QUALITY ASSURANCE PROGRAM: FINDINGS AND RECOMMENDATIONS

College of Midwives of Ontario

1. Quality Assurance Program

Introduction

The Quality Assurance Program (QAP) is mandated under the Regulated Health Professions Act (RHPA), 1991 and is defined as "a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members" (s. 1(1)). Since the intent of the program is to be supportive rather than punitive, the overall impact of an effective QAP is generally believed to be more significant than the impact of the complaints and discipline/fitness to practise activities of the College. The components of the College of Midwives of Ontario's (CMO) QAP can be found under the General Regulation made under the *Midwifery Act, 1991* (O. Reg. 335/12).

The Quality Assurance Program is comprised of the following components:

1. Provision of clinical information
2. Continuing education and professional development (CE/CPD)
3. Peer case reviews (PCR)
4. Quality of care evaluations (QCE)
5. Self-assessments (SAQ)
6. Peer and practice assessments

Background

The College's current program is written in the General Regulation and each General and Supervised Registrant with the College is required to report annually on six PCRs, three QCE Action Records and three CE/CPD activities. Midwives who are registered in the General class for less than 11 months are eligible to pro-rate some, or all, of their activities. In 2015, the requirement for completing an approved activity in Fetal Health Surveillance (FHS) every three years was implemented and is embedded in the CE/CPD requirements. The SAQ is required of registrants every three years and upon returning to the profession after a leave.

The QCE Action Record is designed to collect information that will assist practices and midwives to improve the quality of their care. The policy requires that midwives provide the QCE to all clients at or within six months of discharge from care. According to the QCE guideline, the returned QCEs should be reviewed on a regular basis. The questionnaire has 29 questions divided up into 6 parts: prenatal care, labour and birth care, postpartum care, continuity of care, informed choice and consultation and transfer of care.

PCRs are designed to be educational and should be conducted in a confidential and non-punitive environment. Each PCR must have a minimum of four midwives from at least two different practice groups. Registrants must report on 6 PCRs every year but two of these can be replaced by interprofessional case reviews.

The College describes CE/CPDs as activities that maintain or improve a registrant's knowledge, skills or judgment related to the practice of midwifery. Approved activities include taking

courses, preceptorships and writing articles for publication. Two PCRs, beyond the six required, also can be used as a CE/CPD. Registrants must report on three CE/CPDs each year. In addition, every three years, a registrant must complete an approved activity in Fetal Health Surveillance (FHS) that can be used as one of their CE/CPD activities for that year.

It is important to note that any activity that meets a registration requirement of the College (i.e. Emergency Skills (ES), Neonatal Resuscitation (NRP) and CPR) is not eligible as a CE/CPD activity.

The SAQ is an 11-page questionnaire designed to fulfill the regulation's requirement for self-assessment. In 2015, the Quality Assurance Committee (QAC) directed staff to put the SAQ on hold until a more relevant way of self-assessment could be developed. Currently, a shortened questionnaire is planned for recirculation to fulfill the College's obligations under the regulation until the revised QAP in its entirety, that includes a method of self-assessment, is implemented.

Compliance with QAP

The history of compliance with the QAP since 2010 is provided in Table 1. The table looks at the registrants who were required to submit (i.e. General registrants not exempt). The information is limited by numerous factors but provides a general overview of the number of registrants who submitted completed QAPs during any given reporting year.

Table 1: Compliance data

Date	Number of eligible registrants	Number of compliant	Number of non-compliant & incomplete	Percentage compliance
2010	417	350	67	84%
2011	461	391	70	85%
2012	494	428	66	87%
2013	537	490	47	91%
2014/15	590	531	59	90%
2016	640	618	22	96%

The current components of the QAP were written into regulation in 1994 and have remained essentially the same with a few minor changes. It is time to apply the current evidence about promoting *continuing evaluation, competence and improvement* to the College's QAP. The evidence shows that one of the essential considerations in competency-based programs for professionals is consideration for local contexts, professional cultures and the needs of the practitioners (Austin and Gregory, 2015). In support of this, the College held focus groups with registrants to understand, from their perspective, what was working and what wasn't working in

their required QAP activities so a revised program could combine these registrant-identified needs and professional culture with the existing literature.

Focus Groups

Four focus group interviews (focus groups) were held in November 2016. Three focus groups (Guelph, Ottawa and Toronto) were held in-person. A fourth focus group, in Thunder Bay, was held over the phone. Each focus group had between five and eight members and lasted between 68 – 88 minutes. Focus group questions were specific to the current QAP. In general – the purpose of the focus groups was to understand what works and doesn't work about the current QAP. All participants were registered with the CMO. Most practitioners were General Registrants and worked in urban practices but there was representation from registrants in the Inactive class and rural registrants. Most participants were in practices of eight or more midwives and worked full-time in shared care arrangements.

What was clear from the focus groups was that participants did not understand that the QAP was a mechanism for them to maintain competence but rather saw it as a College strategy to "check in" on them. Participants generally felt that CE/CPD and PCRs met the goals of the QAP and the QCEs did not. The following section combines the findings from the focus groups with published research, discusses discrete categories of the current and proposed new QAP, and makes recommendations about how the goals might be achieved.

Discussion

Current requirements

Quality of Care Evaluation (QCE) Action Records

There is research to show that positive changes can occur in a practitioner's clinical knowledge, and communication and collaboration skills when they receive feedback from multiple sources (e.g. intraprofessional and interprofessional colleagues and clients (Austin & Gregory, 2015)). This technique is generally used as a way of assessing a practitioner's competence rather than a way to maintain or improve competence. Since the QCE captures the feedback from only one source (clients), the improvements that can be found with multi-source feedback cannot be applied to this component of the QAP. In fact, the findings from the focus groups show that participants generally felt that there was very little to learn from the QCEs that supported the goal of the QAP. "I find getting the evaluations is helpful, but finding something from the evaluations to give to the College is not". Participants believed there was value in gaining client feedback and some thought it was essential for midwives to gather client feedback, "I think it's almost not negotiable to hear from our clients – we need to hear from our clients." The generally held view of participants however was that reporting on the QCE did not meet the goals of the QAP and that submitting actionable items should not be a College requirement. Participants also agreed that most of the information they collected from clients on the QCE is positive and there is little that comes back that is helpful to reflect on individual practice, "it's helpful for generic group practice improvements or a pat on the back but I don't see the benefit

of it for an individual midwife because there is no way you can really capture that". In addition to the above concerns noted, participants also expressed the following:

- the anonymous nature of the form means you may not even know who the feedback is for
- the form is old and in need of updating
- the QCEs provide very little new information

The responses from participants support the findings from an evaluation conducted by the College in 2011that found

> *shortcomings both from a local practice improvement perspective and a College perspective. It also seemed to be a clinician-directed questionnaire. Analysis showed that the results of the QCE are extremely positive but with little variation. This lack of variation in responses suggests that the form itself may not be a valid way of measuring clients views of their midwives' care.*

This points to obvious shortcomings in using the QCE as a tool for capturing the information it was designed to capture, as well as a regulatory requirement that is not fulfilling the goal of the QAP to *promote continuing evaluation, competence and improvement* among registrants.

Recommendations

1. QCE be removed from the QAP as a College requirement
2. The intent of the QCE, as a form of quality assessment measurement, be included in the *Professional Standards* for midwives
3. Registrants be informed that the College's QCE is not a valid tool for capturing client feedback
4. Registrants be encouraged to continue to collect feedback from clients as part of best practice but that these not be developed, implemented or evaluated by the College

Peer Case Reviews (PCR)

PCRs were almost universally supported by participants. There was a sense from some participants that PCRs were part of the professional identity of midwives, "it's so ingrained in our culture – we grew up as midwives doing it. For the next generation if it wasn't required [if] they had other options – would they do it? I think it would be a loss." The benefits, including networking, mentorship, sharing midwifery best practices and self-reflection were reported by most participants suggesting that they can be events that add to the ongoing learning of registrants in numerous ways. This is supported in a small body or research that shows that learning and quality of care outcomes were improved among midwives who participated in small, peer group learning (Engels, Verheijen, Fleuren, Mokkink, & Frol, 2003). Travaglia and Debono (2009) found that formalized case reviews (such as morbidity and mortality rounds) can facilitate practitioner learning through candid discussions about events and potential solutions to mistakes. Systematic approaches to these kinds of reviews, however, are more likely to provide better learning outcomes for participants (Joseph, Garrubba, Melder, & Loh, 2015).

Some participants criticized peer reviews for their tendency towards providing support to midwives rather than as a place to discuss challenging clinical care. Others felt that support was an important part of the activity…

> *I think there is a very therapeutic aspect to it that we don't talk about or value but when there's a bad outcome and you have an emergency peer review that ability of midwives to hold that space is huge – like I don't think we can quite put words on how valuable that is in a profession where you feel vulnerable and where bad outcomes are quite traumatic*

Participants also spent time discussing the number of PCRs that are required and how this leads to registrants focusing on the quantity of PCRs rather than the quality. One participant said this about choosing charts to review "…it's like oh my god – its peer review, I've got to rush around trying to get something, it's just a practicality. Your life gets so busy – you know you've got to do it but it usually catches us on the hop."

Another participant said "when there's a case that seems to be prepared and well-presented – like it makes sense. But that is infrequent. Most of the time it's a last-minute presentation and we're all guilty of it". This suggests that rather than critically evaluating care, the PCRs can be a requirement that midwives simply want to complete without effort, or "a chore" that does not meet the goals of the QAP. In addition, participants mentioned barriers to PCRs that included the sheer number of participants (at times over 40 midwives calling into one PCR) and the logistics of conducting them such as organizing them and their administrative and financial costs.

Another barrier to learning for participants was the uncertainty around the confidentiality of PCRs. There was concern that the clinical care discussed might not be considered confidential and a belief, by some, that the very important cases often don't make it to PCR for fear that they might be reported to the College. Despite these concerns, participants believed PCRs should remain in the QAP because of their contribution to ongoing learning and ability to meet the goals of the Program.

Recommendations

1. Describe, for registrants, the intent of PCRs
2. Develop clear guidance around the confidentiality of PCR and who can attend (e.g. midwives, students, general, inactive, Aboriginal clause, out of province)
3. Provide clear guidance around how to conduct peer reviews (perhaps more like Morbidity and Mortality rounds, adopt best practice from other disciplines for conducting them such as:
    - Limiting numbers of registrants in attendance
    - Criteria to measure the review against
    - How to prepare them. This can include research that shows the following contribute to more rigorous reviews of client care in a peer reviewed forum such as what happened, was there a breach of standards, what can be done to prevent a recurrence, what are the key lessons for the organization or individual

4. Consider requiring that all midwives present a peer review every reporting period (feeds into self-assessment)
5. Encourage inter and intraprofessional case reviews
6. Consider the potential barriers for some practices in attending PCRs
    - Organizing them
    - Time to prepare for them
    - Is it possible to do them by webinar? How secure would a web format be?

Continuing Education/Continuing Professional Development

Continuing Education and Continuing Professional Development are two distinct terms; the former refers to the continuation of educational activities after the completion of formal education and the latter refers to outcomes focussed activities that are often self-directed (Austin & Gregory, 2015). This is an important distinction to make when discussing this part of the QAP.

Participants, in general, enjoyed participating in CE/CPDs and many appreciated the flexibility of the current program that accepts everything from reading a journal article to attending a conference. Other participants felt there should be stricter rules around the type of CE/CPD because "…midwives tend to study what they like – not necessarily what they need" and "why is a one-hour webinar worth as much as a three-day conference?" While the flexibility may be appreciated, it is not in keeping with the current evidence that shows lectures and other didactic techniques have little to no effect on improving practitioner behavior whereas participation in interactive activities, such as clinical simulations and case-based learning, have been shown to have moderate-to-high beneficial effects (Austin & Gregory, 2015). A systematic review, that includes research on midwives, reported similar findings showing that interactive activities are important in improving practitioner behavior; though this does not necessarily mean client outcomes are affected (Elliott, Murrell, Harper, Stephens, & Pellowe). While there was a desire by some participants to retain the right to employ print-based, didactic forms of learning, the current evidence does not support this as a solitary activity for improving knowledge.

Research shows that competent practice requires both technical skills and non-technical skills (Kodate, Ross, Anderson, & Flin, 2012). The seven basic non-technical skills discussed by Flin & O'Connor (2008) are situation awareness, decision-making, communication, teamwork, leadership, managing stress and coping with fatigue. Since skills such as communication are essential to practice and are often cited as areas of concern for the College, a QAP that acknowledges the contribution of these skills to midwifery practice warrants consideration.

In terms of the number of activities required by the College, there is no evidence to support three activities as an appropriate or inappropriate number. In fact, there is evidence showing that there is little, to no, benefit from setting a specific number of CE/CPD hours in terms of affecting positive change in clinician behaviour (Austin & Gregory, 2015). Like the CMO, common practice among Ontario regulators is to set a required number of hours or points for CE/CPD for compliance with QAP - thereby quantifying the commitment to ongoing learning. Some Colleges, like the College of Pharmacists of Ontario, has elected to use learning objectives without specifying numbers of hours or credits.

Currently, the QAP requires that all registrants participate, without necessarily completing, a Fetal Health Surveillance (FHS)activity every three years. Allowing registrants to individually participate in an online module poses problems by contradicting the research showing that didactic or print-based continuing education material may have little to no effect on changing clinician behaviour. A 2011 systematic review found that communication, team training and emergency response are essential in FHS training which suggests that an online module, in isolation, may result in little to no improvement in FHS knowledge and skills (Pehrson, Sorensen, & Amer-Wahlin, 2011). Additional problems are posed by the three-year time frame. The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends regularly updating FHS skills and proposes that all care providers participate in an interdisciplinary, FHS course update every few years (Liston, Sawchuck, & Young, 2007). Pehrson et al. (2011) found that knowledge of FHS is retained at six months post-training but that clinical skills may start to diminish prior to six months. So, while there is no widely accepted time frame within which organizations recommend updating FHS, the current three-year requirement is arbitrary and adds to the numerous reporting deadlines that focus group participants were frustrated by.

Recommendations

1. Use the title CE/CPD to describe the components of the QAP with the details, such as PCRs, an acceptable activity within the CE/CPD
2. Get QAC feedback about using discrete learning goals as outcomes measurements rather than hours and points as input measurements OR move to a credit-based system to encourage midwives to adopt more multi-modal continuing education activities*
3. Remove the three-year FHS requirement from the QAP and, if FHS to remain a College requirement, consider including it as a continuing competency in the registration regulation
4. Communicate with the Association of Ontario Midwives (AOM) about the learning needs of registrants for their consideration when developing webinars and other learning programs
5. Require non-technical CE/CPD activities with guidelines about how to do that
6. Registrants design their CE/CPD activities based on their self-assessment reducing the prescriptive nature of the current QAP

Self-Assessment

The College's Self-Assessment Questionnaire (SAQ) was put on hold by the QAC because they felt it did not meet the goals of a self-assessment tool, they considered it labour intensive and did not lead to adequate self-assessment and reflection. Focus group participants also did not find the SAQ a valuable tool and did not feel it met the goals of the QAP. One participant said, "I have not learned from it, it is just a task I have to do to be registered as a midwife". Another participant spoke on behalf of the focus group by commenting, "I think it would be the minority in

* To be determined by QAC

the room that did not mind the SAQ". In addition to not meeting the goals of the QAP, participants also were concerned about how the College might use information contained in the SAQ. One participant described her hesitance about the SAQ

> *Maybe that comes from the culture of our profession and relationship with the College where, you know, it's been very regulated and almost punitive so that's what the College represents to us. And when you are also asking us to self-reflect we are like "ooooh". It seems scary*

Another participant simply said "…in the SAQ you are kind of making stuff up but in a more thoughtful way."

What the current research says about self-assessment is that when practitioners self-identify their own learning needs, it can lead to more engagement in their continuing professional development activities. It is not, however, easy to self-reflect with research to show that the ability to self-assess may be the worst in practitioners who are the least competent (Austin & Gregory, 2015). Motycka, Rose, Ried, & Brazeau (2010) recommend that this challenge may be partially addressed using external feedback.

Recommendations

1. Develop a guided SAQ using objective measures of performance
2. Attach SAQ to learning goals
3. Self-assess both technical and non-technical skills
4. Ensure that self-assessment addresses the needs of the practitioner as well as the systems within which they work
5. Consider how members could use BORN reports to reflect on practice (could be points in CE/CPD) – optional rather than mandatory

Reporting

Focus group participants were frustrated by how many different College activities they had to report on and submit, and that deadlines seemed to always be changing. Examples given were Active Practice Reports (APR), Continuing competency documentation (ES, NRP and CPR) and five discrete QAP activities (including Fetal Health Surveillance and SAQ). Numerous participants did not understand the need for the different reporting deadlines and found remembering them onerous and confusing because dates and requirements seemed to change over the past few years. In the words of one member, "I see [QAP], to be honest, as a necessary evil I have to remember to do because there are so many other different reports we have to do….it does seem to be another workload."

Some participants said they liked reporting on QAP every year and some said they did not. The benefits of yearly reporting for participants was that they know what they must do every year and then just go about doing it. What participants did not like about yearly reporting was that it could be challenging to meet the goals of the QAP. The "life of a midwife", specifically being on-

call, posed barriers to planning and attending some QAP activities. In support of this, a yearly reporting cycle is shown to be inadequate for most professionals to achieve their own learning goals and that longer cycles, from two to five years, may be better by providing practitioners time to reflect on learning needs and achieve their learning goals (Austin & Gregory, 2015).

Participants discussed wanting to report their QAP to the College thinking that this accountability would be a motivator to complete it and some felt there was no point in the QAP if it wasn't necessary to report it. However, numerous participants described reporting as a psychological and physical barrier to completing the QAP. Regarding PCRs, one participant felt that "the most frustrating part is not the actual peer review, it's the documentation". Registrants report on their activities by listing them in the database where a staff member checks each entry for completeness. This takes a great deal of time and resources.

Portfolios are the way numerous health care regulators require their registrants to document their QAP activities. A portfolio can be formal or informal and can be used to house the professional history of the practitioner. In addition to being an ongoing record, portfolios are often the beginning of the registrant's ongoing learning starting with a guided self-assessment, the development of a learning plan that identifies learning needs and eventually reflecting on how well the activities met their learning needs. Austin and Gregory (2015) suggest that portfolios can be an effective way to assess practice improvement and professional judgement. When discussed with participants, some liked the idea of portfolios and some felt it would be much more work that they did not want to have to do. Others liked the notion of a portfolio as a place to organize things and reduce the administrative burden of tracking and submitting multiple certificates of completion (CPR, NRP, ESW), APR and QAP activities.

> *I am a fan of things that are not in addition to the things that I already have to do. That is where we tend to fall down as midwives and is why things like peer reviews tend to get forgotten about and left and then all of a sudden you are scrambling….and we've had a lot of changes in terms of when we're reporting and how we're reporting and all of that and some of the changes have been great but the fewer things I have to remember the better. So, if every October we do everything - our renewal - our QAP - our self-reflection - whatever - once done - all in one place - we're much more likely to remember it as a profession than if in July we report on this, and October do this and one every five years do this.*

Recommendations

1. Implement a portfolio based reporting system allowing registrants to house all College required documentation including (e.g. QAP activities, continuing competencies)
2. Coordinate registrants' requirements to report on activities college-wide and use portfolio to do so
3. Increase the reporting cycle from every year to every two to three years*

* To be decided by QAC

4. Get rid of pro-rating (to focus on outcomes rather than inputs) as the flexibility in the program will make this unnecessary
5. Self-assessment will guide the QAP and be in line with registrants reporting cycle (not due at different times)
6. QAP reporting will be done using a declaration of completion
7. Registrants will be randomly assessed with a certain percentage going on to have their QAP checked for completion
8. Develop a system of who reports and when in the three-year cycle
9. Revise the database portfolio to reflect these changes
10. Develop a document about the QAP, the regulations where it lives, its intent and its outcomes (stressing that it is for the good of registrants – not just a College mechanism for keeping track of members)

Who will report

The current regulation requires that registrants in the General and Supervised classes must participate in the QAP. The proposed legislation requires that General, Supervised and Inactive registrants submit a QAP. With this new requirement, there was some concern that it was unfair to midwives who had temporarily left the profession for things like sick leave or parental leave. Another potential challenge with requiring Inactive registrants to report was noted by focus group participants who stated that Inactive registrants have a difficult time meeting their PCR requirements. An important consideration is the difference between an Inactive registrant who is on short term leave from practice and an Inactive registrant who maintains registration for purposes other than clinical midwifery. As such - the College needs to carefully consider how to promote ongoing learning and competence in Inactive registrants who are non-clinicians as well as those who are providing clinical care at some time during their reporting period.

Members in Type 1 Alternate Practice Arrangements (APA1)

QAP requirements for members working in an APA1 are approved by College staff and exclude the QAC from exercising their powers under the RHPA to approve exemptions from any or all components of the program; "Upon application by a member, the Committee may grant an exemption to the member from any of the requirements of the program because of illness, maternity leave or any other circumstance the Committee considers appropriate." O. Reg. 335/12, s. 4. (*This Part applies only to members who hold a certificate of registration for the general or supervised practice class. O. Reg. 335/12, s. 2.*)

Recommendations

1. Consider having two streams where, for example
    - General, Supervised and Inactive **with** intention to practice fulfill CE and CPD guided by self-assessment
    - Inactive **without** intention to practice fulfill CPD only.
2. Develop a process for non-compliance among inactive members
3. All members working in APAs will be referred to QAC for exemptions if they cannot complete their QAP requirements

4. If APAs remain or if the practice contexts change – consider *contexts of practice* so registrants practicing in rural/remote regions, for example, might need something different (e.g. more interprofessional activities)

Exemptions and non-compliance

The Quality Assurance department has a process for managing cases where registrants do not submit their QAP as well as for registrants who apply for an exemption from the QAP.

Recommendation

1. Maintain the current process for QAP non-compliance
2. Revise the risk framework for considering QAP exemptions and non-compliance in accordance with the changes to the QAP (e.g. lower the threshold for defining non-compliance if the reporting period is lengthened)

Implementation

There was a lot of confusion among the participants about aspects of the QAP. The most concerning was the lack of understanding regarding the intent of the QAP, the requirements around confidentiality of peer reviews and self-assessments, and what the College does with the information gathered from the QAP. These concerns highlight the lack of knowledge about, and engagement in the QAP that is currently felt by numerous participants and is perhaps reflective of the larger registrant population. As one participant said…

> *If you are thinking about how to get midwives engaged in the QAP program you have to look at what the QAP is giving back to midwives because right now the QAP program is work… people don't think of peer review and think "oh I'm so glad that QAP made me come to peer review". They aren't thinking "oh I'm so glad I have this opportunity to fill out my self-assessment form-good thing we have a QAP program". … I would say if you are looking for ways to engage with members about the QAP - its making that link in their mind - I think it's more of a campaign of the goal and of the "we want you to be great midwives and here are all the things", make it more about the benefits we are getting out of it, not so much about the work.*

Recommendation

1. Develop a QAP guidebook providing clear and detailed instructions/guidelines on the QAP including who it applies to, its purpose, components, how to complete it, submit it and outcomes of non-compliance. It will also provide guidance about confidentiality as it relates to the components of the program
2. Implement the revised QAP when the following conditions have been met
    - New QA regulation has passed
    - All supporting documents for the QAP have been developed
    - The database is fully functional
3. Develop a video (PowerPoint presentation) for the College website explaining the new QAP so members have continuous access to information about what the changes are,

how to work with the new QAP, negotiating the QAP portion of the database and the expectations
4. Share findings with membership

Regulations

The regulations should reflect a revised QAP that is based on member feedback and current evidence. Rather than add the details that are in the current regulation – the regulation should be flexible or broad enough to allow the Quality Assurance Committee (QAC) to approve revisions to the programs to keep in line with emerging evidence, best practice and local contexts.

Recommendations

1. The new Quality Assurance regulation has been submitted and a revised QAP will be implemented pending acceptance of this regulation

Conclusion

It is important to make a QAP that meets the needs of registrants within the mandate of the RHPA but also to consider the College resources required to manage such a program. A new database has streamlined the process but more changes will need to be made on behalf of the database, staff and the registrants to successfully implement a revised QAP. Once approved by Council, the revised QAP will need an implementation and evaluation plan. The evaluation plan will be developed alongside implementation and will include surveying registrant's during the first reporting cycle to determine its accessibility, and then again after the first reporting cycle to determine its value.

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