NCSBN
National Council of State Boards of Nursing

2018 NCSBN Annual Institute of Regulatory Excellence (IRE) Conference - Measurement of Continuing Competence in Nursing Regulation Video Transcript

Event
2018 NCSBN Annual Institute of Regulatory Excellence (IRE) Conference

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- [Christine] Thanks everybody. It's a real pleasure to be here and to be able to give you some information about our journey. We've actually been in development for the last five years or so and we're actually building on foundational elements of our program as well as adding new elements.

So I'm going to take you through what looks like a lot of information and it is, and I've provided a lot of information to you, screenshots, because I wanted you to get the idea of what we're doing.

However, I'm going to skip over a lot of it really quickly. Likewise, there's a comprehensive literature review. I'll touch on a few of the articles that have really influenced us, but again it's there if anybody would be interested in that. So I want to really focus on five main questions.

Who we are as a college? What's our strategy? Why are we taking this path on quality assurance? What are the methods we're using? And I'll focus on the new method of multi-source feedback quite a bit and I'll touch on the others.

What are we aiming for? What are the outcomes we're aiming for? And where are we in the journey? We are just starting to implement but I'll give you a bit of a picture of where we are. So as the college in British Columbia, we're a province of about 5 million people.

We have 40,000 registrants just over. And this is registered nurses and nurse practitioners. We came under new legislation in 2005 called The Health Professions Act. And at that time, we were limited to regulation only.

Before then, we were an association as well as a regulator. So over the last decade, we've been doing a lot of work to unwind our association programs and to reprogram our regulatory functions. And quality assurance is one of the regulatory programs that we're moving forward with.

The legislation directs us in a positive way to promote high-practice standards, and it also provides for assessment of professional practice. As we unwound our association programs, our board in their wisdom said to the staff, "You know, we really need to think about how we're going to do our regulatory functions. What's our philosophy?How are we going to do the work?"

And so the colored words that you see there, we did a project where we engaged with a lot of our stakeholders to understand how they perceived us currently. A lot of confusion and lack of understanding about regulation vis-à-vis Association vis-à-vis Union. And a lot of information for us to think about in terms of our visibility or our lack of this ability with our registrants and stakeholders.

And so after looking at the trends, and we looked at trends for modern regulators around the world, we came up with the five principles that you see. Just cultured, these are all principles and concepts that we've all heard and are really linked, I think, today to a modern regulator in how we do our work.

Just culture, a principle based approach, we are regulating a professional. Right touch regulation. What's the method to look at what risks and relative risk? We're looking at ongoing learning and professional development, lifelong learning and collaboration.

We're part of a big system. What is our role and how can we contribute to quality competent care for the public? Our strategic plan focuses on four areas: right-touch regulation in the public interest, building on and maintaining the credibility of the nursing profession, leadership and influence, and partnership and collaboration.

So with those things in mind as we set about to align our programs with our strategy. The goals, the strategic objectives that we focused on are around the public having confidence in how we regulate nurses and meeting the public expectation that nurses maintain competence throughout their careers.

For nurses, we want to engage with them. We want to support nurses to meet high practice standards, and as a college, we want to obviously integrate the principles of how we do regulation into our programming.

But the bigger question at the end of the day is, what is the data that we will generate to help us look at our own regulatory effectiveness and how we contribute to the system for the public in our province? So this is a picture that encompasses all of the components of the program.

And I'm not going to go through all of these but I will touch, I think everybody is quite familiar with our program logic model. I'll touch on some of the areas. So we did really want to focus it in research. And there's not a lot of research that says this method or this design will link to affecting the public quality issues.

We know that there's still a lot of quality issues for the public in our system. We've read all of, you know, to quality reports in the U.S., Canada, and around the world that say there are still a fair percent of patients that receive harm while they're in our care. So what's the research around, how we can best impact that from a regulatory perspective?

So I'll talk more about that. We heard from nurses that they did not want this to be time consuming,

laborious, so we really spent a lot of time pilot-testing. And, again, I'll go through some of that. And we know that to have people take action that we need to apply consistency, transparency, have fair policy and process and all of those distributive justice principles, I guess.

So we looked at all of the things behind the scenes, the legislation obviously was changed by our provincial government and then we went through looking at the bylaws and the confidentiality policies and how we were going to ensure nurses that this program has a firewall between quality assurance and the complaints.

We did not want nurses mixing the two. And we actually have built in that right up front in the web-based tool kit, we point nurses into direction if they need to report an incident because we do have legislation that, you know, mandates us to report reportable incidence of harm to public.

So we really wanted to have that firewall. So we do have a statutory committee and we do have external assessors for one component of our program. I'll talk more about that. So all to say, and then finally, I'll say here, we know that data is not going to change behavior, that we need to have an ability to follow up on concerns and to do a coach approach for behavior to support behavior change.

Where did we derive our tool kit? It all came from our professional standards of practice. And I'll talk about...So the professional standards, there's four of them. It's responsibility and accountability, ethical practice, knowledge-based practice and client focus.

We're not assessing performance on job responsibilities or technical skills. We are assessing on our professional standards and our nurses meeting those. So from research, we had done quite a bit of work with the Professional Standards Authority in the UK and they had come and done an external review for us to look at all of our programs.

So we're certainly in tune with their right-touch regulation and looking at, you know, proportionate risk. However, we don't have much data. We have our complaints data, but we have no data that says nurses most of the time meet standards, part of the time, whatever.

So that's what we're aiming for. We've got...You know, we've got several different methods. We know that there's not one method that fits all there. They all have limitations and so we've taken a multifaceted approach.

As I mentioned, we're focusing on the non-technical or the soft skills and this is a great book that we learnt a lot from. And when you look at the quality literature, you see that much of what falls down for patients is the soft skills, the communication, the coordination, you know, information got missed about the patient and then something happened on toward for them.

The competence is constantly evolving. I mean, you know, just a presentation we had earlier about, you know, the future, I was saying to Daniel I was into the future and now I got to come back to reality. I love thinking about the future. But we know that practice is constantly changing, so how do we embed in professionals the ability to reflect, to change behavior and based on feedback that they trust and are able to have good conversations about?

Zyban Austin, someone mentioned earlier and, you know, we've certainly looked at his research as well and want to empower nurses to be able to take action based on feedback. A couple of researchers in British Columbia are doing feedback, are doing research around the professionals like feedback from trusted professionals and that's when they're more likely to take the feedback seriously and think, "Okay.Is there something here that I need to think about and change?"

We also didn't want to focus only on ratings, but give nurses said to us early in pilots, "We want to be able to say what strengths are as well as areas for improvement."

And then the final piece that'll mention here is, it's been a long development journey, and as we've pilot-tested the products, you know, we've thought a lot about the marketing approach and how to nudge behavior in the right direction. And so in the tool kit, a lot of that is embedded.

Like, how can we support nurses to take the next step and think about, "Okay. My plan then, because I got that feedback is X." And, you know, so we've built all of that in by using the quality circle, if you will. "I got this feedback, I need to do something about it, here's what I'm going to do.And did it help me or didn't it? And do I need to do something different?"

We started with a reflect of model in the college. And this...So at registration or licensing time, nurses would attest that they had gotten peer feedback, that they've completed an assessment according to their standards, developed a learning plan and they reported on the number of hours that they work in the last five years.

So those are long standing components, but we got no data, none, other than the hours for registered nurses. For nurse practitioners, they're fairly new to the province and so when we implemented nurse practitioners in '05, a quality assurance program was set up based on onsite peer review. We actually engaged nurse practitioner assessors from the U.S.

and Washington has helped us out a lot and because we had no nurse practitioners in province to be, and the other provinces in Canada at the time we were the last and our scope was different and it mirrored your scope in the U.S. more than some of the provinces at the time.

So we have now moved that program to a psychometrically tested tool kit. We still have an onsite peer assessor, peer review, and we're moving to prescription review component as nurse practitioner start prescribing opioids, which is fairly new in our province.

As you can imagine, that's quite a labor intensive process and quite expensive because we have to fly people across the province, they go in to the nurse practioner's practice.

And every nurse practitioner goes through that in their first two years of practice. We've done an evaluation and nurse practitioner say, "It is really helpful for us to have that in our first two years of practice because, you know, we're new to the province, we don't fit in the system. It's great to hear from a more senior colleague that we're doing okay on these parameters that we check."

However, round two, cycle two, it's not as helpful, so we're going...For economic reasons as well, we will move nurse practitioners into the multi-source feedback approach. The prescription review is in

development and it's not something I'm going to spend a lot of time on because I want to focus on multi-source feedback.

So this is all a web-based tool kit. Nurses, when they come to renew their license, do a self-assessment on the standards, the professional standards that I mentioned. Then they tell us after they've invited colleagues, 3 to 20, 3 is the minimum to get a report, 20 is the maximum, registered nurses or non-registered nurses.

They can invite physicians, physiotherapy, their colleagues that they work with that they would like some feedback from who's observed them, you know, meeting their standards and doing their work. So we are in implementation with this now. I'm going to show you a video shortly of how it works and this is a video on our website to help nurses understand what they need to do.

And then we will roll this out over a 5-year cycle because with 40,000 registrants, we're starting out with 7,000-ish this year. We're in the middle of that now. And then we will have a five-year cycle. Initially, we may be able to speed it up as time goes on and we will add nurse practitioners as well.

Multi-source feedback approach is being used by the employers in our province as well. So we've talked a lot to them as we've develop this about what should we be assessing, what are you assessing and how can we put the system picture together?

So the employers are using this as well, so that's, I think, a strength for us because we'll be able to put the pieces together. So we'll show the video. It's about two minutes. ♪

[music] ♪So I'm going to actually go fairly quickly through the next slides because I want to give you an opportunity to ask questions if you have them.

What I'm going to focus on is, you can see the scales that we use there. This one here. So rarely did I see you meeting the standard, is the first down on the light green. Sometimes I see you meeting the standard. Often times I see you meeting the standard.

Usually, I see you meeting the standard. Regularly or unable to assess. So that's the scale. Then there is an ability you can see for examples of behaviors and/or comments as well. It's on a mobile, so nurses can complete this on a mobile as well.

And I'm going to skip through all of these because these were our screenshots of what you saw. So we needed to think about, "Okay.How are we going to help facilitate change?" And what we've done is developed a continuum of support, where if there's a certain rating, you know, things are going quite fine, we won't call you.

If there's a rating, the triggers, we've got sort of cut points that obviously we're testing as well as we implement. But if we see a lot of rarelys or sometimes, then we will reach out to the nurse.

And I'll show you we've got a coaching model. And then there's another area where if we see risk, you know, we may need to do something more. We obviously always would call to get more information, but we may need to refer to the quality assurance statutory committee that I mentioned.

So the continuum of support as being developed by staff with some of our stakeholders, and we will test it out...we tested it in our pilot projects but we will get a full test of it with 7,000 registrants right now.

As I mentioned, continuous improvement and then opportunity for improvement, there is the two categories where we will reach out and then the third category is definitely need some attention and we will reach out but maybe need to have further conversation with the nurse if action isn't taken.

So we have been educating our staff who will be doing the outreach. It's called an R2C2 model. It sounds Star Wars-ish. But essentially, it's these four areas, rapport building, exploring reactions, exploring to content, and coaching for change.

And Daniel, I was thinking about the levels of logic as well and it would make a really nice addition probably for us to think about here. It's obviously, you know, we're reaching out to nurses to support them to meet high practice standards. We're not reaching out to find bad apples.

Our idea is that we want to shift the curve to the right so that more nurses are meeting high-practice standards. You know, there are the regular stats, but we don't have much data and we have none specific to our college. And then we've got the immediate, intermediate and longer term outcomes that we're aiming for.

And in terms of making it easy, you know, nurses have been part of ongoing feedback as we've been doing the pilot testing and some of that is all fine or we're changing it as we go making the product a bit better.

We're also looking at the ratings and comparing those, and this just gives you a brief comparison of two pilots that we did with 300 and then 1,000 people. We're not seeing huge variation in the ratings at the moment. For self-assessment, it's actually people rate themselves harder than their colleagues rate them which, you know, is probably not surprising.

So it'll be interesting to see as we go on what these frequencies show us and what the value is here obviously. I'm going to skip through these. And where we are right now as I mentioned we're in the middle of our 2018 renewal, licensing renewal, and we've got 7,000 registrants.

To date, probably about just over 1,000 have completed and some people have gone with 20 colleagues. So there are some real keeners out there and, you know, then we have others who've done the three. So I'm happy to answer any questions that you might have if I have one minute or two left.

Two minutes? Okay. Sorry about that, but you're welcome to contact me, you know, any time if you want more information. - [Woman 1] [inaudible] not answered the question...

- Yes. - [Woman 2] [inaudible] - Oh, okay.

- And I know you hadn't given... Just a quick review on this. Sorry I left because I stepped on this and hit myself in the face with the microphone.

- No injury. No injury.

- So does the board monitor all of the nurses' feedback? Or how do you select who you're going to monitor? You just randomly?

- How do we select who goes into the cycle for assessment? We do it randomly. So of the 40,000, 7,000 got selected this year, right? So that's random. Then of those 7,000 when we get the reports, we will use that model, the continuum of support model to say what percent, who are the people that we're not reaching out to.

Their scores were over here, they seem to be doing fine. They're, you know, usually always meeting standards according to the feedback we got from their colleagues, right? Then if they fall into the other buckets where they are rarely meeting standards or sometimes meeting standards, those registrants, we will reach out to and say, "You know, how did you see this feedback?"

And using that coach model that I talked about. And then if there are any that fall in the third category, those would go to the QA committee. If we did not get...Like, when we reached out to the registrants, they were like, "You know, I'm doing fine.

I'm not paying attention to this feedback, etc, etc. Then those would go to the QA committee.

- And then what would the QA committee do?

- The QA committee have powers to say, "Okay. We want an onsite review of this practice." Or, "We want the nurse to come and meet with us and tell us about whatever the observation was that's concerning." Yeah.

- So is this is the...

- But they only have the power to recommend and refer to the inquiry and discipline committee. That's how our legislation is setup.

- And it's considered legally defensible of this type of an evaluation?

- Must be, yeah. I mean, it's within our legislation that we can assess professional performance. Yeah.