employers and members of the profession
- Emphasis on the goal of the program to protect the public (for example, a revalidation process)
- Establishment of an integrative system amongst regulatory activities, employer appraisals and engagement with the public.

[d] The College further consulted by email and/or telephone with select Ontario health regulators, including: dental hygienists, dieticians, massage therapists, occupational therapists, naturopaths and physiotherapists. Four Canadian RN regulators were also consulted, including: Alberta, Nova Scotia, Manitoba and British Columbia.

[e] Most RN and LPN nursing regulatory bodies use the term "Continuing Competency Program" (CCP), which is equivalent to the QA program in Ontario.

Overall

Regulators are beginning to use innovative approaches to quality assurance by integrating multiple methods of assessment and using technology to achieve better outcomes. Engagement with the public, members and employers is still lagging among Ontario health regulators and nursing regulatory bodies in Canada. Some of the approaches toward engagement taken by nursing regulatory bodies in the United Kingdom and New Zealand offer valuable lessons for health profession regulators in Canada.

Health Regulated Professions — Ontario, Canada

Legislative framework — The *Regulated Health Professionals Act, 1991*

There are 26 health care professions in Ontario regulated under the *Regulated Health Professions Act, 1991* (RHPA). The act sets the legislative requirement for all regulated health professionals to establish a quality assurance program.

As defined in Schedule 2 of the *Health Professions Procedural Code*, the purpose of the QA program is to "assure the quality of practice of the profession and to promote continuing evaluation, competence and improvement among the members."[3] The RHPA also sets the minimum requirements that each profession must have in a Quality Assurance program, including:

(a) continuing education or professional development designed to
  (i) promote continuing competence and continuing quality improvement among the members
  (i.1) promote inter-professional collaboration
  (ii) address changes in practice environments
  (iii) incorporate standards of practice, advances in technology, changes made to entry-to-practice competencies and other relevant issues in the discretion of the Council
(b) self, peer and practice assessments
(c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program.[4]

Each profession sets its own regulations for additional profession-specific QA requirements and components in their individual Act. While the QA regulations align with the minimum requirements established in the RHPA, individual regulatory colleges execute these common requirements in a variety of ways. More specifically, there is variation in terms of how the continuing education or continuing professional development components are applied, as well as the mechanisms used for assessment of competence and compliance with the program.

Objectives of QA programs across the province

The objectives of the QA programs are consistent across the province: quality improvement of health professionals' knowledge, skill and judgment to ensure public protection.

The underlying assumption is that requiring members to be engaged in ongoing learning and improvement contributes to the protection of the public. Precisely how and why engagement in quality improvement assures public protection does not appear to be clearly articulated by health regulatory bodies in Ontario.

For example, all Ontario health regulators report QA outcomes on their annual reports. However, the data focuses predominantly on the percentage of members that participated in the QA program and the resulting outcomes. There is an opportunity for health profession regulators to clearly articulate the link between the QA outcomes for individual members with the greater goal of public protection.

QA components and compliance mechanisms

There is variation in the main components used by health regulators and how they operate:

Continuing education (CE) or continuing professional development (CPD)

Continuing education or continuing professional development is one of the mandatory requirements that all health professional regulatory colleges are required to integrate in their QA programs. All Ontario health regulators meet this requirement. However, the way in which it is applied in practice varies across the professions. Some colleges require their members to complete different activities that may be self-directed, group activities, and/or accredited or unaccredited activities by specific institutions.[5]

These types of activities are usually implemented in QA programs as number of hours or credits accredited or unaccredited by institutions. Eighteen of 24 Ontario health regulators require members to participate in a minimum amount of hours in a specific activity.[6] Whereas the rest of the regulators do not set minimum standards for this requirement. Some regulators identify the specifics of the minimum continuing education and/or continuing professional development requirements in their regulations. For example, dental technologists specify that after registration, members must obtain at least 90 continuing quality improvement credits in every three-year period.[7]

The regulatory colleges that require their members to be involved in certain activities also expect completion of those activities within a specified timeframe, usually measured in years. Chiropractors are required to complete 40 hours of continuing education activities, of which a minimum of 20 hours must be in structured continuing education (CE) activities and a minimum of 20 hours in unstructured CE activities over a two-year period.[8]

Tracking, reporting and documenting CE and CPD requirements

Ontario health regulators use different methods of tracking health professionals' records of CE and CPD completion. They are often referred to as: Professional Portfolios, Learning Portfolios and Professional Development Plans. Some regulators track and collect this information online, some use paper-based processes and others do not track this information at all. More recently, a number of jurisdictions are integrating online processes for tracking, reporting and documenting CE and CPD requirements.

In the case of physicians, all members of the College of Physicians and Surgeons of Ontario (CPSO) are required to report their CPD activities to one of three approved bodies:[9]

- Royal College of Physicians and Surgeons of Canada (Maintenance of Certification (MOC) Program)
- College of Family Physicians of Canada (Maintenance of Proficiency+ (Mainpro+))
- Medical Psychotherapy Association of Canada.

This is a unique reporting mechanism used only by CPSO. They require proof of the official confirmation document that members receive by one of the approved tracking organizations.[10]

Most commonly, regulators require their members to keep track and record completion of CPD requirements, whereas others require proof of the CPD requirement only when selected for the peer or practice assessment.

Self-assessment tools

Self-assessment is a requirement for all Ontario health professions to integrate into their QA programs. This is a requirement that members have to complete and acknowledge completion of thorough self-declaration mechanisms. The objective of a self-assessment process, as identified by most Ontario health regulators, is to help members identify and address learning needs or gaps through a reflective process and the development of their learning plans.

The methods and tools that regulators use to address the self-assessment requirement varies. Some regulators use basic questionnaires that outline lists of competencies specific to the profession.[11] Through the completion of the questionnaire, health professionals are encouraged to self-identify whether or not they meet the expected competencies set by the regulator. This is one of the most common tools that regulators use to determine health professionals' gaps in competence.

More involved methods of self-assessment are used among pharmacists, physiotherapists, chiropodists, physicians and dentists, including the use of a guided reflection as part of the self-assessment component.[12] This involves the collection of data or information from alternate sources to inform decisions regarding where improvement may be needed. Dentistry uses an online 200-question multiple choice and case study examination based on peer derived standards.[13] This is an example of a guided reflection process in which health professionals complete a multiple choice exam that helps them identify their learning needs.

Compliance mechanisms for the self-assessment component

A few regulators have made completion of self-assessment a mandatory requirement for their members, while others only use self-declaring mechanisms. For example, the College of Dental Hygienists of Ontario (CDHO) requires all members to complete the self-assessment tool annually using an online portal.[14] This tool helps dental hygienists assess their practice and identify learning goals that will direct their continuing education, professional development and continuing quality improvement activities.[15]

The CDHO uses a third-party vendor to collect and analyze the results of a member's submission.[16] If the results indicate that they "partially" meet the standard, they are then advised to work on the gaps and include them in their learning goals. Those that do not complete the self-assessment tool are then selected to participate in next year's peer and practice assessment.[17]

The College of Dietitians has taken a similar approach in making the self-assessment tool mandatory. In 2011, it implemented a verification process to make sure that the Self-Directed Learning tool (SDL) is submitted annually.[18] As well, every year, approximately 10% of SDL tools are randomly selected, and those members whose tools are found incomplete or inadequate in the last two years are referred to the QA Committee.[19]

Most regulators simply encourage members to complete an annual self-assessment and require them to acknowledge completion through self-declaration at annual renewal. Only a few regulators are using more robust mechanisms to ensure its compliance.

Peer and practice assessment

Methods and tools for assessing competence

All health regulatory colleges mandate the peer and practice assessment components and set specific expectations through QA regulations. However, they use different types of assessment methods to evaluate health professionals' competence. Some of the most commonly used assessment methods include:[20]

- CPD portfolio review/audit
- Practice site visits
- Chart reviews
- Examinations
- Behavioural interviews
- Multisource feedback
- Objective structured clinical examination (OSCE) or simulation.

These assessments are typically evaluated by assessors who are referred to as "peers".[21] Peer assessors are also members of the profession. Regulations outline how a Quality Assurance Committee requires peers to conduct the assessment of a member's competence and in what context. The most frequently used method of assessment among regulators is CPD portfolio review audit.[22] Another commonly used assessment method is practice site visits.[23] This assessment involves a peer assessor visiting the member's primary practice setting for about half a day. Specific clauses in QA regulations allow peer assessors to have access to a member's facilities to conduct the assessment and access patient/client charts.

Chart reviews and/or chart stimulated recalls are assessment methods used by a number of professions, including optometrists, opticians, physicians, physiotherapists and dieticians.[24] This type of assessment usually involves a review of the professional's patient care. Chart stimulated recalls involve a more formal, structured and in-depth interview process between the health professional and the assessor.[25] The intent of this type of assessment is to stimulate deeper reflection and discussion regarding patients' care plans.[26]

In addition, simulation-based assessments are used among pharmacists and NPs. Generally, this type of assessment is in the form of objective structured clinical examinations (OSCE). These examinations consist of multiple stations, each simulating a unique clinical scenario of real practice interactions.[27]

More recently, health regulatory colleges have implemented assessment strategies based on multisource feedback. For example, dieticians, medical radiation technologists, occupational therapists, physicians and opticians have established this approach, which allows practitioners to have a better understanding of their performance based on their peers' feedback. This assessment is based on feedback collected by members from their colleagues and patients.[28] Dieticians are required to collect at least six anonymous surveys from colleagues and nine from patients, whereas medical radiation technologists require feedback from six colleagues and 15 patients.[29] The multisource feedback is usually the initial assessment conducted in a two-step process of the peer and practice assessment as demonstrated in the section below.

Peer and practice assessment frameworks

There are two distinct frameworks Ontario health regulatory colleges have established for the peer and practice assessment component of QA programs:[30]

1. Single-level framework
2. Tiered/laddered framework.

Single-level framework

Eighteen of 24 health regulators use a single-level framework where members who participate in the QA program are randomly selected for the same assessment (See Attachment 1 – Single-level framework, Peer and Practice Assessment, Ontario).

Tiered/laddered framework

Six of 24 health regulators have recently implemented a two-step, layered framework: occupational therapists, dental hygienists, dietitians, physicians, optometrists and opticians. All selected members are required to participate in an initial assessment, often collecting feedback from multiple sources.[31] If the results of their assessments are not satisfactory, they are required to participate in a more in-depth assessment (See Attachment 2 – Tiered/laddered framework, Peer and Practice Assessment, Ontario).

Findings from the College of Dieticians of Ontario[32]

An example of this tiered approach is demonstrated by the College of Dieticians of Ontario (CDO). Prior to 2012, the College conducted behavioural interviews for 2% of its membership annually (approximately a total of 4,000 members). The College felt they were not meeting the legislative mandate of the QA program by engaging such a small number of members annually. However, engaging with more members through behavioural interviews was costly.

Instead, CDO implemented a two-step process, where 10% of members were selected to participate in multisource feedback. According to their data, 91% of participants successfully complete Step 1 and exit the program. The 9% who are not successful are required to move on to Step 2 as shown in Attachment 3 – Peer and Practice Assessment framework, College of Dietitians of Ontario.

Step 2, part of the peer and practice assessment, involves a behaviour-based interview conducted by a peer assessor. A chart review is conducted if the dietician provides direct patient care.[33] The QA Committee may require a member to undertake continuing education or a practice enhancement program when Step 2 results identify practice concerns or learning needs.[34] In extreme circumstances, the Committee may impose terms, conditions or limitations until the member meets the required standards of practice.[35] With this innovative approach, CDO has been able to engage more meaningfully with members.

Compliance mechanisms – approaches to selection and sampling

The selection criteria and sample size of members selected to participate in an assessment also varies among professions.

Data from annual reports reveals that between 1 and 20% of health professionals are selected to participate in practice assessment annually. However, the majority of regulators select on average between 2 to 5% of their members. The Ontario College of Pharmacists selects one of the highest percentage of practitioners: 20% of pharmacists who provide direct care to patients.[36]

Health regulators use different strategies to select members to participate. For example, 12 regulators randomly select their members to participate in peer and practice assessment.[37] Two regulators select members to participate, if there is evidence of non-compliance with the QA program or other practice related concerns, and 10 regulators select participants using a mixed approach of these strategies.[38]

The selection criteria also depend on: the type of framework or model regulators use; the

cost associated with conducting the peer and practice assessment; non-compliance with QA requirements; age, in the case of physicians; and, for audiologists and speech-language pathologists, not meeting the recent practice requirements.

Recent trends in strategies used by Ontario health regulators to revise QA programs

Regulators have been using different approaches in revising and enhancing their QA programs and processes. Some recent trends include:

- Implementation of multiple assessment methods (including, dietitians, dental hygienists, occupational therapists)
  - Layered framework for peer and practice assessment
  - Implementation of multiple assessment strategies within the peer and practice assessment, including multisource feedback
- Use of technology to increase member engagement and reduce confusion about QA processes (including, occupational therapists, massage therapists)
  - Refreshing the look and functionality of web pages used to access QA requirements as well as the QA requirements themselves, in the case of occupational therapists
  - Online portals for self-assessment component

- **Enhanced stakeholder engagement (including health care professionals and employers)**
  - Regulators are making efforts to better engage with stakeholders
  - For example, audiologists and speech-language pathologists have developed specific resources for employers

- **Regulators focusing on risk (for example, physiotherapists, massage therapists)**
  - The College of Physiotherapists recently examined factors associated with risk to competence/performance, and are developing a framework for assessing risk and methods of mitigating risk[39]
  - The study's findings related to risk areas will be taken into consideration when developing a new QA program in the near future. Some main findings noted in the study related to:[40]
    - Age as a significant factor in relation to competence
    - Gender – more specifically being male – as a risk to competence in a number of areas
    - Members subject to investigation as a risk for further investigations
    - Non-compliance in one area as linked to non-compliance in another area
    - Location of education as a risk to competence
    - Frequent changes in worksite as a risk to competence
    - Personal wellness as it impacts competence/performance
  - The College of Massage Therapists is moving to a selection process that considers risk factors, such as history of late completion or submission of mandatory QA tools (patterns of behaviour), practising in identified high risk sectors (not yet identified), ICRC or disciplinary history and a component of random selection[41]

- **Review of QA data to enhance the peer and practice assessment processes (for example, occupational therapists, physiotherapists)**
  - Occupational therapists are reviewing data from the two-step process of their peer and practice assessment to understand if it is the best and most valid method of selecting members to move from Step 1 to Step 2 of the assessment process[42]
  - They plan on using their findings to possibly revise the two-step process.

Nursing Regulatory Bodies – Canada

Legislative framework

Registered Nurse/Nurse Practitioner and Licensed Practical Nursing regulatory bodies

The legislative framework of nursing regulatory bodies in Canada differs from Ontario's regulation of health professions. While some provinces have an umbrella legislation that sets regulatory requirements for all regulated health professions, similar to the *Regulated Health Professionals Act* in Ontario, other provinces do not. In most cases, Registered Nurse (RN) and Licensed Practical Nurse (LPN) jurisdictions in Canada set the continuing competency programs in their respective Nursing Act and by-laws.

For the most part, the legislated requirements on continuing competence only include the components of the program. These regulations do not include a competence assessment component and/or method of assessment, with the exception of Alberta. In the case of Alberta, RNs and NPs may be selected to undergo a practice visit for the purpose of assessing continuing competence based on criteria developed by the Competence Committee.[43] Most RN regulators in Canada generally use chart review methods to assess NPs' competence given their broader scope of practice.

Objectives of continuing competence programs (CCP) across Canada

The objectives of the CCP programs in Canada are similar to the way Ontario health regulators define the purpose of QA programs. The focus is on quality improvement and assurance of public protection.

Similar to Ontario health regulators, nursing regulatory bodies in Canada do not clearly articulate how a nurse's completion of CCP would ensure public protection. Although, in the recent revisions of CCP programs, a few regulators have made efforts in engaging with the public to enhance the CCP programs. One recent example includes the College of Registered Nurses of Nova Scotia (CRNNS), which will be explored on p. 14.

CCP components

Self-Assessment

Most Canadian nursing regulatory bodies have integrated a self-assessment component in their CCP programs. Generally, they use self-declaring mechanisms for nurses to acknowledge completion of self-assessment at annual renewal. Regulators have developed individual self-assessment tools for members to use in order to reflect on their own practice, knowledge and competence; in most cases, it is a questionnaire based on nursing standards of practice.

Continuing education (CE) or continuing professional development (CPD)

All Canadian RN and LPN regulatory bodies require nurses to complete CE or CPD as part of the CCP program.

One unique feature of CCP programs is the requirement of practice hours, which is typically the evidence of practice requirement for registration. For example, the College of Licensed Practical Nurses of Manitoba requires LPNs to maintain a minimum of 1,000 hours in a four-year period,[44] whereas the College of Registered Nurses of Manitoba requires RNs to have either 1,125 hours in the previous five years or 450 RN hours in the previous two years.[45] Nurse Practitioner requirements also vary. For example, Manitoba requires NPs to have completed 900 extended practice hours in the previous three years or 300 extended practice hours in the previous year.[46] Generally, verification of practice hours is collected either through self-declaration or verification audits by regulators.

Compliance mechanisms – approaches to sampling

Data from most nursing regulators' annual reports indicate that members are randomly selected for an audit. The range of selection varies between 1 to 10% annually. However, most regulators select approximately 5% of their members annually. Generally, members are randomly selected for a detailed review of their CCP activities.

The review is aimed to confirm that their learning plans and professional development activities are contributing to their competence, relevant to their area of practice and consistent with all other requirements of the program. In addition, given the practice hour requirements established in many jurisdictions, regulators also conduct verification of practice hour audits where they confirm maintenance of practice hours within a specified timeframe. For example, in Manitoba, 10% of LPNs are randomly selected for a verification of their practice hours.[47]

Recent trends from Canadian nursing regulators

Canadian nursing regulatory bodies have implemented new approaches to enhance their CCP program and processes. Some changes that have been developed include:

1. Competence assessment frameworks

- While the Canadian RN and LPN regulatory bodies do not mandate a structured practice assessment component in the CCP programs, recently the College & Association of Registered Nurses of Alberta (CARNA) has signalled changes to their regulation that would allow them to add a continuing competence assessment component to the current program[48]
- This component is currently being developed and the specific requirements are yet to be determined[49]
- While CARNA's regulations give specified authority for practice visits in cases where there is concern about nurses' competence, the regulator believes that it is important to have a competence assessment framework as part of the program, especially related to areas of risk
- The need for this change was initially identified in 2008 based on findings from the literature[50]
- CARNA is also evaluating the validity of the selection process for members undergoing a random audit every two years.

2. Multisource feedback

- A common trend implemented or currently under development by some nursing regulators in Canada is the addition of multisource feedback to their CCP program
- British Columbia (both CRNBC and CLPNBC) as well as Manitoba (CRNM) are in the process of integrating multisource feedback into their programs
- The rationale for implementing multisource feedback includes:[51]

- Supports the role of the college in protecting the public
- Supports RNs and NPs in their practice
- Based on literature and best practices, a CCP should be multi-faceted
- Multisource feedback is used successfully by other health care professionals.

Findings from British Columbia Introducing Multisource Feedback

- By-law changes were approved on August 15, 2016[52]
- The College added "My Professional Plan" and completed Phase 1 of implementation in 2016
- Results from Phase 1 of the multisource feedback project were promising and showed that satisfaction levels among participants were strong, with over 80% rating their experience as good or excellent, and 80% rating the report's usefulness as good or excellent[53]
- In 2017, CRNBC will select a group of 1,000 RNs and NPs to complete the multisource feedback every five years
- The platform of "My Professional Plan" will be available to all registrants of CRNBC in 2018.[54]

Findings from Manitoba Introducing Multisource Feedback

The College is currently evaluating the use of multisource feedback as part of its quality assurance program. Through psychometric testing, the multisource feedback tool has been found to be both reliable and valid. The College has noted the following challenges with implementing the tool:

- Although the questions on the multisource feedback questionnaire were based on entry-level competencies, not all questions are applicable to all practice settings
- Some of the questions address competencies that colleagues may not see, or be able to provide feedback on, depending on the practice setting (same for patients)
- There are high "unable to answer" results on a number of questions that don't apply to specific practice settings
- More work is needed to identify the preferences of patients about providing feedback
- Members expressed anxiety with respect to handing the questionnaire to patients as they feel it is not appropriate at all times and worry about the change in the dynamics that it may create
- Members may also have a patient population that is unable to provide feedback on the questionnaire (for example, dementia and/or sedated).

The College is working on supporting nurses through these challenges and is developing appropriate resources for them. They are also currently evaluating both the scoring process and if multisource feedback can be used as a preliminary screening tool to identify a member's need for a more in-depth assessment.

3. Verification process and mandatory education

Findings from College of Registered Nurses of Nova Scotia (CRNNS)

The College recently launched a new quality improvement program to assist RNs and NPs in tracking their continuing education. The CCP includes mandatory education for all nurses and verification of a random sample of learning plans. Nurses have 10 months to complete the CCP's five requirements to receive an active-practising licence and work in Nova Scotia.

The program's five requirements include:[55]

- Working a minimum number of nursing practice hours, or completing a nursing program within a certain amount of time

- Participating in a reflective practice process (self-reflection, self-assessment tool and learning plan)
- Confirming on their licensure application that they have developed a learning plan
- A learning plan that meets CRNNS criteria, if randomly selected to submit the plan for review
- Successful completion of CRNNS mandatory education.

The College's most recent review determined that verifying a random sample of learning plans from nurses was considered best practice among RN regulators in Canada and that mandatory education would further support nurses in meeting their accountability as self-regulated professionals.[56] The mandatory education is based on a regulatory topic selected by the regulator. The topic is selected based on the most frequent resources on which the regulator offers practice advice and develops into learning modules that all nurses must complete every two years.[57] Completion of a quiz by nurses is also required. Nova Scotia also consulted with the public during these revisions. The results showed that 88% believed that nurses should demonstrate continuing competence on a regular basis in order to maintain their nursing licence.[58]

Health Regulatory Bodies – International

Nursing regulatory bodies

The continuing competence frameworks and programs vary among nursing regulatory bodies internationally. This section highlights some unique features of continuing competence programs in the United States, the United Kingdom, Australia and New Zealand.

United States

The review of three state boards of nursing, Massachusetts, Texas and California, reveal that the quality assurance programs are generally based on nurses' completion of mandatory continuing education. These requirements are outlined in the state board of nursing regulations. For example, the state of California requires registered nurses to complete 30 contact hours of continuing education every two years.[59] Contact hours are part of acceptable courses by Colleges. Typically, contact hours are calculated based on specific formulas. For example, one-quarter unit consists of 10 contact hours, whereas one semester unit contains 15 contact hours.[60] Similarly, the state boards of Massachusetts and Texas also require nurses to complete mandatory continuing education. However, the specific number of hours varies.

A common element noted across these state boards is the fact that they do not require nurses to undergo a formal process of self, peer and practice assessment. In terms of compliance mechanisms, in California, RNs are subject to regular random audits.[61] In Massachusetts and Texas, the board may require nurses to verify that they have complied with the mandatory continuing education requirement at any time. However, it is a responsibility of each nurse to maintain evidence of the requirement for their own records. All three states require additional mandatory continuing education for Advanced Practice Registered Nurses (APRNs), who are similar to NPs in Canada.

The United Kingdom

In 2016, the Nursing and Midwifery Council (NMC) in the United Kingdom, implemented a unique approach to quality assurance with the process of revalidation.[62] Prior to 2016, revalidation was widely perceived to be a quality control mechanism.[63] Revalidation was defined as the process by which a regulated professional periodically has to demonstrate that he or she remains fit to practise.[64]

Currently, revalidation allows nurses and midwives to maintain registration with the NMC by demonstrating their ability to practice safely and effectively. It is a process that aims to promote good practice among nurses and midwives, and strengthen public confidence in the professions.[65] Thus, revalidation has shifted its focus towards quality improvement by also including elements of quality control mechanisms.

An important feature of this process is that is it designed so that it can be undertaken as part of a regular appraisal with employers.[66] All nurses and midwives must complete the components of revalidation every three years. All of these components and requirements work together to assure nurses and midwives are safe to practice and ensure public protection. The components include:[67]

Practice Hours

- 450 practice hours or 900 hours if revalidating as both nurse and midwife

CPD
- 35 hours of continuing professional development (of which 20 must be participatory)

Practice-related feedback
- Five examples of practice-related feedback obtained from a variety of sources including patients, service uses, carers (personal support workers), colleagues, feedback received from annual appraisals, complaints

Written reflective accounts
- Reflection helps nurses identify changes or improvements to make and embed the Code in their practice

Health and character declaration
- Nurses have to declare health and character information with the revalidation application

Professional Indemnity Arrangement
- Nurses and midwives must declare that they have, or will have when practising, appropriate coverage under an indemnity arrangement

Confirmation
- Confirmation required from employers on the completion of a nurse's revalidation.

Australia and New Zealand

Nursing regulatory bodies in Australia and New Zealand operate in a similar fashion. They both require nurses to complete a CPD requirement.

The Nursing and Midwifery Board of Australia allows for flexibility in terms of what type of CPD activities nurses have to complete in order to meet the requirement. The regulator recommends that nurses complete a range of CPD activities annually. For example, RNs with prescribing authority are required to complete a total of 30 hours, in which 10 hours should relate to obtaining, supplying and the administration of scheduled medicines, specific to their scope of practice.[68] This is considered to be more effective for learning than completing CPD activities of one type.

Similarly, the Nursing Council of New Zealand requires nurses to complete specific CPD activities. Nurses in New Zealand meet this requirement by declaring at annual renewal:[69]
- Completion of 60 days (or 450 hours) of practice in the last three years
- Completion of 60 hours of professional development in the last three years
- Meeting the Council's competencies for their scope of practice.

Nurses can demonstrate continuing competence by either completing an approved Professional Development and Recognition Programme (PDRP) or undergoing a recertification audit, which includes self, peer and practice assessment.[70] Both processes are approved by the Nursing Council to meet nurses' continuing competence requirements, but are developed by employers and professional organizations. This particular approach ensures that the regulator continuously engages with employers.

Both processes are based on the submission of a practice portfolio. However, the PDRP looks at more than just competence to practise, for example, recognizing additional contributions made by nurses to the workplace.[71] The assessment tools used by the PDRPs may also be different, as the nurse usually supplies more evidence in a portfolio than is required for an audit.[72]

Other health professions

The review of other health profession regulators, such as medicine and pharmacy, also revealed different approaches to regulating quality assurance. For example, the General Medical Council (GMC) in the UK has also established a revalidation process.

The focus of GMC's approach to revalidation is based on members' participation in an annual appraisal process based on GMC's core guidance for doctors.[73] Colleague and patient feedback is one element of supporting information that doctors need to collect and reflect on for their revalidation. Along with the other supporting information doctors collect, it helps them reflect on how they work, and identify ways they can modify and improve their practice. Typically, licensed doctors have to revalidate every five years by having an annual appraisal through their employers and the GMC.[74] The GMC revalidates the practitioner based on recommendations received from the responsible officer in the organization that is supporting the physician with the appraisal and revalidation.[75]

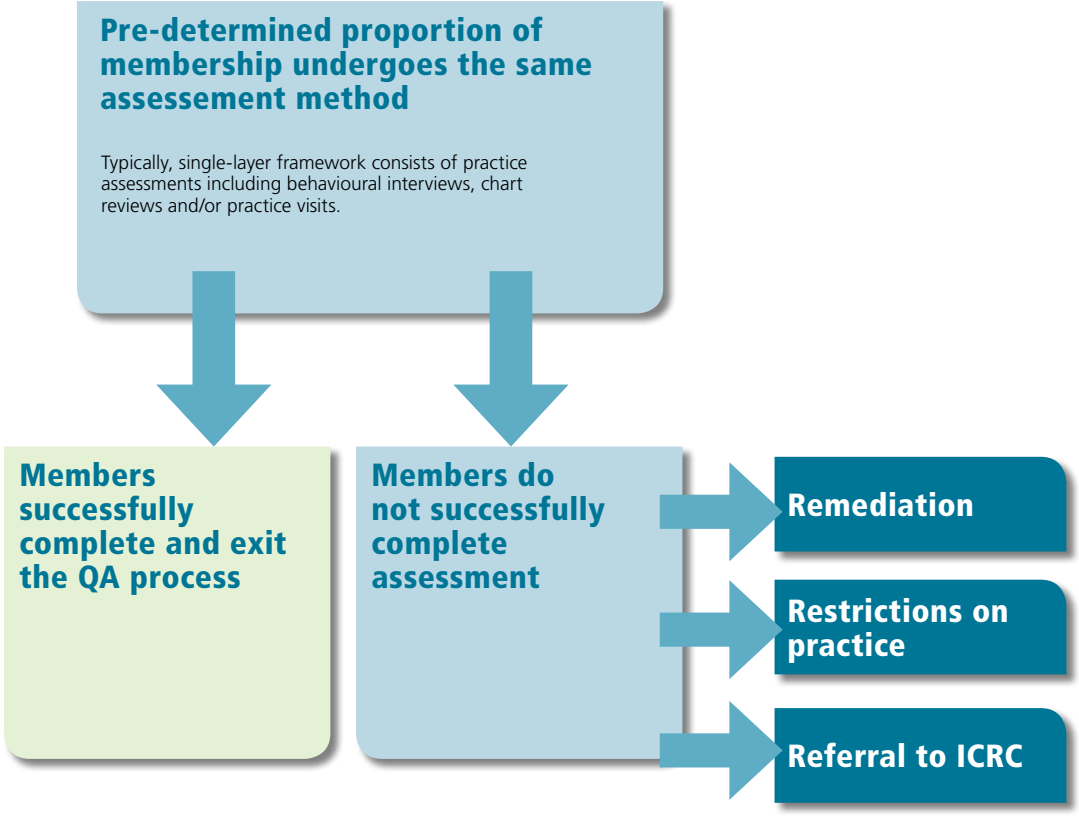
One particular feature of GMC's revalidation process is the emphasis on public protection. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC.[76] The GMC highlights that the process will help them strengthen the way they regulate doctors. In addition, they have established an integrated approach to include employers in the revalidation process, which would lead to a stronger system of appraisals for doctors. Over time they believe revalidation will lead to safer care. The GMC is also working with researchers to monitor the implementation of revalidation and evaluate its impact.

Attachments

Attachment 1 – Single-level framework, Peer and Practice Assessment. Ontario
Attachment 2 – Tiered/laddered framework, Peer and Practice Assessment, Ontario
Attachment 3 – Peer and Practice Assessment Framework, College of Dietitians of Ontario

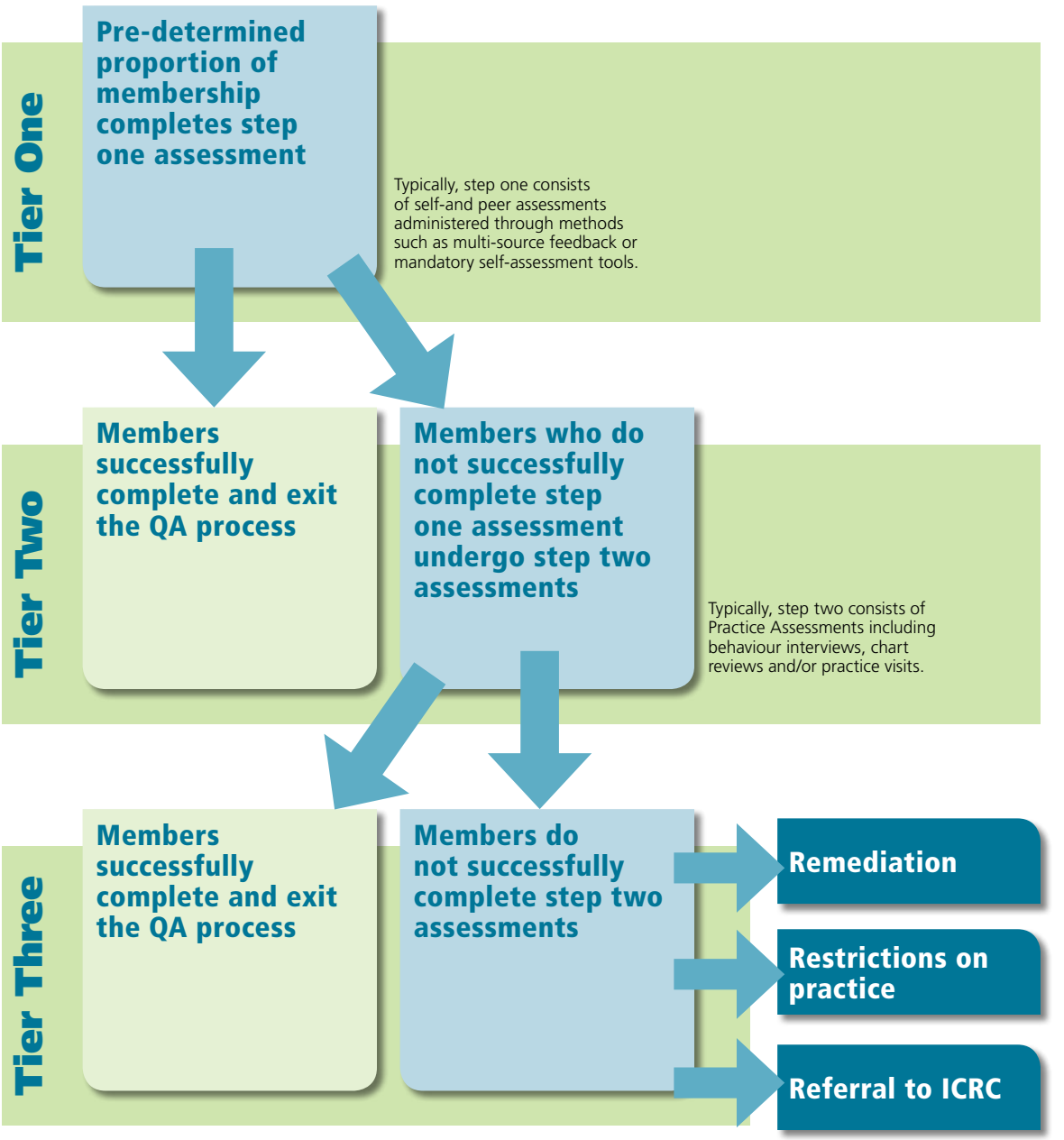
Attachment 1 – Single-level framework, Peer and Practice Assessment, Ontario

Single-level framework

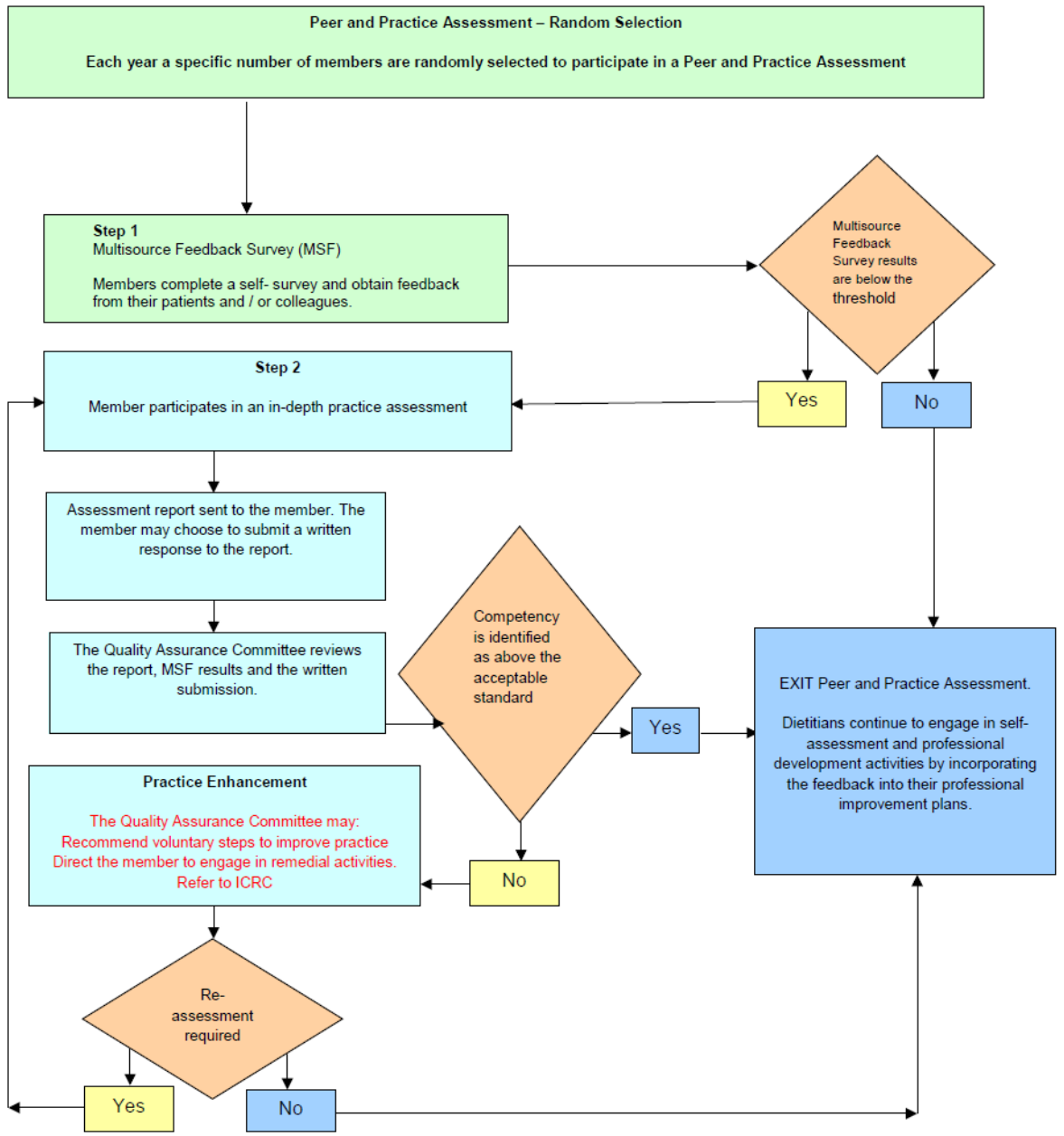


Attachment 2 – Tiered/laddered framework, Peer and Practice Assessment, Ontario

Tiered/laddered framework



Attachment 3 – Peer and Practice Assessment framework, College of Dietitians of Ontario



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