

Recency of practice and emergency registration: preparing for surge capacity in the time of COVID-19

The COVID-19 pandemic has placed a huge strain on the health and aged care workforces globally, with nurses being at the forefront of patient testing, tracking, and care. The World Health Organization (WHO) estimates that 10% of all COVID-19 infections are among healthcare workers (HCWs). With over 20 million infections worldwide, this would equate to two million HCWs infected.¹ The number also varies greatly, ranging from 1% through to 40% of infections.² While not fully quantified, the number of nurses who have died as a result of COVID-19 is known to be high. The International Council of Nurses' (ICN) CEO, Howard Catton, has called for accurate reporting of data about nurse deaths, particularly as it appears that nurses may comprise the majority of healthcare workers (HCWs) who have died due to COVID-19 infection. Catton made the observation in a June press release that:

“[n]ursing is looking like one of the most dangerous jobs in the world at the moment. We need to get these data for every country and work out exactly what is going on that explains the variations that are evident with even a cursory glance at the figures. Only then will we be able to learn how best to keep our nurses safe and prevent any repeat of these terrible statistics in the future.”³(para 12)

Back in June, ICN's analysis, based on data from the National Nursing Associations (NNAs), official figures, and media reports from a limited number of countries indicated that more than 230,000 HCWs had contracted the disease, and more than 600 nurses had died.³ Those figures can only have increased since then. In addition, the workforce is depleted, not only through death, but also through illness and the requirement for isolation following potential exposure or infection. As a result, many countries have called for either retired nurses, or nurses who had been out of the workforce, to return and be upskilled to take on clinical work so that currently practising nurses could step up to the COVID-19 front line.⁴

The recently released *State of the World's Nursing Report 2020* showed that, across the world, there is an estimated shortage of six million nurses.⁵ The pandemic has put further pressure on an already overstretched health system. Healthcare systems across the world are operating near or above capacity. This will continue for many months, if not years, and the health workforce cannot be readily 'turned on

and off' – it takes long periods to educate, train, and equip new staff.

In addition to the risks of sickness and death from COVID-19, there are other physical and psychological tolls that COVID-19 will take on nurses and other HCWs for many, many years to come. Depression is seen in 50% of the workforce in some countries, in addition to high anxiety rates, and moral injury.⁶ Those nurses who are stepping up to address surge capacity also need to be prepared for these eventualities.

NURSING WORKFORCE SURGE CAPACITY AND EMERGENCY RE-REGISTRATION TO PRACTISE

As part of the ICN's work in the early stages of the pandemic, and during discussions in a series of webinars and other forms of communication with NNAs, a common theme emerged regarding the need to develop strategies to increase surge capacity within the nursing workforce. Given that different member countries had differing regulatory structures and policies, NNAs requested an informal paper with advice and a potential framework that could be adapted to the varying requirements of different countries.

International evidence suggests that factors such as the degree/level of professional experience, age, and time away from practice appear to impact on the maintenance and decline of competence.⁸ Evidence also suggests that clinical practice experience guided by a nurse preceptor within a refresher program can be experienced as beneficial for nurses returning to practice following time away.⁹ There is also limited evidence suggesting that it is important to gain consistent practical clinical experience within the year following study completion to support ongoing competence.¹⁰

Based on this and other evidence, we developed a matrix of interrelated factors that could be taken into account when determining who might be eligible to return to practice, what level of work they might be able to undertake, and what further education or preparation they might require. It was envisaged that suitable practitioners would be granted temporary "emergency registration". This matrix, together with informal advice and a scoring system, was provided to member countries on request as a draft framework that

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might assist their workforce planning (see Table 1). Many countries, including Australia, had already developed emergency registration provisions, so it was felt there was no requirement for formal advice from ICN.

In order to use the framework, firstly, a series of questions should be considered when setting criteria for emergency registration:

- 1 **Recency of practice:** How long is it since the applicant last practised any form of nursing?
- 2 **Former scope of practice:** Where did the applicant last work and what level of seniority did they hold in that role?
- 3 **Level and extent of expertise:** For how long had the applicant practised since registration and how skilled were they considered to be?
- 4 **Level and extent of education:** What qualifications does the applicant hold and how current are they?

Based on these criteria, a scoring system was developed to support the assessment of appropriate applicants to a suitable role.

TABLE 1: CRITERIA AND SCORING FRAMEWORK FOR COVID-19 EMERGENCY TEMPORARY RETURN TO PRACTICE

	Criteria	Scoring		
1	Recency of practice	<5 years	5–10 years	>10 years
		3 points	2 points	1 point
2	Scope of practice	Clinical front line	Clinical education	Administrative/non-clinical work
		3 points	2 points	1 point
		Highly skilled clinical nurse	Some clinical nurse expertise	Junior clinical nurse
		3 points	2 points	1 point
3	Level and extent of expertise	+10 years clinical experience	5–10 years clinical experience	<5 years
		3 points	2 points	1 point
4	Level and extent of education	Clinical Masters degree or higher	Post graduate degree less than a Masters degree	Graduate clinical certificate
		3 points	2 points	1 point

Based on the scoring system and documentation to support the scores, it was suggested that differing emergency registration levels could be applied. Applicants would need to demonstrate they had had no previous restrictions on their registration and also that they concurred with the level of registration to which they were allocated. Four levels were proposed and the roles each level might be expected to perform are discussed below.

- Full emergency registration (>12 points) could be granted to applicants who were considered competent to take up registration as frontline clinicians immediately.
- Level 2 emergency registration (9-11 points) might be granted to those applicants who required online education in essential refresher topics such as infection control, resuscitation, manual handling, medications management. These programs could be fast tracked through university and/or employer websites.
- Level 3 emergency registration (7-8 points) might be awarded to applicants who were not considered suitable to work on the front line, either due to recency or physical constraints, but might be able to provide guidance and support to the public under protocol in telehealth and other online services.
- Level 4 emergency (5-7 points) might be awarded to applicants who were not considered suitable to work on the front line, either due to recency or physical constraints, but might be able to provide guidance and support to the public under protocol in telehealth and other online services. However, in order to be able to take up these positions, they would also require online education to be able to update essential clinical knowledge.

We envisaged that the emergency registration would apply for 12 months and, at that stage, and depending on the national requirements for an emergency workforce, all applicants would be given the opportunity to apply for permanent registration with the understanding that conditions might continue to apply until full registration requirements were met. Ideally, these former emergency registrants would be given special consideration and support to meet the requirements.

Additional necessary issues to be addressed as part of the emergency registration process were also considered to include; whether the applicant adequately understands the level of commitment required to serve in this capacity; that there needed only be one system through which emergency registrations are granted; that practising without a licence even during an emergency would still carry legal ramifications such as civil or criminal charges, and that employers would need to address the registration level of applicants and their requirement for professional liability insurance.

The information, whilst informal, has been shared as guidance with nurse leaders in many countries and all WHO regions across the world. Countries have been rapidly re-registering and recruiting nurses who have retired or left the profession. In an effort to protect the public, the nursing profession, and trust in the profession, it is essential that the elements discussed above be considered in developing a framework for emergency registration. The decisions made now will have an immediate impact and one that will be sustained for many years to come.

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