Regulation Matters:
a CLEAR conversation

Episode 60: Inquiry to Audit – Improving Communications
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Line Dempsey: Welcome back to our podcast, Regulation Matters: a CLEAR conversation. Once again, I'm your host, Line Dempsey. I'm currently the chief compliance officer with Riccobene Associates Family Dentistry here in North Carolina and Virginia, and I'm also CLEAR's president for the 2022-23 year.

As many of you are aware, the Council on Licensure, Enforcement and Regulation, or CLEAR, is an association of individuals, agencies, and organizations that comprise the international community of professional and occupational regulation. This podcast is an opportunity for you to hear about important topics in our regulatory community.

On this episode we'd like to talk about the College of Registered Nurses of Manitoba's Inquiry to Audit Project. Joining us today is Carol Puchailo. She is the nurse practitioner and a practice specialist with the College of Registered Nurses of Manitoba. We're glad to have you with us today. Thank you.

Carol Puchailo: Thanks, Line. Thanks for the invite. I'm so glad to be here.

Line: Well, we're happy to speak with you, and let me also thank our listeners for joining us today. Now, I understand that the College of Registered Nurses of Manitoba is a self-regulated nursing body and that you have various ways that the public and employers can contact you to discuss any concerns they may have. Those concerns could be anywhere in the range of inquiries or consultations, reviews or audits. What we'd like to talk with you about today is the initiative your practice team took to critically think through your systems processes with a focus improving upon communication. So what we're really referring to is this Inquiry to Audit project. And I think you call it the I2A. So, why did you call it that?

Carol: That's a good question. Well, you know, really it was because we love acronyms here at the College of Registered Nurses. And it's kind of, you know, we have our own language. I'm sure you can agree with that, Line; in any given regulatory college or institution we have ways of making it simple for us, but yet it actually is like a secret language. So it was our administrative assistant who just kind of coined the phrase 'inquiry to audit,' because it's four different pieces of the puzzle for different

processes. And instead of saying all four at once, we just said I2A, to just make it simple, make it sweet. So it was one of those names that stuck, and it's kind of fun to say.

Line: Absolutely! I liken it to-and I know we didn't create it-But we use DEI a lot for diversity, equity, and inclusion, and it's just become part of the vernacular. So hopefully, this I2A will catch as well. So why was it important to the College of Registered Nurses in Manitoba to review the communication process for the public, you know, or employers or registrants. Why was that important?

Carol: Well, firstly, it was because, you know, there's a miscommunication, or there was some information that went astray or went awry. So our process, you know, usually goes smoothly, but when it doesn't go smoothly, it was obvious to the whole team and to the departments in quality that we could use a little tidying up. You know we could figure, how did we go wrong? Why did that information get neglected or get missed? Or why didn't we answer the questions that were targeted to us? You know, what happened? Why was there a miscommunication or a mismatch? And really, I mean, we're always striving in quality to perfect or get better, right. That's the whole goal of quality assurance is to get better, is to improve continuously. So why couldn't we apply this process to ourselves? And I think that's probably the hardest thing to do is take a quality project and look thoroughly at your own way you do business, and ask yourself, how could we do it better? How could we improve this? And how could it get better for the public, how to get it better for our registrants, so that we could have a cleaner, clearer, simpler process.

And our goal is always to ensure that practice conforms to our public benefit policy, because we want to be accountable to the public. We want to make sure, at the end of the day, we're self regulated, but we're actually here for the public's benefits, so that we have good high quality nursing care out there.

Line: Yeah, I think that's brilliant that you will take the moment to look at the process, because often we get used to doing the exact same thing. And that's what we've always done, and you know that there's a resistance to change, if you would. And so, being able to look at things from an outside body back in and figure out how to move and improve the process, I think, is a brilliant way to make sure you're staying in touch and in focus with those that are maybe not used to it. Even just like when we talk about the jargon of using the I2A, right. You know, you've gotten used to it, but the public maybe doesn't know that term, right? So, being able to look kind of retrospectively or introspectively at it is great. So I'm assuming that there's been some challenges in this. What kind of stuff did you face?

Carol: Oh, my gosh! Well, the challenges were pretty evident, you know. So the biggest part is that in quality we're here to improve prescriptions that are written. We're here to improve nursing behaviors and outcomes. But in conduct, which is a different part of our team, they're more investigative, right. They look at what went wrong, and how it went wrong, and how do they mitigate that or create a rehabilitation program for registrants so that they can actually get back to working. So we don't always talk to each other. We can't actually, because there could be a breach of privacy or a breach of information that shouldn't be shared with groups outside of conduct.

So, you can see how you have to be parallel yet work together for the same good, for the quality benefit for the public. But we can't necessarily sit down and have open meetings or open discussion, so you can see how sometimes information can get misunderstood, or it can go the wrong way.

And you know what we found, too, is that, you know, the privacy was important to keep a registrant's information important, but at the same time what had to be shared and what had to be kept, and we're still in the process of always negotiating that, so that just enough information is shared between quality practice and our conduct team.

Line: Well, looking at this internal dialogue at your regulatory body, who benefited from it?

Carol: Well, in the end, I'm hoping that our interactions with the public definitely is number one priority, but that the registrant who comes into the process, who either is asked to answer some questions or to give us more information, is directed in the right way at the right time. And we call that the right touch, that we don't use any heavy-handed language, but that we are directing the person through the process much more smoother. And when we had to go back and define what is an inquiry, what is a consultation, and what is a review, and what is an audit? That's how we learned how do we figure out where this person should go. And we created an algorithm and a map, sort of, to give us a direction on which way a registrant can enter our process. And so, I think for sure the registrant would benefit from this.

And us as staff- we also benefited from it because we defined our terms of reference. We defined what and how a case is explained. So I think it got clearer and clearer as we negotiated the roles and we got role clarification.

Line: So I guess you know, looking at that, I guess maybe the best way to ask is, how did changes occur at the college?

Carol: It was incremental. Steps were taken to create a flow chart that sort of described the organizational process map, and that acted as our standing and starting point. So if somebody were to call in with a complaint, we would know that sometimes all complaints are is just that they wanted to share some information. So, a complaint could actually go from something that wasn't necessarily a complaint to 'Oh, I wanted to ask a question.' And then we can take that information and say, Okay, that was just an inquiry. People just wanted to know where could they find something on our website, and that simplified the process. And then, who is in the best position to answer that question. So, for example, it was our administrative assistant who was in the best place to answer inquiries because they were facts-based, right. And so all the facts that were needed were already there on our website, and we just had a person to help navigate.

And a consultation was the next sort of thing that we identified. Consultations are a little more in depth. They have to do with our practice directions, our sort of clinical guidelines for nurses, and that would have to be a practice consultant from the quality practice team that would take that call and

answer that call.

And then, a review would be a consultant as well. But the review is a little deeper. In a review, we would ask more in depth questions about how did you meet those expectations when we talked to the registered nurses. How did you meet your expectations? So we were just asking them to reflect and give us back answers.

And then, when you have to go to an audit; an audit is a little deeper, and it goes to finding out what happened, what went wrong. It was like, you know, some sort of case happened that, in the public's best interest, if we don't intervene, something terrible could happen to the public, so we know we had to have the right touch at those four sort of critical junctions.

Line: Now, would you want to do the process over again? I feel like the answer is going to be. . .it should be. But why or why not?

Carol: The answer should be, absolutely, we have to do this process over and over again. What we wouldn't want to do over again is the critical incident that occurred. But you can't always manage what happens out there, outside of the walls of your institution. So we have to be better prepared for the future, and I think we are better prepared now that we had to critically analyze our process.

So, the thing that I would say about this is quality assurance is continuous. It's iterative. You have to keep tweaking, keep working at it, keep adjusting, because if you don't adjust properly to the right touch, then you're going to actually do harm, right? So, of course it's why we want to serve the public, and it's why we want to improve our systems. And this process has to be revisited from time to time. So, personally, I think the process is better done collectively, when all the team players in quality can get together and we all can sit and reflect on it, and we can say what's been working and what hasn't been working. Because we can get bogged down in the mud. You can really get too deep into an inquiry or an audit and sometimes lose your way, depending on what the scenario is. So I'd have to tell you that, yes, we're always working on quality assurance here at the college, and we're always working on getting better.

We've closed I2A for example, like the actual process is closed. But we've learned some lessons, and we're taking that to our next phase.

Line: Right. So, what lessons have you learned?

Carol: Well, you know, I'd say that the most important thing is that we learn to continuously evaluate ourselves. So, it's a process that worked well, and we felt that we were successful at it, but we had to always check in with ourselves. So, we've got six month check-ins that the quality practice team does to just validate our process and see how it's working for us. It's going to be an ongoing conversation that we have with ourselves, and we're going to encourage this dialogue with ourselves to continue.

Another lesson that we learned was always involve the communication department of our college. We created like a frequently asked questions, so that our communication team developed the plan, and they made sure that we had a strategic approach when working with nurses and nurse practitioners, and that's just going to be ongoing as well.

Another lesson that we learned was always being open and learn to modify. And so, when we modify what we're saying and what we're doing, we improved our survey. So, we sent out a survey, and it landed flat. I think a lot of people looked at the survey and went, 'Oh, what are they asking?' So, our second survey, we improved our communication out, and we got better results. We got better answers and better communication between our registrants and ourselves. So, that led to less inquiries; that led to less people calling in to get clarification.

I always think too, being flexible when we're evaluating our process. That's definitely what we learned from this that we had to adapt, based on the recommendations, and that we had to self-reflect. Also, knowing that this process had to be fair and transparent. That's one of the right touch philosophies. It's one of the right touch ideals we're striving here, to make sure that our process is fair and transparent.

Those are some of the top things we learned, and of course we learned to use social media, because again, that's one of the ways that miscommunication can happen. We had people using social media to try to put some pressure on us as a regulatory body. And then we had to understand how to use social media appropriately, and how to communicate back with social media. And it is a great tool, but any tool can be misunderstood or misused, right?

Line: Right, of course. Well, I guess, what are the next steps for the college now?

Carol: Well, I think from this. . . So this happened, I think, about a year and a half ago before I came on board, and they were looking at the program to understand how nurse practitioners prescribe opioids. They wanted to use sort of the inquiry to audit process to help unfold how would we evaluate nurse practitioners' opioid prescribing. Because, as you know, Line, opioids and the prescription of opioids in North America are at an all-time high, and they have caused harm to the public. And this is not something that happened overnight. This happened, you know, since the 1990s, and we're trying to do a cleanup. We're trying to help nurse practitioners do better and be better prescribers.

Our hypothesis is that nurse practitioners are really good at prescribing opioids, and that they are safe prescribers of opioids. But we want to prove that; so, our next step in this process is to start an opioid monitoring project, and that's underway. We've got an external consultant
who's helping us write our self-guided reflection tool, and we're hoping to get a pilot in the near future. We're looking at inviting two to four nurse practitioners to help us write our self-assessment questionnaire, and we want to take that to our registrants who are nurse practitioners and get them to pilot it and to give us feedback, and to let us know if what they're doing out there is what we believe our hypothesis to be-that most nurse practitioners in our province provide good, solid opioid

prescriptions that are of little -I'm not going to say no harm-but of little harm.

Line: That's brilliant. That's great. I'm glad that you have a roadmap for that. Well, this has been an excellent conversation. It's been great to hear about this initiative in particular, and it's always wonderful to hear about projects with other regulatory bodies that can help lead our members and listeners to think about their own processes and areas for improvement, again, that kind of self-reflection on that. So thank you, Carol, for speaking with us today.

Carol: Yeah, thanks, Line. Thanks for having me, and I'm really looking forward to the next steps and to see where this will take us.

Line: Absolutely! Well, it has definitely been a pleasure, and we love to continue this conversation. The podcast episode will be posted on CLEAR's website, and you can reply with your comments. Here are some additional questions for our members to think about.

Was there a critical incident that led your team to look at how you handle concerns from the public, or from employers, or from other health care providers? Why is it important for regulators to self-reflect on their communication strategies? So please share your thoughts with us.

I also want to thank our listeners for tuning in for this episode. We'll be back with another episode of Regulation Matters: a CLEAR conversation very soon. If you're new to this podcast, please subscribe to us. You can find us on Podbean or any of your favorite podcast services. And if you've enjoyed this podcast episode, please leave a rating or comment in the app. Those reviews help us to improve our ranking and make it easier for new listeners like yourself to find us. Feel free to visit our website at www.clearhq.org for additional resources, as well as a calendar of upcoming programs and events.

Finally, I'd like to thank our CLEAR staff, specifically Stephanie Thompson; she is our content coordinator and editor for this program. Once again, I'm Line Dempsey, and I hope to be speaking to you again very soon.

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