Continuous Professional Development & Patient Safety

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Health and Consumers

Introduction

60 experts in the area of continuous professional development

representatives of regulatory, professional and educational bodies and the European Commission

Aim: to discuss ways to optimise CPD of health professionals to improve quality of care and patient safety

Session 1: the impact of CPD from the research, educational and clinical perspective

Session 2: different national approaches to organise the CPD of health professionals

The European context

The increasing cross-border mobility of health professionals underlines the importance of the need for deeper understanding of the variety of CPD approaches in different MS

CPD is a component of quality care, since periodic, regular evaluation and results of clinical performance influence the quality

Appropriately skilled staff is essential to meet the demands for new care approaches and improved services for patients in the context of evolving medical science

EU initiatives

- Increasing awareness of professionals to achieve improved healthcare quality and ensure patient safety
- Increasing patient safety culture is inevitable
- Promoting education and training of health professionals on patient safety - *„Patient safety education into curricula"*
- International mutual recognition, acceptance of actions in CPD
- Exchanging of information and best practice for optimising CPD in the Member States under PQD directive

CPD

Continu**ing** professional development and Lifelong learning ensure

- ✓ health professionals to remain fit to practice
- ✓ having appropriate knowledge and updated skills required
- ✓ maintaining and developing knowledge, skills and professional performance
- ✓ wider domains of professionalism (broader concept of personal development - attitude, behaviour - taking into account managerial, organizational, systemic factors)
- ✓ contribute to improving healthcare outcomes and patient safety

CPD as a self-education, self-improvement should become an integral part of practice

What can we learn from research evidence, education and clinical practice?

Continu**ing** – since it never stops

Different forms: lectures, on-site trainings, small group meetings, skills trainings, on-line distant learning, multidisciplinary team working, educational outreach visits

Various trainings but no common methodology and tools

No standard and mandatory CPD curriculum → the real CPD is based on personal motivation through different ways of learning

Learning comes from immersion in practice and integrating CPD into daily clinical practice

What can we learn from research evidence, education and clinical practice?

- We use credits that recognize the learning process
- Measuring the effectiveness of CPD is difficult to capture
- For a reliable assessment, the contextual variables need to be taken into account
- Evaluation of learning outcomes must focus on professional performance in real clinical practice
- Audit and feedback → performance improvement
- Some CPD activities need to be prescribed: structured peer-to-peer dialogue or coaching can improve performance and can help ensure a "safer" health professional

What can we learn from research evidence, education and clinical practice?

Communication errors = elevated risk

Inter-professional education (IPE) = collaboration of different professions

Aims to change multidisciplinary cooperation between health professions

Requires a system change – new attitude of professionals

To assess the quality of interprofessional teamwork: *Interprofessional Practice and Education Quality Scales*

Need for tools that further developing the competences

Need for collaboration and providing learning opportunities to stimulate IPE

Two interventions - clinical practice

1. Jeroen Bosch Hospital in the Netherlands

new nursing leadership programme for continuous education for nurses

improve clinical outcomes by empowering bachelor-trained nurses to become leaders

→ *shared organizational vision + multiprofessional working context*

2. Spanish "Zero project"

reduce hospital infections in intensive care units

training module for doctors & nurses (50.000)

→ decreased incidents

What can we learn from national CPD models?

1. England

a new system of revalidation of the nurses' licences will start in April 2016

promote the integrity of nurses - Professional Code of Practice and Behaviour

undertake at least 35 hours of CPD every three years in order to re-register

Revalidation is about promoting good practice

Key success factor: *regulators work in partnership with the health professionals*

What can we learn from national CPD models?

2. Ireland

a new revalidation system for pharmacists was introduced in January 2016

adapted from a Canadian model - a self-directed portfolio linked to a core competency framework (no hours, no credits)

CPD portfolio for inspection every 5 years

peer led, peer supported and peer assessed system

Key success factor: *partnership between the regulated and regulator*

What can we learn from national CPD models?

3. Sweden

voluntary CPD framework

Swedish Associations of Local Authorities and Regions provide guidance and support

systematic approach to create a learning environment that links better professional development to better system performance and better patient outcomes

Key success factor: *collaboration of different actors participating the „development dialogue"*

What can we learn from national CPD models?

4. France

the current CPD system has recently been reformed with a new legal act in 2016

introduction of a CPD obligation over a three year period

updating knowledge, evaluation of professional practice and risk management

„High council of CPD”

the new system has launched a debate over public funding

Workshop Conclusions: Lessons Learned

- **Learning comes from the practice** itself and there is no best method of learning to ensure better patient safety and quality of care.
- **Measuring** the impact of CPD should focus on **real clinical performance** not on attitude and skills. The quality of the CPD programme is not the only factor for success.
- Difficult to find long-term **indicators** on improved patient outcomes by CPD due to the many dependent variables.

European Commission

Workshop Conclusions: Lessons Learned

- **CPD credits** do not reflect what professionals really learn and there is no evidence that the collection of CPD is effective. Performance improves with use of learnt skills and knowledge in daily practice.
- Improving the patient safety culture depends on a range of factors, most importantly **behavioural change and the working environment.**

  Interprofessional education can stimulate system change.
- More **hard evidence** required from research on collaborative practice to bring about system change.

Workshop Conclusions: Lessons Learned

- Lessons from new revalidation schemes link a minimum number of CPD hours practiced with **peer support, practice-related feedback** and a **reflective process**.
- Structured **peer dialogue** important for learning process and as "isolated" professionals give rise to concern.
- Collaboration and a **shared organizational vision**, involving all actors – regulator, employer, CPD provider and professional – is key for effective CPD combined with a (collective) codes of professional conduct and ethics.

Workshop Conclusions: Lessons Learned

- **European cooperation**

  the **exchange of good practice and research** can contribute to a better understanding of relations between better care, better results and better professional development.

  European cooperation and dialogue can **raise awareness** and help strengthen the evidence for investing in continuing professional development for better clinical performance and quality of care for the patient.

  EU arenas for **preventing failures** and harm in care, ensuring better clinical performance

For further information

http://ec.europa.eu/health/workforce/policy/index_en.htm

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