

## Summary of research to inform registration standards reviews

AHPRA's Research Unit (RU) has conducted two research studies to inform reviews of core registration standards. The initial study in 2015 considered relevant grey and academic literature, National Scheme data and international benchmarking from a regulatory perspective. It updated previous research commissioned by the National Scheme from the Joanna Briggs Institute at the University of Adelaide in relation to CPD and by Professor Liz Farmer in relation to recency of practice. The RU updated its 2015 work in 2017 to identify additional relevant grey and academic literature and to broaden the scope to include research relevant to the Chiropractic and Optometry professions. The reviews have also considered the research commissioned by the Medical Board of Australia as part of its [development of a Professional Performance Framework](#) and the [final report of its Expert Advisory Group](#).

### Initial National Scheme research on CPD

In 2012 AHPRA commissioned the Joanna Briggs Institute (JBI) at the University of Adelaide to undertake a systematic review of the literature on CPD in regulated professions, with a focus on health practitioners. That review was to address the evidence-base for CPD in maintaining or improving competence, identify the characteristics of effective CPD and provide evidence for the effectiveness of mandatory requirements.

Overall, the JBI review found good evidence that CPD is effective in increasing practitioner knowledge. There was, however, less evidence for knowledge transfer to change practice and even less linking CPD activities to improvements in patient safety. CPD activities that included interactivity, multimedia, multiple-instructional modes and repetition were found to be consistently more effective than learning exercises designed and delivered using a single instructional mode.

Specific CPD activities and teaching modes identified as more effective than no intervention were:

- audit and feedback
- assessment and supervision
- reflective learning
- attendance at conferences and other educational meetings
- journal clubs
- printed materials
- on-line learning and classroom-based learning
- simulations, and
- public health campaigns

There was, however, limited evidence for the relative effectiveness of different CPD activities against each other.

The review concluded that there was sufficient evidence to suggest that activities promoting self-reflection should be fostered, particularly the use of portfolios. Supervision and feedback were found to enhance learning outcomes and peer interaction reduced feelings of professional isolation.

Finally, the JBI review was unable to find any direct evidence concerning the relationship between accreditation or other quality controls and effective CPD. However, their search strategy was restricted to peer-reviewed systematic reviews whereas this kind of regulatory information is more likely to be found in the grey literature that has been reviewed in the 2015 and 2017 RU reviews.

## CPD Conclusions from 2015 and 2017 studies

### *Effectiveness of CPD*

Evidence from the Medical Board of Australia's work on revalidation (which culminated in its proposal to develop a Professional Performance Framework) has also been taken into account

A recent synthesis of eight new systematic reviews of the literature about the effectiveness of CPD published since 2003 concluded<sup>1</sup> i;

- "CPD is able to improve clinician performance and patient health outcomes
- has been shown to be more reliably positive in its impact on clinicians' performance than it has been on patient health outcomes.
- The effect of CPD on patient outcomes has been more difficult to demonstrate due to the complexity of intervening variables, and
- leads to greater improvement in physician performance and patient outcomes if it is interactive, uses more methods, involves multiple exposures, is longer, and is focused on outcomes that are considered important by clinicians."

The RU's research indicated that:

- Including a component of planning and reflection would align with best practice and may support inter-professional practice.
- CPD may have an important role to play in facilitating safe workforce flexibility by requiring practitioners who are taking on new areas of practice to undertake professional development relevant to the expanded scope.
- The patients of practitioners who exercise prescribing rights may benefit from a requirement to undertake CPD relevant to that area of their practice.
- CPD appears to be as important for experienced practitioners as recent graduates.

### *Characteristics of CPD*

- Definitions of CPD vary widely. However, a core characteristic is that it is a component of lifelong learning (LLL) that begins from graduation.
- There may be variation in the spectrum of expectations for CPD between groups or cohorts of a profession that is proportionate to the inherent level of risk of harm to the public from the specific profession.

### *Adult learning*

- Classical adult learning theory suggests that learners should be involved in the planning and evaluation of their learning programs, which should also be experiential, relevant and involve a problem-centred approach.
- Health practitioner performance can be improved by providing individual feedback in a safe environment where they can discover the strengths and limits of their knowledge, compared to information provided by an external source, and which empowers them to take responsibility for the changes that result from those discoveries.
- Evidence suggests that practitioners learn more when CPD processes are continuous throughout a career with shared accountability and responsibility for learning.

### *Assessment*

- eLearning, including assessment, is widely recognised for the purposes of CPD in the United Kingdom (UK), USA and some European countries.

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<sup>1</sup> R.M. Cervero and J.K. Gaines, 'The impact of CME on physician performance and patient healthcare outcomes: an updated synthesis of systematic reviews', *Journal of continuing education in the health professions*, vol. 35, no. 2, 2015, pp. 131-138.

- Research supports assessment of activities relevant to identified learning needs that will:
  - focus on the task, not the individual;
  - be specific and clear;
  - not provide normative comparisons;
  - not provide grading; and
  - not threaten self-esteem.

#### *CPD diversity*

- Recent CPD-related research has increasingly emphasised the need for inter-professional education.

#### *CPD on therapeutic substances*

- There has been a shift towards a wider range of health practitioner groups being involved in prescribing, dispensing and/or administering therapeutic substances, which raises the question of specific CPD for groups or cohorts within a profession involving different risk to the public.
- Mandatory CPD requirements have been introduced in the UK National Health Service for practitioners who prescribe therapeutic substances.

#### *Accreditation of CPD*

- In some cases internationally, CPD is subject to a quality assurance process described as accreditation. This quality assurance activity may be undertaken by a number of different bodies and does not usually occur within a statutory framework, as distinct from the accreditation functions in the Health Practitioner Regulation National Law as in force in each state and territory.
- There is no clear scientific evidence showing that CPD accreditation is more effective than no accreditation. However, there is a lack of research on the topic.
- CPD accreditation for healthcare professions is common in other countries with comparable economies to Australia.
- Accreditation of CPD activities is more common than accreditation of CPD providers in European countries.
- Professional organisations and regulatory agencies are the most common bodies to accredit CPD activities in Europe, although Ministries of Health also play a significant role.
- Research is needed to better characterise the relationship between CPD and quality of care, patient safety and patient outcomes; with a view to accreditation systems becoming more outcome-driven.
- While CPD accreditation agencies in the United States of America (US) were loosely linked to regulation, they were more closely aligned with the technical developments that drive change in professional practice.
- Internationally, accreditors of CPD are often faced with a tension between the interests of the public and the profession.
- In Australia regulation of medical practitioners, with specialist and general registration, is tied to completion of CPD that is accredited by the relevant specialist medical college.

- CPD for National Regulation and Accreditation Scheme (the National Scheme) professions covered in this review is less well documented in the literature than for medical specialties. This may reflect a less developed stage as regulated professions.
- Internationally, there were a number of models for CPD accreditation found in the course of this review, from governmental agencies to independent voluntary and self-regulated forms. Common features of these models include that these are free from commercial bias and are publicly accountable.
- The National Law is silent on CPD accreditation.

## ROP Conclusions

Key points from the 2015 RU study in relation to recency of practice are:

- There is very limited research evidence about the amount of recent practice required to maintain competence.
- There is a small amount of evidence that shorter breaks from practice (1 – 5 years) have less impact on competence than longer breaks (5 years plus).

## PII Conclusions

Key points from the 2015 RU study in relation to professional indemnity insurance are:

- There is little published research about professional indemnity insurance requirements for registered health practitioners. A contributing factor may be because data in this area is generally protected as commercial-in-confidence.
- **Combining research with other information**

When undertaking registration standard reviews, National Boards draw on a number of sources of information in addition to research and international benchmarking, including their regulatory experience pre and post-National Scheme and National Scheme data. These other sources of information are particularly important where the research evidence is limited. National Boards continue to monitor the research evidence as it develops so that their regulatory work is informed by the best available evidence.

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<sup>i</sup> Cervero RM, Gaines J. The impact of CME on physician performance and patient health outcomes: an updated synthesis of systematic reviews. *J Contin Educ Health Prof.* 2015;35(2):131–137.