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Implementation report of Directive 2005/36/EC - Survey 2024 - Professional Organisations - nurses

Fields marked with * are mandatory.

This survey focuses on the profession of nurse responsible for general care subject to the automatic recognition system based on minimum training requirements under Directive 2005/36/EC.

You will find a series of questions in various formats, including multiple choice and open-ended questions.

We aim to make the process as straightforward as possible, and your responses based on your experience as representative of a professional organisation are crucial to ensure the success of this data collection phase.

Please fill out this online survey by 6 September 2024.

* Please add your name and the name of the professional organisation you represent

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1 Minimum training requirements for nurses responsible for general care

1.1 Is the current minimum length of training for nurses responsible for general care expressed in years in Article 31 of Directive 2005/36/EC still appropriate?

*'The training of nurses responsible for general care shall comprise a total of **at least three years** of study, which may in addition be expressed with the equivalent ECTS credits'*

- (●) YES
- ( ) NO

1.2 Do you think that lowering the current minimum length of training expressed in years could have an adverse effect on patient safety?

- [x] YES
- [ ] NO

Please explain

> Lowering the current minimum lenght of training could have an adverse effect on patient safety. At this moment, in the context of shortage of nurses and lack of harmonization in nursing education, it is too dangerous. Countries could have the temptation to reduce the minimum requirements and could not guarantee that the services provided in any member state meet the same public health and safety standards. But related to the question 1.1, consistently, the current minimum length of training for nurses responsible for general care should be expressed in ECTS credits in Article 31 of Directive 2005/36/EC, rather than in hours..

1.3 Are the minimum hours of theoretical and clinical training expressed in Article 31 of Directive 2005/33 /EC still adequate i.e. **minimum of 2300 hours of clinical training and minimum 1533 hours of theoretical training**?

*'The training of nurses responsible for general care shall consist of **at least 4 600 hours** of theoretical and clinical training, the duration of the*
theoretical training representing at least one third and the duration of the clinical training at least one half of the minimum duration of the training.'

- [ ] YES
- [x] NO

What would be a suitable minimum length and why?

> The current minimum length of training for nurses responsible for general care should be expressed in ECTS credits in Article 31 of Directive 2005/36/EC, rather than in hours..However, the balance between clinical and theoretical training as currently proposed in the Directive can be retained.

1.4 Under Directive 2005/36/EC, clinical training means 'in direct contact with a healthy or sick individual and/or community'. Would you be in favour of counting simulation labs as minimum clinical training hours under the Directive?

- [x] YES
- [ ] NO

In your view, what would be a suitable proportion of direct contact and simulation methods in the minimum length of clinical training set out under Directive 2005/36/EC?

The proportion of theoretical and clinical training should be expressed as a percentage of these credits.
In 2014, a large-scale American study (Harder et al., 2014) showed that simulation (up to 50%) can replace traditional clinical training if conditions are met, such as trained faculty, sufficient staffing, expert-led debriefing, and realistic environments. Nursing programs must ensure ongoing commitment and resources to maintain quality simulation, incorporating best practices.
Simulated placements can provide effective training in core skills with reduced risk to patients and learners. Between 11% and 30% of clinical training time can be replaced with simulated placement (Bridget et al., 2022).
Moreover, a study by Sullivan et al. (2019) showed that the efficient simulation environment is emerging as evidence in favor of a 2:1 clinical-to-simulation ratio.
Therefore, it seems necessary to determine a percentage of clinical activities that can be replaced by simulation. According to the literature, the minimum threshold should be 10%, including all types of simulation (procedural, with actors, high or low fidelity, etc.). The choice of methods should be left to the instructors to align the educational objectives with the needs
Experience in other countries :
- Internationally, programs vary in the number of hours of clinical training, while maintaining a high level of qualification and safety in care:
o 900 hours of clinical training, including simulation (Canada)
o 1000 hours of clinical training, including 400 hours of simulation (Australia) target for current reform
- In Portugal, the Higher Education Evaluation and Accreditation Agency confirmed in April 2019 the following standard for the regulation and evaluation of undergraduate nursing study cycles:
‘Clinical training, with a minimum of 2000 contact hours includes the teaching modality: internship (IS) or clinical training (CLT), and may also take into account other modalities, such as fieldwork (CT), tutoring (OT), seminars (S), theory (T), practical theory (TP), practice (P) and laboratory practice (PL). The hours of other forms of training, other than the work placement (W) or clinical placement (CP), may not exceed 20% of each teaching unit (TU) of the clinical component, for a maximum total of 200 hours’.
- In the United Kingdom, the Nursing and Midwifery Council has just adapted the Standards for education and training and specifies that clinical teaching must ‘provide no less than 2300 practice learning hours, of which a maximum of 600 hours can be in simulated practice learning.

1.5 How do you define simulation methods in the clinical training for nurses?

Healthcare simulation is an educational modality that creates or recreates a clinical situation (in-hospital, out-of-hospital, with one or more healthy or sick people, a community, etc.) or an environment that enables learners in initial or continuing training to experience a representation of a real event for the purposes of practice, learning, assessment, testing, or to better understand human systems or actions. This modality replaces or amplifies real-world experiences with guided experiments that evoke or reproduce substantial aspects of the real world in a fully interactive way.
The simulation-based learning experience corresponds to a set of structured activities that represent real or potential situations in training and practice. These activities enable participants to develop or improve their knowledge, skills and attitudes, or to analyze and respond to realistic situations in a simulated environment. One or more typologies are used, designed to promote, improve or validate a participant's progression from novice to expert. Selecting the appropriate modality for the simulation-based experience enables training needs to be matched to objectives, available resources and constraints (financial, human resources, etc.). The modality is the experience platform. It encompasses many possibilities and includes simulated clinical immersion, in situ simulation, computer-assisted simulation, virtual reality, procedural simulation and/or hybrid simulation. These modalities can include, but are not limited to, the following: standardized/simulated patients, mannequins, haptic devices, avatars, partial-task trainers, etc.

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1.6 Is the current list of minimum competences in Article 31 of Directive 2005/36/EC still adequate?

'(a) competence to independently diagnose the nursing care required using current theoretical and clinical knowledge and to plan, organise and implement nursing care when treating patients [....] in order to improve professional practice;
(b) competence to work together effectively with other actors in the health sector, including participation in the practical training of health personnel;
(c) competence to empower individuals, families and groups towards healthy lifestyles and self-care;
(d) competence to independently initiate life-preserving immediate measures and to carry out measures in crises and disaster situations;
(e) competence to independently give advice to, instruct and support persons needing care and their attachment figures;
(f) competence to independently assure the quality of, and to evaluate, nursing care;
(g) competence to comprehensively communicate professionally and to cooperate with members of other professions in the health sector;
(h) competence to analyse the care quality to improve his own professional practice as a nurse responsible for general care.'

- YES

- NO

What changes should be made to this list?

FINE propose to add in c and g competences :
(c) competence to empower individuals, families and groups towards healthy lifestyles and self-care in a sustainable environmentally friendly practice;
(g) competence to comprehensively communicate professionally and to cooperate with members of other professions in the health sector, including the use of technology and digital advancement in an ethical responsible and accountable manner;

1.7 Currently, Directive 2005/36/EC foresees a combination between training subjects listed in Annex V point 5.2.1 and a competence-based approach listed in Article 31. In your view is this approach suitable or would you tend to favour a competence-based approach only? Please explain.

The current approach is inappropriate. It is important to support a competence-based approach and there should be an Annex V based on learning outcomes linked to the competences in Article 31.
The competences of article 31 highlight the autonomy and responsibility of the nurse responsible for general care. The annex could therefore be based on the levels of the European Qualifications Framework, which offers a database created by the European Union to promote the comparison of education levels and diplomas. This would facilitate the harmonization of the level for nurses responsible for general care in Europe as well as its place in a clear education continuum between countries. And help member countries implement reforms that make it possible to increase the level of education to level 6, bachelor degree, in higher education, for countries which still have professional level.
To date, the directive allows the recognition of qualifications for different levels of education, professional and higher education, which creates confusion. The 8 levels are expressed in Knowledge, Skills, Responsibility and Autonomy:
The competences in article 31 refer to level 6, the bachelor level of higher education:
- Advanced knowledge of a field of work or study, involving a critical understanding of theories and principles
- Advanced skills, demonstrating mastery and innovation, required to solve complex and unpredictable problems in a specialised field of work or study
- Manage complex technical or professional activities or projects, taking responsibility for decision-making in unpredictable work or study contexts; take responsibility for managing professional development of individuals and groups

Knowledge is growing exponentially; programs cannot absorb all this new mass of knowledge. Is a list of subjects enough to ensure that the curriculum achieves the competences appropriately? Annex V must be clear related to competences and allow flexibility in the construction of education programs to respond effectively to the emergence of new theoretical and technological needs, in a constantly evolving context.
If Annex V nevertheless continues to be expressed in "subjects", the contents must be identified as being applied in the context of nursing and health care based on nursing science, which is not listed at the moment nor in Article 31, nor in Annex V:
Instead of “Nursing, basic sciences and social sciences” : replace with “Sciences” inside nursing science… and others sciences and shared theories. EBN and EBP are the cornerstones of care quality and safety
Only “sciences” because in today’s world there is a growing awareness about the need to learn and embrace environmental sciences as well as the wider non-human facets of biology. The concepts of ONE health and PLANETARY health are essentially based on this principle of bringing non-human biology into the scene of health care
A health systems approach draws our attention to cross-sectoral governance of health and education systems and calls for integration and coordination to overcome “professional silos” in health care (Kuhlmann, Batenburg, Wismar et al. (2018)).
Need to update point B of Annex V: clinical training. In what way?
1. Content should be structured or organized according to learning outcomes and based on clinical reasoning:
- Evaluation (observation approach)
- From assessment to clinical decision-making-health care ethics and critical thinking
- From assessment to diagnosis and nursing intervention and outcomes (being able to link all processes to establish a plan and carry out the nursing intervention)

2. Content can also be structured or organized based on variables such as:
- location (e.g. hospital, clinics, community, home care)
- developmental stage (e.g., mother care, infant, child, adolescent, adult, elderly, end of life)
- the type of care (acute, chronic, psychiatric, mental health, palliative, etc.)

In the revision of Annex V we no longer find home care, which does not meet changing health needs.

1.8 As regards the minimum training requirements for nurses, only the list of knowledge and skills and training subjects can be amended through a delegated act - would it be helpful if all the minimum training requirements for nurses responsible for general care would be subject to a regular update through a delegated act? [For more information on delegated acts, please see Article 290 of the Treaty on the Functioning of the European Union]

FINE's answer is NO. We hesitate because it could make sense in the future, if the level of education is clear between countries. But, at this moment, in the context of shortage of nurses and lack of harmonization in nursing education, it is too dangerous. Countries could have the temptation to reduce the minimum requirements and could not guarantee that the services provided in any member state meet the same public health and safety standards.

2 Closing Section

2.1 Are there any issues with the application of the current minimum training requirements that you would like to flag?

Regarding the current and future shortage of nurses responsible for general care, Europe must above all focus on the attractiveness of the profession and, by extension, of the education. The directive does not help to clarify the level of education by accepting that nurses responsible for general care can still be educated at a professional level. Experts and members of FINE observe that in countries where the level of education is clearly determined at the bachelor level in higher education, with a clear continuum, towards the master's and doctorate in nursing science, this creates attractiveness for training, this reduces the risk of mortality for the population and the mobility of nurses is increased. For example in Portugal, Spain, Norway, Finland, Greece, Malta, etc.
In a political horizon, countries should aim to reserve the title of nurse responsible for general care for qualified bachelor nurse. In some countries the title of "basic nurse", is confusing. It means that we can find basic nurse who don't meet the minimal requirements and lower habilitations, to take care of the people living in the countries, and "super nurses" who can move in Europe.
FINE also emphasizes the fact that the definition of clinical learning, expressed in hours and "at the bedside" is not realistic. Moreover this is believed to deter attractiveness and to limit of the relevance of the nursing profession to interested parties by limited the role and scope of the profession to "the bedside". This is not realistic in the current health context wherein qualified nurses are increasingly engaged and even leading care and practice away from "the bedside" in community settings, occupational health, primary health and many other settings. Nor does it take sufficient account of the intellectual aspect of the profession, the need for leadership, and so on. A certain number of tasks can be learned in situ but not necessarily 'at the bedside'.
Clinical training should be expressed in ECTS credits and should be pegged across the European Qualifications framework, in line with all other EU related structures and Frameworks.
Against this backdrop, FINE proposes to broaden the definition of "clinical learning" to
- simulation activities, case analysis, professional portfolio, professional integration activity sessions, written report, having a direct link with a healthy or sick individual and/or a community
- and which promote the analysis of professional practice, the deployment of clinical reasoning, feedback on action, self-evaluation in order to demonstrate safe and effective practice.
While the direct contact with the clinical care context is essential, the clinical training credits could be enriched for a part of them with these activities conducive to learning and developing the competences of the nurse responsible for general care while aiming for quality support.

2.2 In the context of the preparation of the Implementation Report, the European Commission intends to also contact professionals (nurses) who have experienced the recognition process by moving to another Member State and to gather their feedback - would you have any suggestions on how to best reach out to those professionals (nurses)?

Nurse who move from Malta to other EU country : ecmaceda@gmail.com or work email : emille.ched.pabello.maceda@region.dk
FINE can provide to the Commission other contacts if needed.
FINE wishes to share its expertise with the European Commission on all matters relating to nursing training in Europe and the recognition of qualifications for nurses responsible for general care.

Contact

Contact Form