2018 NCSBN Scientific Symposium - Regulation: Can Competence be Assured? Video Transcript

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I'm just finding my PowerPoint. I might just give you a little bit of background to the work that I'm going to present this afternoon. This was a large study undertaken over two years. Here we go. Thank you. And I'm here representing two colleagues who were also part of the study.

My research team was Professor Mary Chiarella, who's a professor at the University of Sydney and Dr. Elaine Papps, who's in New Zealand. And I started this study really as a piece of work to follow on from some previous research that I'd undertaken for the Nursing Council of New Zealand and also looking at the relationship between legislation policy and public safety, and the impact it has on nursing practice standards.

So during those previous pieces of research, it became apparent to me that when we look at competence indicators and we look at competence frameworks and those mechanisms that have been put in place around the world in many jurisdictions, they may assure public safety but they certainly can't ensure on any given day.

And for the practitioners that are regulated and meet the requirements of the competence indicators, we still see a number of competence notifications. And so, in this piece of work which was funded, I'm pleased to say, by the National Council of State Boards of Nursing, so I want to acknowledge them at this point and I also want to acknowledge the Nursing and Midwifery Council in New South Wales who gave us access to five years worth of performance data, and this piece of research, we're focusing particularly on performance notifications or complaints.

So we excluded any complaints to do with conduct and also... Excuse me. I've had a cold. So I'll just grab some water if some people wouldn't mind me bringing that out. And also anything to do with physical or mental illnesses. So particularly performance indicators. So we have competence awareness indicators and many of the jurisdictions around the world use similar indicators.

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Certainly the most common appear to be self-assessment, practice hours, and continuing education or continuing professional development. Arguably, competence is always about ensuring safe practice. But we believed there was a missing thread. And insight or variations of that word, the definition, moths, depending on who you're talking to, has come up in a lot of the research we've undertaken and we decided it was time to investigate that more fully.

There's very little research that's been undertaken looking at insight and behavioral attributes as they relate to competence. Medicine is one of the only disciplines that seems to have a body of literature around that but no particular definitions in place. So what does this missing thread mean?

I've just done a little Johari window here to try and capture some of the basis of what we're talking about. So as you'll see in the first box, Awareness Competence, there's a tick. So if somebody's aware of the practice, they have self-awareness into what they're doing on any given day and they meet the competency requirements.

So for Australia and New Zealand, I'm talking about their self-assessment, their practice hours, and their hours of professional development. And they tick those boxes, then they apply for the re-registration or recertification depending which country you're in.

They're given to being competent. Then you have a group who are aware. They're very aware, but they're also not competent. But because they're aware they're not competent, that's not actually at issue because they often will self-select out or they will raise that and they don't continue their registration.

We have a problem with a group of people who are unaware. They don't have any insight into their practice. However, they may still meet the criteria. They may be able to tick the box because they've done the number of CPD hours, they're in practice. It's concerning if they're assessing themselves against practice standards and they have no ability to reflect on their practice.

So that becomes a problem. But they may well slip through and they're re-registered in their own practice. And some of those people are the people that we picked up in our work we did with the New South Wales Nursing and Midwifery Council. And then we have another group who are completely unaware.

They don't meet the competencies. And hopefully, we would pick them up because if they're filling in the forms accurately and honestly, they won't meet the practice hours or they won't meet the CPD hours. I do need to say that most of the complaints we had when further investigation was done, if indeed they were bonafide complaints, it was around CPD hours that there seemed to be a number of issues.

So the purpose of this research, we had a number of reasons for doing it at the commencement. We wanted to look at the relationship between CPD residency of practice and performance competence. We wanted to explore whether remediation might provide any guarantee of performance competence because there are a number of levels of remediation offered to nurses and midwives who come under competence notifications or complaints.

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We wanted to look at the relationship between awareness and insight and performance competence. So we're particularly looking at performance. And we wanted to define, if possible, the characteristics of insight to understand how that might be demonstrated in practice.

So the research was undertaken in three phases. The first phase was an investigation of case law. So we looked at the case law from New Zealand and Australia and in fact, we were able to access that information through ICN in Geneva.

However, there are only 53 cases over that five-year period. So we decided to put those aside. And those cases, of course, were at the extreme end. So often, there was an overlapping with conduct issues and a number of health issues as well. so we put those aside. The second grouping was the grouping of case files that we received from the New South Wales Nursing and Midwifery Council.

We were lucky to access that. And I'll show you some statistics of the number of nurses registered in New South Wales as opposed to Australia, the rest of Australia, and New Zealand. And you'll see why we were pleased to get that sample as they have the biggest cohort of nurses and midwives in Australia. We did a qualitative and quantitative analysis on those, and that's the piece of information that I'll talk to you more about in this presentation.

We also were very lucky to interview 22 key stakeholders. Now, they were people who work in regulation, in professional bodies, and nursing unions who have supported and worked with nurses who have undergone performance notifications complaints processes.

Very experienced people in the field. And we had 10 participants from New Zealand and 12 from Australia. And then finally, we looked at the statistics across both countries. All the data was analyzed and the information triangulated. So I'll take you through some of that now.

So just to give you a picture of what we were looking at, you'll see on the top line across the five years of data that we looked at, the nurses and midwives registered nationally in Australia. And then there's a breakdown of registered nurses, registered midwives and enrolled nurses.

Now, please, don't add those up and wonder why they don't add up to the total number at the top. That's because, in Australia, nurses and midwives, you can hold your registration as a nurse and a midwife. You can also be a nurse and an enrolled nurse or you can be a midwife and an enrolled nurse. So some of those people were registered in two categories.

And then you'll see, below that, the number of nurses in New Zealand nationally, and the number of midwives in New Zealand nationally. They're two separate registrations and two different councils. And the breakdown of nurses in terms of nurse practitioners, registered nurses, and enrolled nurses.

In the state of New South Wales, you'll see that, for example,, in 2015 there was 99,505 nurses and midwives. So that's the largest state in terms of the registering body of nurses.

Nurses are registered nationally in Australia. However, when you register you also identify the state that you're working in. So these are all nurses and midwives across both countries, who are registered as in

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practice. And now we come to the performance complaints or performance notifications depending on which country you're in.

And there's a breakdown there and you'll see that there's actually very small numbers. The percentage is very low and we've extrapolated out any who came under mental health or conduct issues. So this is purely performance related complaints.

And as you will see, in 2015, in New Zealand, 0.14%, and in New South Wales, 0.23%. So very low numbers but still a concern. And so we wanted to know more what happened with these people. So we were originally given 960 files from the Nursing and Midwifery Council.

They had redacted the data. We signed all the confidentiality documents and I won't go through the extensive process we undertook to do that and we were required to be on the premises. We hand-sorted every file, and you'll see we had a total of 712 that met the criteria.

So whilst they had already sorted them and gone through the files to pull only performance data, we found there were a number of files either that were duplicated or had indeed conduct and health issues. So those were removed. The data was de-identified, aggregated initially for year, age, year of complaint, registration status.

We did find that some... Because we had five years worth of data, we did find that there were some frequent fliers that had more than one notification within that 712. And indeed some of them had a notification as an enrolled nurse and a registered nurse, for example. So they were very similar issues in all of those cases and some of those cases are related particularly to a lack of insight.

The age distribution, there's actually no surprises here. Seventy-nine percent of the New South Wales nursing and midwifery workforce is over the age of 50 years. And you'll see that the biggest number of complaints fell within the age groups of 50 to 59 and 60 to 69.

The top four areas of complaints were aged care with 150 complaints, mental health with 69 complaints, midwifery and maternity services, 66 complaints, and emergency departments, 53.

And then for the other discipline areas, there was a scattering across. But those ones had the most significant detail. And as I said, we read through every one of these case files. When we read through them, we pulled out 142 complaints that dealt specifically with insight, and I will come to those shortly.

So a number of them had mention of lack of insight, lack of self-awareness, etc. But there were 142 that were of a significant concern. So in terms of the aged care complaints, as you can see, they ranged across a whole range of aged care facilities, dementia units, residential aged care facilities, and nursing home facilities.

The complaints were mostly about registered nurses and enrolled nurses. In New South Wales, there has been legislation, up until quite recently, that every aged care facility must have a registered nurse on the premises. And you can see that the complaints in New South Wales for aged care made up 21% of the notifications and the average across Australia is only 8%.

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Across the rest of Australia, there isn't a requirement to have a registered nurse in every facility. So obviously, if there was a complaint that may not be made against a registered nurse, so that may be part of the difference.

I'm sure it's not that the aged care facilities in New South Wales are any better or any worse in terms of what they provide. And not all of the complaints related when we delved a little deeper, specifically to the nurse. However, the initial complaint often came in about the nurse.

And when you unpack that, some of the systems issues, environmental issues, etc., overshadowed the complaint. And I will talk about those a little later. In terms of the complaints, many of them were around clinical issues, medication errors, poor physical and clinical care, neglect by management, and poor administration of the facility also was raised.

And often, the nurse was the person who was identified, as I said before, in the complaint that many of the facilities are privately owned. Poor communication was featured in a small number of the complaints and poor documentation.

The second highest area of complaints was the mental health complaints. And the number of those complaints were made about inadequate monitoring, failure to assist the patients adequately, misdiagnosis, and of concern, a number of them were around breaches in confidentiality.

So sharing information with other staff, with people who were outside of the institution, and also within hearing of relatives of other clients. The third area was interesting. That was midwifery maternity services.

Now in Australia, midwifery is a separate registration. However, we have a number of dual-registered nurses and midwives. And most of these complaints were actually made about the dual-registered nurses and midwives. And that may have been a timing thing because when we were actually undertaking the study directly entry midwifery, there were fairly self-direct entry midwives on the register and in practice in New South Wales.

The numbers are far higher now. The focus of the complaints, a lot of them were around allegations of rudeness or being unkind. And there were a number of complaints that, when we went through the files in detail and looked at the cases, were made in circumstances that were quite stressful when there was fetal mortality, there was high stress, and often the family felt excluded.

But when further investigation was done, it was around some of the processes that were required in emergency situations. And poor performance in the adequate monitoring and lack of support came through with some of the more recently graduated midwives and nurse midwives who were working in facilities and the lack of support that they were receiving.

And the fourth area, and that was no surprise to me having been a critical-care in an emergency department nurse, there were a number of complaints focused around emergency department. They were right across the board.

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They weren't just at the major tertiary hospitals. They were also in the rural and remote hospitals. The majority of the complaints came through were around incorrect triage, failure to recognize patient deterioration, and medication errors. Poor communication and rudeness came through again.

However, again, that was related to high-stress situations often where the family had been excluded from the room or didn't feel they were receiving enough communication when emergency treatments were occurring. So, as I said, we also pulled the 142 case files that had significant information indicating a lack of insight.

Now, there wasn't a consistent language used. Some people were saying inability to reflect on their practice. Others said complete lack of insight. Situational awareness was used, lack of situational awareness, inability to think critically, inability to be aware of what was happening around them.

So there were a whole lot of terms that were used. And when we distilled that data and through the interviews as well, some consistent language did emerge. But one of the things we wanted to define was how was insight manifested in practice and what did it look like. And I've just listed here because it would take far too long to go through all of the data.

But there is a paper published in the journal at the back of the room and there is a full report online. As you can see, we've noted here a list of the things that were demonstrated in the case files when a nurse or midwife was deemed as showing insight. Now, sometimes that came later in the process, during the extensive remediation processes they may have had in place or indeed during the counseling processes when they came before the Nursing and Midwifery Council.

So ownership and taking responsibility of the incident, evidence of reflection and analysis of the incident. And often, reflection is one of the processes that the nurses and midwives, if they come under complaint, are encouraged to do. They have to document and provide a journal to the assessors. And so obviously that was an opportunity for them to reflect on what was happening.

Some of them did it very well obviously, and some not so well. Analysis of the context in which the incident occurred, and that was quite a critical one. And I'll come back to that. Recognition of their own failures or mistake, expressions of remorse, sorrow, and regret, making an effort to improve oneself through targeted education.

And many of these nurses and midwives, before they got to the point of their actual meetings with the council, had already taken those steps. Thinking about and describing what the practitioner would do differently next time. And many of them came to the meeting with explanations of how they would do it differently next time.

And seeking out counseling and mentorship. So conversely, we had a number that did not demonstrate any of those things. There were a number of cases where the practitioner did not seem to understand what the actual issue was.

They made absolutely no attempt to change. And in many cases, particularly in the large public organizations, before a complaint had actually been made, the organization that was employing the nurse or midwife had put in significant remediation and worked through quite extensive processes of support.

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And often, to no avail. And so in the end, they'd made a complaint because actually, in legislation, they're required to make the complaint. The practitioner often blamed others, people, for the incidents. So there were a number of cases where they had repeatedly said, "Well, I don't know why I'm here because, actually, Joe does this and Joe did that.And actually, my manager should have done this."

And so instead of any acknowledgment of accountability for what had occurred, it was a blame to other colleagues or indeed the employer. And making excuses for the error without constructively analyzing what had happened and how they could do better next time and when the practitioner was non-compliant with any strategies.

So the council had a number of strategies they would put in place depending on what the complaint was. And for some practitioners, there was absolutely no compliance with those and the processes went on over a number of months. And further education was one of the things that is always put in very early and it appeared to be something that many of the people who had absolutely no insight did not engage in or they would attend but not participate.

So just to get the piece of paper. So we looked at all of the different examples of insight and how it exhibited in practice. And really, there were three different types of insights. So personal insight, where the nurse or midwife was able to recognize and acknowledge that they were under stress or might need extra help or assistance.

They are aware of what's happening. They are aware of altered circumstances. Contextual insight, where they could recognize and acknowledge what was happening in the environment around them. And if there was a challenging incident occur, make changes to their behaviors and actions.

And then situational insight. And some examples of that were where the nurse or midwife had found themselves out of depth because they had a challenging patient or scenario. In some cases, they didn't recognize what was happening and they just were focused on themselves.

And sometimes, those nurses were the ones who, when the investigations were undertaken, colleague, staff, etc, would report that they would regress to just doing the task in situations rather than being aware of what was happening around them.

So, emerging themes. From the interviews, from the data, etc., there were a number of emerging themes. I won't read through them all. The personal employer expectations were quite important, though.

So I will touch on that. New graduates. There seems to be...and I'm not sure if that's the same in the United States, but certainly in Australia, a deception that new graduates feature more commonly in notifications nowadays than in the past. We found that to be untrue. Yes, new graduates did feature in some of the notifications. But often, when their environment was assessed, they were working in situations that were untenable.

They weren't supported well, they were perhaps in an organization where they were leading a ward. As a new graduate, the expectation of the employer was that they would hit the ground running. I'm sure

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some of you have heard those words before. And put in situations that were quite blatantly unsafe. That's not to say that some of them lacked insight as well about these situations.

But they certainly didn't feature any more highly than any of the other people in the notifications. And the other was around expectations and performance in terms of education, ongoing education, and an understanding of what constitutes professional development.

And that is certainly not sitting in a room just being a sponge, absorbing what's happening. It's about the quality of that and how you implement that in practice. And there seem to be a lack of understanding and motivation amongst many of these nurses to undertake meaningful, professional development.

So you'll be pleased to see the conclusion slides up there. So competence does not always ensure a safe performance. I'm not going to read through all of those things today for you. But if you slip down to the last bullet points, I've just bullet-pointed for you some of the things that are more likely to occur if somebody has insight and less likely to occur if somebody demonstrates insight into their practice.

So obviously, more research is needed in this area. We do need to get a common language in terms of insight and the behavioral aspects that certainly do impact on practice.

And this is just the beginning of that journey. So there are several publications. The one just in the journal down the back of the room and there are two other publications that I've just heard have been published this week as well in <i>Collegian</i>, so if you would like to read a little bit more about the data and how we analyzed it.

Thank you.

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