2021 NCSBN Annual Meeting - INRC Mobility Project: How similar are our regulatory expectations and processes? Video Transcript

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Event
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- [Alison] The International Nurse Regulator Collaborative's Mobility Project: How Similar are our Expectations and Processes? So, I'm here today to talk to you about this project.

Formed in 2011, the International Nurse Regulator Collaborative, or INRC, is a collaboration of nine jurisdictions around the world, Australia, British Columbia and Ontario from Canada, Ireland, New Zealand, Singapore, Spain, the United Kingdom, and the United States, which is represented by NCSBN.

The INRC provides a forum for collaboration between the members. It focuses on the changing and evolving world of regulation, and the impacts created by an increasingly connected and mobile world. Its aim is to be proactive and to stay ahead of impending changes. The forum's purpose is to promote international regulatory research, share knowledge and ideas, and work together to influence policy to protect the health and safety of the public.

In 2018, the INRC members decided to undertake a research project to explore whether it would be possible to recognize each other's licensure or registration across the member jurisdictions. The purpose of this would be to reduce barriers and to allow for more easy mobility between the members.

They undertook this project because over the past seven years of working together, they had come to recognize that their healthcare systems, the roles of the nurses that they regulated, and their standards for licensure or registration were reasonably similar.

So, by way of clarification, the U.S. uses the term licensure for its regulatory processes, while the other INRC countries use the term registration. This is just one example of the use of different terminology for similar processes within the INRC jurisdictions.

So, now the mobility project. The mobility project currently has three phases. Phase 1 was the initial feasibility study, which investigated whether it was possible and desirable to develop some type of a regulatory mechanism that could support the mobility of nurses across the jurisdictions.

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Phase 2 was the in-depth review of the consistency of the licensure or registration standards that underpin nursing practice in each jurisdiction. And Phase 3 is the review of the operational processes used in each jurisdiction, and this phase is currently underway.

The findings from Phases 1 and 2 comprise two large and detailed reports. In this presentation, I will try to give you an overview of the main findings of this work. So Phase 1 explored whether trans-jurisdictional mobility was potentially feasible, and what would need to be in place for this to happen.

So, this phase included a literature review, a high-level review of the jurisdictional procedures and processes, and the interviews with senior regulatory executives in each of the jurisdictions. All types of regulated nurses were included in this phase, so we had practical and vocational nurses, or enrolled nurses as they are known in Australia, New Zealand, and Singapore, and all the different types of registered nurses, including psychiatric and mental health nurses, and child learning disability nurses from Ireland and the UK, and nurse practitioners in all their different designations from Australia, British Columbia, Ireland, Ontario, New Zealand, Singapore, Spain and the U.S.

The UK does not regulate nurse practitioners. And this phase examined at a high-level all the factors underpinning registration or licensure. Now, these factors included current global issues, the legal educational and disciplinary frameworks that the regulators use, their current information, communication, and technology capacity.

It reviewed the basics of the standards and requirements and processes for licensure and registration that were used in each jurisdiction. And then it identified the commonalities and differences between the jurisdictions. This was a big undertaking, so be prepared. There's a lot that we're going to briefly touch on in these findings.

Firstly, legal frameworks. All the INRC jurisdictions have their eligibility for licensure or registration established in either legislation or regulator enacted by-laws, standards, or rules. The only way that these requirements can be waived is through a government-to-government mutual recognition agreement of which there are three that directly impact the INRC jurisdictions.

We have the trans-Tasman agreement between Australia and New Zealand. There's the Canadian free trade agreement which affects British Columbia and Ontario. And then there's the European Mobility Directives, which affect Ireland, Spain, and the UK. So, for the purposes of this presentation, the EU countries are effectively Ireland, Spain, and the UK.

Now, the UK has left the EU through Brexit. But the UK regulator, the Nursing and Midwifery Council has been required by government legislation to keep in place in fact all of the EU mobility arrangements. And also, when referring to the U.S., this will be the findings from a majority of the states, while it is acknowledged that there may be a few states that are an exception to a finding.

So, all jurisdictions have a legal framework that requires an educational qualification, language proficiency, and good character in order to obtain licensure or registration. And seven of the nine jurisdictions also have a requirement for recency of practice.

Some jurisdictions have specified legal requirements for an external assessment or examination prior to licensure or registration. Well, for others, this is at the discretion of the regulator. And all the jurisdictions except Spain allow the regulator to determine the acceptability of the educational qualification.

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In Spain, only the government ministry responsible for universities can do this. So, from the information that was obtained, it did not appear that there were any significant impediments within the legal frameworks of the jurisdictions that would prevent the development of some kind of a pathway that could either streamline the process or allow for recognition of other INRC regulatory credentials.

So, all the jurisdictions have a scope of nursing practice that's guided by law, education and individual competence. In six of the nine jurisdictions, the scope of practice is specified in legal regulations determined by the government and the regulator. While in the other three jurisdictions, it is largely determined by the employer and the registrant.

Some jurisdictions have specific lists of controlled or restricted activities, while others use flow charts and guidance documents. All jurisdictions have documentation that addresses the expectations at entry to practice, the standards for nursing practice and professional behavior, and the standards for accrediting or approving a nursing education program.

In all jurisdictions except Spain, the regulator has the ultimate responsibility to accredit or approve a nursing education program. In Spain, this ultimate responsibility lies with the government ministry responsible for universities. However, in all jurisdictions, the processes and steps that are followed to earn a credit or approve an educational program are similar.

In all jurisdictions, the regulator or its approved disciplinary council are responsible for addressing complaints, fitness to practice and professional discipline. Now, complaints can address conduct, competence and health concerns, and all jurisdictions have a similar process to review, investigate and determine outcomes.

In all jurisdictions, the registrant can have conditions placed on their practice, be suspended from practice, or have their license or registration revoked, and this is noted on a public register. This was one of the areas where it was noted that there was a significant degree of variation in the terminology used across the jurisdictions.

Grandparenting of nurses, a term that probably many of you are not familiar with at all. Grandparenting refers to the requirements for licensure or registration changing over time, and whether the registrant having gained full licensure or registration is required to upgrade to the new qualification to maintain their licensure or registration.

In most cases, this change refers to the initial educational qualification requirement being raised to the level of a university degree. So, all INRC jurisdictions, except Spain and the U.S. have grandparented nurses and have not required them to upgrade to their new level of qualifications.

Obviously, the number of these grandparented nurses is decreasing in all the jurisdictions, but a significant number of them still remain. These registrants may only have a hospital-based certificate or a diploma, but there is no regulatory restrictions being placed on their practice. In Spain, in 1977, it was made mandatory for all RNs to have a university degree, and all nurses were required to upgrade to this level to maintain their registration.

In the United States, no state has a requirement for a university degree for initial licensure and diplomas, associate degrees, bachelor and master's degrees are all accepted. Information, communication and technology. In order for there to be trans-jurisdictional mobility, there must be real-time sharing of registrant data.

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This may require data sharing arrangements between the jurisdictions, and there must also be privacy and security mechanisms put in place. Currently, all the jurisdictions had their registrant databases and processes digitalized, and some are using cloud-based platforms.

Currently, there is some electronic data sharing arrangements that are in place within the INRC jurisdictions. I'm sure most of you are familiar with the U.S. Internal Data Sharing System Nursys. Australia also has a practitioner information exchange portal where they share information internally with other organizations and with some international organizations.

And the EU has their internal market information system, which provides for sharing of registrant data and disciplinary information between Ireland and Spain. Post Brexit, the UK has a sharing agreement with the EU member states, but it is much more restrictive than it was under the previous system.

B.C., Ontario, New Zealand and Singapore currently do not share any registrant data. However, B.C., Ontario and NCSBN are currently working on a cloud-based system similar to Nursys for Canada. Initially, this will only include British Columbia and Ontario, but other provinces are expected to join. The next part of this phase looked at the most common elements required for licensure or registration, and how consistent these elements were across the jurisdictions.

So, in the area of establishing identity, all jurisdictions required some form of government issued identification to establish identity, and no jurisdiction required mandatory in-person attendance for domestic applicants, although some of them do for international applicants.

For international applicants, Canada and New Zealand require CGFNS to verify all documentation, and the U.S. requires one of their authorized credential evaluation organizations to do this. Language proficiency.

All the INRC jurisdictions have language proficiency requirements for either English, French or Spanish. English is the most commonly required language, with seven of the nine jurisdictions requiring it, and eight of the nine having a minimum proficiency standard for it. Ontario has a bilingual language policy accepting either English or French proficiency, while Spain obviously has a requirement for Spanish.

For jurisdictions with English requirements, all applicants are required to demonstrate some form of language proficiency assessment. This can either be through their educational background, or previous practice experience, or through an English language proficiency test.

The IELTS language test is the only test accepted by all jurisdictions that use an external test. The most commonly accepted minimum overall score is 7.0, but there are variations across all jurisdictions and in all sections of this test.

In the area of educational preparation, all jurisdictions have specified requirements for their domestic programs, which are based on their practice standards and requirements for entry to practice. In some cases, these include minimum clinical hours, and they have specified stated content elements which must be included in their curriculums.

These expectations for domestic programs are then used to measure equivalency for international applicants. All INRC jurisdictions, except Ontario, Spain and the U.S. have at some time offered specialized entry to practice RN education.

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Most commonly, this was in the areas of mental health or psychiatry, children or learning disabilities. British Columbia, Ireland, Singapore and the UK continue to offer some or all of these specialized educational programs. RNs with this specialized education are registered in separate categories on the jurisdictional register.

So, most of you would be aware that passing the NCLEX examination is a requirement for licensure or registration for both domestic and international applicants in both the U.S. and Canada.

New Zealand also requires their domestic graduates to successfully complete the New Zealand state final exam before being registered, but they do not require this for international applicants. Australia, Ireland, Singapore, Spain and the UK do not require an examination for their domestic graduates, but Australia, Singapore and the UK require this for some of their international applicants.

When an examination is required for international applicants, Australia uses the NCLEX, and Singapore and the UK use their own internally developed exams. Recency of practice and continuing professional development are required by most of the INRC jurisdictions.

Ireland and Spain do not have any regulatory requirements for recency of practice or continuing professional development. And in the U.S., some states have these and some do not. British Columbia, Ontario and the UK have more stringent requirements for continuing competence, which includes every nurse being required on a regular basis to obtain feedback on their practice from other professionals, and they are required to create, implement and evaluate their own learning plan.

The majority of jurisdictions require a self-declaration of good character and fitness to practice for both initial and continuing licensure and indoor registration. This also includes disclosure of any criminal history. Half the jurisdictions require a formal criminal record check for initial licensure or registration.

And in most cases, this must also include their country of residence and any country that they've lived in for more than three months. British Columbia undertakes a formal criminal record check on all registrants every five years, while Spain only requires a criminal record check if the nurse is working with children.

So, nurses moving within the INRC jurisdictions can currently do so under either a labor mobility mutual recognition agreement or as internationally educated nurses. Australia and New Zealand have a mobility agreement, as do the EU jurisdictions, Ireland, Spain and the UK.

And Canada has its internal mobility agreement. For nurses not covered by these mobility agreements, if the receiving jurisdiction deems their education as equivalent, then they meet all the other requirements, they're usually eligible for licensure or registration.

Or in the case of Canada and the U.S., they are then able to write the NCLEX. If their education is not deemed equivalent, all jurisdictions except Spain and the U.S. refer them to a competence assessment process. Currently, the UK refers all non-EU international nurses to their competence assessment process, as there is no educational equivalency.

So, as part of this feasibility study, the benefits, opportunities, risks and challenges of recognizing each other's credentials was investigated. The identified benefits were that the process for low risk applicants could be streamlined. It would increase the opportunities for mobility, and it would also address the

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concerns that have been expressed by all regulators about nurses providing telehealth across international borders.

This would also provide the opportunity to come to an agreement and better align regulatory practice and educational standards across the jurisdictions. It would reduce the regulatory workload, it would help to more clearly define what nursing practice is, and it would provide increased opportunities for learning, sharing, and working together within the framework.

The identified risks were this process must not result in the lowest common denominator, and there must be a common standard for the expectations and assessment of internationally educated nurses. However, there are challenges if we want to get there. We need to accept and trust each other's standards and processes.

We need to figure out how to do this within each jurisdiction's legislative framework. We need a better understanding of the terminology and language used in each jurisdiction. And we need to be able to share data in real-time. And we need also to agree on the processes for licensure or registration, and the use of external assessments.

So, overall, the key findings for the feasibility study were that the similarities significantly outweighed the differences. There was significant evidence, drivers, and interests to support continuing this trans-jurisdictional mobility work and making it clearly desirable to continue the project. It was also decided that all future work would be limited only to our ends with a generalized education.

So, the next steps then became to undertake a more detailed review of each jurisdiction's expectations or standards for entry to practice, professional practice and behavior, and educational program accreditation and approval and to start developing a language... sorry, a glossary of language used across the jurisdictions.

These steps then became the focus for Phase 2. Phase 2 was the mapping of each jurisdiction's entry to practice requirements, professional practice and behavioral standards, and standards and processes for educational approval or accreditation.

The purpose of this was to identify the level of consistency across the jurisdictions and the existence of gaps or differences. So, to do this, each jurisdiction's documentation was reviewed and then entered into one of four mapping frameworks specifically developed for this purpose.

Two of these mapping frameworks were used for the entry to practice requirements, and one each for professional practice and behavioral expectations and educational program approval. For a topic or a theme to be included in the mapping framework, it had to appear in four or more jurisdictions documentation.

A review was also undertaken of the background and processes used to develop each of the jurisdiction's standards, and all the terminology used was entered into a developing glossary. Now, all the jurisdictional regulators except the U.S. had specific documents that fitted into these categories.

For the U.S., the NCLEX test plan and knowledge statements were used for entry to practice requirements, the nurse licensure compact model rules, and the American Nurses Association code of ethics were used for the professional practice and behavioral expectations, and the model rules and the

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new NCSBN guidelines for nursing education program approval were used for educational program expectations.

So, the findings from Phase 2. While this was an extremely detailed review process, it did produce more succinct findings, so you get a bit of a reprieve here. First, entry to practice expectations. Seven out of the nine jurisdictions had updated their expectations within the last five years, and six had set timeframes for continuing reviews and updates.

For five jurisdictions, this review period was either three or five years, and all jurisdictions had similar processes to develop their expectations, which included a literature review, consultation with stakeholders, the development of draft expectations, and then approval by the regulator's board or council.

Three jurisdictions used an online survey to validate their expectations with practicing RNs prior to the final approval. So, these are the categories that were used in the first mapping framework content expectations for entry to practice. There are 11 categories in this framework, with the ones noted in lighter blue being subcategories of a main category, in this case, management of care.

The findings from the category, population, and context to practice, were almost exactly the same in all jurisdictions, with the exception that two jurisdictions did not specifically state maternity or obstetric nursing care as a requirement. Across the other 10 categories in this framework, 82 subcategories were identified, far too many to comment on in this presentation.

However, this table shows you the level of consistency at the category level across the jurisdictions. For a jurisdiction to obtain a checkmark in a category, every subcategory in that category had to be included in their documented expectations. As you can see, overall, there was a high level of consistency, with 89% of the categories being addressed across the jurisdictions.

British Columbia and Ontario addressed all the subcategories in every category of the framework. And most of the gaps occurred in two categories, promoting health and well-being and leadership management and coordination. Where there were gaps in most cases, the jurisdiction had only one subcategory missing in that particular category.

So, this is the second mapping framework that was used in the entry to practice area. And this relates to expected knowledge and skills. And under these seven categories, there were 57 identified subcategories. Again, there was a high-level consistency in what was expected with the main difficulty in comparing being the different levels of specificity provided in the different jurisdiction's documentation.

Some jurisdictions stated their requirements down to discrete tasks, while others used more generalized and higher-level descriptions. It was also difficult to determine the level of knowledge expected in any area, as the words "an understanding" or "a basic level of knowledge for safe practice" were often used in the description of the statement.

So, the next area of Phase 2 that was investigated was the expected standards for professional practice and behavior. Five of the jurisdictions had updated their expectations within the last three years, and all but one jurisdiction had standards that were less than 10 years old with that jurisdiction currently undertaking a review.

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Every jurisdiction also had additional practice or clinical standards and guidelines that relate to specific areas of practice. These standards or guidelines cover a wide range of topics from consent and privacy and confidentiality to expectations relating to areas as diverse as advanced care directives, diabetes, and vascular access.

Across the nine jurisdictions, there were 69 of these more specific standards and guidelines. So, these are the categories and subsections used in the mapping framework for professional practice and behavioral standards. In total, there were 61 subcategories identified across these six main categories. Again, far too many to discuss in this presentation.

But this is the level of consistency across the jurisdictions. While the level of consistency in this area is less than was found in the entry to practice expectations, it is still reasonably high at 73%. Three jurisdictions, Australia, New Zealand, and Ontario addressed all the subcategories in all the categories in the framework.

And every jurisdiction addressed all the subcategories and the category works in collaboration in partnership with individuals, families, and communities. The gaps mostly occurred in two categories, promoting health and demonstrating integrity and trust in the profession. In most cases where there was a gap, this only amounted to one subcategory within a category.

The third area of review were the standards for educational program approval, and this was the most complex one to review and compare. Because all jurisdictions undertook multiple steps and processes in their program accreditation and approval process, a number of different areas were investigated and reviewed.

There were often multiple organizations external to the regulator involved. These included accreditation and quality assurance organizations, and government departments or agencies responsible for approving education or universities. The types of areas that were investigated in this area included the types of program approvals given, how the approval of the educational institution was obtained, requirements for monitoring and reporting, steps in the assessment process, standards used in the program approval process, clinical hours requirements, evidence for required for demonstrating compliance, and outcomes measures.

All jurisdictions basically followed a similar process, with some differences noted in the evidence required for demonstrating compliance with the standards and the use of outcomes measures. So, these are the categories that were used in the mapping framework for standards for program approval. Under these seven categories, 35 subcategories were identified, and this is the level of consistency across the jurisdictions.

As you can see, the level of consistency across the jurisdictions was very high, 94%. Four jurisdictions, Australia, Ireland, New Zealand, and the UK, addressed all the subcategories in the mapping framework.

The remaining jurisdictions exhibited only one gap in one subcategory of the framework. All jurisdictions demonstrated all the subcategories in an overview of program governance, program evaluation, and quality assurance, curriculum and content, faculty, and resources for teaching and learning. Gaps were noted in the subcategories of student admission, progression, transfer, discontinuation, and completion, program leadership, and student experience and support.

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This review of the educational standards identified some consistent issues. These were in relation to the requirements for admission to a program, the extent and quality of clinical learning experiences, the appropriate education and support available to nursing faculty, including clinical educators, and the need for appropriate support mechanisms to be in place for students.

The comparison of clinical hours showed significant variation from no required minimum hours to 2,300 hours which is the requirement for all the EU jurisdictions. So, using the minimum average hours in an approved program for jurisdictions who have no minimum hours requirement and the minimum number of hours required in the other jurisdictions, the range of clinical hours was 687 to 2,300 with the average number of clinical hours across the nine jurisdictions being 1,513.

In reviewing the literature, and in discussion with the jurisdictional representatives, it was identified that more work was needed to get a better understanding of the minimum hours requirements, or if other indicators should be used in this area. So, undertaking this comparative mapping of the standards was challenging.

The jurisdictional statements used different wordings, and they all had different levels of detail included within their statements. Some jurisdictions were very high-level and generalized while others used detail and specific and often relating to specific knowledge and tasks. Sometimes all the steps were associated with a particular event or in one statement, and at other times they would break them down into multiple statements.

As a result, to complete these mapping exercises, the statements needed to be deemed substantially comparable or recognizably similar rather than identical. And in doing this, it raised the question, what level of detail is necessary for statements to be considered consistent?

So, this has now led us into Phase 3 of the project. Phase 3 is just beginning and will, in detail, examine the operational processes being used by each jurisdiction, and how the different aspects of the requirements for licensure or registration are interpreted and operationalized in the actual licensure and registration process.

This part of the process will also create a comprehensive description of the terms used by the different jurisdictions when they undertake their work. This phase will involve describing the process used to license or register a domestic applicant. It's helped to identify the approximate number of cross-jurisdictional applicants, and then identify the similarities, issues, challenges, and difficulties that jurisdictions are currently encountering when licensing or registering an applicant from another INRC jurisdiction.

Case studies of successful and unsuccessful international applicants will be used to identify these issues. And this work is proposed to be completed by late 2021. So, when Phase 3 is completed, this project will have produced a very thorough and detailed analysis of the current processes underpinning licensure or registration across all the participating jurisdictions.

In essence, this will also capture the key components that represent current regulatory expectations for RN education in practice. To my knowledge, this comparison has not been undertaken before across this many jurisdictions. The immediate benefits of this work will be to improve the prospects for member jurisdictions to establish efficient, effective, and safe mobility between the jurisdictions.

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But there also are potentially other implications from this work largely dependent on the imagination and the desires of the members. So, thank you, and I'm happy to take any questions.

- [Maryann] Alison, thank you so much, that was quite interesting, and really moves global regulations significantly forward.

Is there anything else you would like to tell us about the next phase of this study and who you'd like to participate?

- Well, the third phase of this study is where we're really looking at the detailed processes that the regulators do. How do you actually go about registering an applicant and from both the domestic applicants and also the applicants that you receive from another INRC jurisdiction. So, it is really trying to get down into that detailed process of what is actually undertaken.

And the purpose of this is so that everybody can understand what the other jurisdictions do, and to kind of be able to gain more confidence and their processes, and to understand where there may be difficulties or maybe challenges, and how can we go about addressing those challenges and difficulties.

So we need to know what they are in order to know how to go forward with the next step. So, what we're asking is that we would really like the jurisdictions to try and provide us with as much information as they can about how you go about doing your registration processes. And that's going to be based on each one of those sections that were in the Phase 1 where we talked about identity, language proficiency, education, etc.

So, all of those different sections. So, that's really what Phase 3 is about.

- Thank you so much. And I have some questions from some of our attendees. The first one is about the NCLEX exam and looks ahead into the future. And she asks, "Will there be a required exam for licensure or registration that will be the same as the U.S. NCLEX? Or will there be any difference in the exam questions based on jurisdictional differences?"

- Well, I guess I can't really answer that question, because that's something that would have to be negotiated. However, I think we need to remember that the NCLEX is an exam of nursing knowledge. It's not an exam of jurisdictional differences. And I think this has been shown when the NCLEX has been implemented in Canada, and, again, when it was implemented in Australia.

And one of the issues that I know that both the Canadians and the Australians looked at was, were there things that were of concern in relation to the jurisdiction versus was it just about nursing knowledge, which is the same everywhere? So, I think the fact that it has been able to be implemented in both Canada and Australia shows that the exam is basically about nursing knowledge, not about what happens in a particular jurisdiction.

- Thank you. There was another question quite similar to that, which I believe you answered, which is, are there plans to require graduates to take the NCLEX? I think you've covered that. We're going to go on to another question, which is, are there plans to add more jurisdictions such as India?

Would the same information be sought from a new jurisdiction?

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- That would be a decision of the International Nurse Regulator Collaborative. So that decision would obviously be entirely up to them, because that's the organization that is doing this. So, when this project was originally started, there were eight jurisdictions, and then one more jurisdiction joined.

And when that happened, that same information that had been obtained from the eight jurisdictions, the ninth jurisdiction became a part of that. But participation in this project is also voluntary. Not all the jurisdictions may choose to participate in the project at the same time. And so, it is a mixture between them wanting to first join the INRC and the other members.

And that would have to be a question that's better addressed by David Benton, or from NCSBN, who's the representative, or also whether or not that jurisdiction wanted to participate in this project.

- Alison, one final, very quick question. What was your most surprising finding?

- I guess the most surprising finding was the fact that we were so set... despite the fact that jurisdictions think that they're different, they're really not very different at all. And I guess that the more I looked into it, the less differences I found. And I think we all believe that we're different, but we're really not very different.

- And with that, we will end this discussion for today. Thank you, again, Allison, very much. We so appreciate all the work you've been doing. Thanks to Allison for joining us today. We're going to pause for a quick break, and we'll be back in five minutes.

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