

**THE ASSESSMENT OF THE CONTINUING PROFESSIONAL DEVELOPMENT OF  
NURSES AT A SELECTED PUBLIC HOSPITAL IN KWAZULU-NATAL**

by

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submitted in accordance with the requirements

for the degree of

**MASTER OF ARTS**

in the subject

**NURSING SCIENCE**

at the

**UNIVERSITY OF SOUTH AFRICA**

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November 2017

## DECLARATION

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### THE ASSESSMENT OF THE CONTINUING PROFESSIONAL DEVELOPMENT OF NURSES AT A SELECTED PUBLIC HOSPITAL IN KWAZULU-NATAL

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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## ABSTRACT

**Background:** The Continuing Professional Development (CPD) Framework established by the South African Nursing Council (SANC) states that organisations have a responsibility to create enabling environments in which the development of nurses can take place.

**Aim:** The aim of this study is to assess the CPD of nurses at a public hospital in KwaZulu-Natal.

**Method:** A quantitative descriptive design was followed. Convenience sampling yielded a sample of 166 nurses consisting of the registered nurse (63.2%) and enrolled nurse categories (36.8%). Data collection was done using a self-designed questionnaire. Statistical analysis was done using the Statistical Analysis System (SAS) Version 9.4 programme.

**Results:** The findings revealed that CPD was ranked the least important area in terms of management priorities. Key barriers to development included staff shortages, lack of funding, poor resources and competing personal responsibilities. The study found that CPD had positive outcomes for nursing practice.

### Key concepts

Assessment, continuing education, continuing professional development, in-service education, learning, nurse, nurse educator, public hospital, training and development.

## ACKNOWLEDGEMENTS

I wish to express my gratitude to my Lord Jesus Christ for giving me the strength and will to complete this study. This work is not for Him but because of Him.

“No one who achieves success does so without acknowledging the help of others.”

Alfred North Whitehead

Therefore, it is with pleasure that I thank the following people:

- Professor SP Hattingh, my supervisor, for her guidance, support, patience and encouragement. Your valuable time, mentoring and reassurance made this research possible.
- To my family and friends for their continued support and encouragement.
- The KwaZulu-Natal Department of Health for granting me permission to conduct the study.
- Mrs SP Nyawo and the management team of the selected hospital for their support in this study.
- The nurses who gave their time to participate in this study.
- Dr Petra Gaylard for her statistical support.
- John Cameron, KZN Language Institute, for editing of the manuscript.
- Rina Coetzer for the technical editing and layout of the manuscript.

## *Dedication*

This work is dedicated to the following persons:

*My sons Joshua and Matthew*

*for being the joy of my life,*

*my greatest achievement*

*My husband Shane,*

*who never stopped believing in me and*

*whose love makes everything possible*

*and*

*In memory of my late mother Mrs Gonam Pillay,*

*my first friend, teacher and inspiration.*

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**LIST OF ABBREVIATIONS**

|        |  |
|--------|--|
| AHPRA  | Australian Health Practitioner Regulation Agency           |
| ANA    | American Nurses Association                                |
| ARC    | African Health Professions Regulatory Collaboration        |
| CPD    | Continuing Professional Development                        |
| ECSA   | Engineering Council of South Africa                        |
| EFQM   | European Framework of Quality Management                   |
| HCPC   | Health Care Professions Council                            |
| HPCSA  | Health Professions Council of South Africa                 |
| HWSETA | Health and Welfare Sector Education and Training Authority |
| ICN    | International Council of Nurses                            |
| IMDC   | Interim Medical and Dental Council                         |
| KZN    | KwaZulu-Natal  |
| NBM    | Nursing Board of Malaysia                                  |
| NCK    | Nursing Council of Kenya                                   |
| NMBA   | Nursing and Midwifery Board of Australia                   |
| NMC    | Nursing and Midwifery Council                              |
| PECAN  | Professional Excellence and Career Advancement in Nursing  |
| PEPFAR | President's Emergency Plan for AIDS Relief                 |
| PHC    | Primary Health Care  |
| PMDS   | Performance Management Development System                  |
| RSA    | Republic of South Africa                                   |
| SAPC   | South African Pharmacy Council                             |
| SANC   | South African Nursing Council                              |
| SAS    | Statistical Analytical System                              |
| SETA   | Sector Education and Training Authority                    |
| UNISA  | University of South Africa                                 |
| USA    | United States of America                                   |

# CHAPTER 1

## ORIENTATION TO THE STUDY

*“Let us never consider ourselves finished nurses ... we must be learning all our lives.”*

Florence Nightingale

### 1.1 INTRODUCTION

Healthcare systems are rapidly developing and changing. New and emerging diseases, global exposure to infectious agents and poisons, the development of new drugs, emerging next generation viruses and new technologies contribute to a dynamically evolving healthcare environment (McCarthy & Iliffe 2013:18). Alsop (2013:vii) advocates that healthcare professionals must be prepared to examine society’s changing demands and take steps to shape change, embrace new practices and discard old ones. The need for new learning strategies throughout a career has become essential for healthcare professionals. In addition to meeting the needs of a changing healthcare environment, healthcare professionals have a professional accountability to the public that they serve. Society’s increasing awareness of health intensifies the expectation that healthcare professionals provide safe and effective treatment informed by current best practice (Green & Huntington 2017:55).

Nurses form the largest group of healthcare professionals globally (Chong, Francis, Cooper & Abdullah 2014:1) and provide 80% of direct patient care (Sodeify, Vanaki & Mohammadi 2013:191). Rogan (2014:13) asserts that a basic nursing education is insufficient for a lifetime of professional practice. A review of literature supports that certification of a qualification undertaken as a healthcare professional does not warranty that the expertise of an individual will be maintained for the rest of their professional lives (McCarthy & Illiffe 2013:14; Tran, Tofade, Thakkar & Rouse 2014:1). The International Council of Nurses (ICN) Code of Ethics for Nurses (2012: online) advocates that “nurses carry personal responsibility and accountability for nursing practice and for maintaining competence by continual learning”. McCarthy and Iliffe (2013:6) reiterate that nurses have an obligation to the public, to their employers and to the government, who offer legal recognition and remuneration for their services, to

maintain competency. Collin, Van der Heijden and Lewis (2012:156) emphasize that professions, including healthcare professionals, tend to deliver services rather than supply products, and the quality of the service is profoundly dependent upon the professional possessing and properly using skills. The authors further state that the probable effect of an inadequate service may have grave consequences for the service user. This accentuates the duty of nurses to continually engage in professional development activities to demonstrate competence and expertise in the execution of their practice.

Continuing professional development (CPD) is defined as the way professionals continue to learn and develop throughout their careers so that they keep their skills and knowledge up to date and are able to work safely, legally and effectively (Health and Care Professions Council 2016: online). Previous studies, for example Kvas and Sleljak (2013:348); Nayeri and Khosravi (2013:564), acknowledge that participation in CPD activities is among the most effective methods for nursing workforces to maintain and improve competence and update knowledge and skills. Balmer (2012:341) adds that attending CPD activities increases nurses' awareness and proficiency in patient care, enhances clinical competency and improves patient outcomes. Beyond the obvious benefit of updated knowledge and improved patient care, mandatory CPD enables nursing to be credited with the status, authority and autonomy that accompany a profession (Ross, Barr & Stevens 2013:2).

The Health Professions Council of South Africa (HPCSA 2017:2) acknowledges that consistent and ongoing commitment to CPD underpins competent practice and protects the public interest and the promotes the health of the South African public. Furthermore, as stated by Pera and Van Tonder (2011:93-94) few professions are more affected by the law than the nursing profession. Nursing is a profession characterised by morality, compassion, competence, care and a high sense of ethical integrity. Any nursing act that transgresses the above principles will lead to punishment by the law. It is the law that protects a person's physical integrity, dignity and privacy.

According to the Medical Protection Society (2017:8) of the United Kingdom (UK) the cost of clinical negligence claims in the UK has increased by 72% over the last five years and is predicted to reach a staggering £2.6 billion a year within the next five years. According to Pepper and Slabbert (2011:29) health malpractice claims in South

Africa are increasing, as patients are becoming more aware of their rights. The authors attribute this to the introduction and operationalisation of the Consumer Protection Act 2008 (Act No.68 of 2008) which has led to health practitioners facing an increased scope of legal liability (RSA 2008: online).

A case-control study conducted by Wenghofer, Campbell, Marlow, Kam, Carter and McCauley (2015:264) which examined the effect of CPD on public complaints in Canada, found that there was a positive relationship between participation in CPD and a lower number of public complaints. Goulet, Hudon, Gagnon, Gauvin, Lemire and Arsenault (2013:518) confirm that CPD activities of sufficient quantity and quality are correlated with a high quality of professional performance. International studies, for example Garafalo (2016:103), are consistent in their beliefs that quality care hinges on having a well-educated workforce.

It is evident from these introductory remarks that CPD is a critical mechanism in ensuring that nurses keep up to date with their knowledge, skills and competencies to provide high quality care to those they care for.

## **1.2 BACKGROUND TO THE STUDY**

Globally, healthcare professionals have recognised the phenomenon of CPD to enable healthcare professionals to adapt to the changing healthcare environment and provide high quality and current evidence-based care (Becker 2017:1; Thomas 2012:60).

### **1.2.1 CPD internationally**

In view of the importance of CPD, many countries have implemented mandatory CPD for nurses.

According to Chong et al (2014:1), mandatory CPD began in the United States of America (USA) in the state of California in 1971. Later in 1973, the American Nurses Association (ANA) advocated mandatory CPD for re-licensure. Currently 35 states in the USA require that nurses participate in continuing professional education in order to renew their license to practice (American Nurses Association 2013:online).



Burke, Redfern and Marks-Maran (2016:92) state that in the UK, the early drivers for CPD began in the 1970s. Currently nurses require a mandated 35 hours of CPD learning activity relevant to practice every three years (Tran et al 2014:4).

In Australia, mandatory CPD has been legislated since 2012 and nurses are obliged by legislation to engage in CPD to sustain practice registration (Katsikitis, McAllister, Sharman, Raith, Faithfull-Byrne & Priaulx 2013:34).

Chong et al (2014:1) argue that mandated CPD is not restricted to Western countries alone, as mandatory CPD for nurses is legislated both in China and Hong Kong.

On the African continent, Kenya has implemented mandatory CPD since 2008 and nurses are obliged to fulfil 20 hours of learning per year to be eligible for the renewal of licensure (Owaka 2014:7).

### **1.2.2 CPD in South Africa**

Whilst most South African healthcare professionals have been subjected to fulfilling requirements for CPD, nursing thus far has been excluded from this requirement. The SANC, a statutory body operating under the Nursing Act, 2005 (Act no 33 of 2005) is in the process of bridging this gap by the introduction of a mandatory CPD system for nurses. The SANC has the obligation to serve and protect the public in terms of matters involving nursing and midwifery services (SANC 2015:6). The SANC fulfils this mandate by ensuring that its practitioners namely, registered nurses, enrolled nurses and enrolled nurse auxiliaries, provide healthcare services that are competent, safe and within the ethical, philosophical and legal framework of the nursing profession. Within this mandate, the SANC has developed a CPD framework for all practitioners registered with the SANC (SANC 2015:6). The CPD framework operates on the premise that learning needs are identified by the practitioner and employer through a rigorous and continuous assessment of practice against professional standards (SANC 2015:7). The development of the CPD framework is discussed in Chapter 2 (see section 2.4).

The CPD framework further places an obligation on practitioners to assume responsibility for meeting the CPD requirements and on employers to create enabling environments to support nurses' CPD so that they can meet their CPD requirements

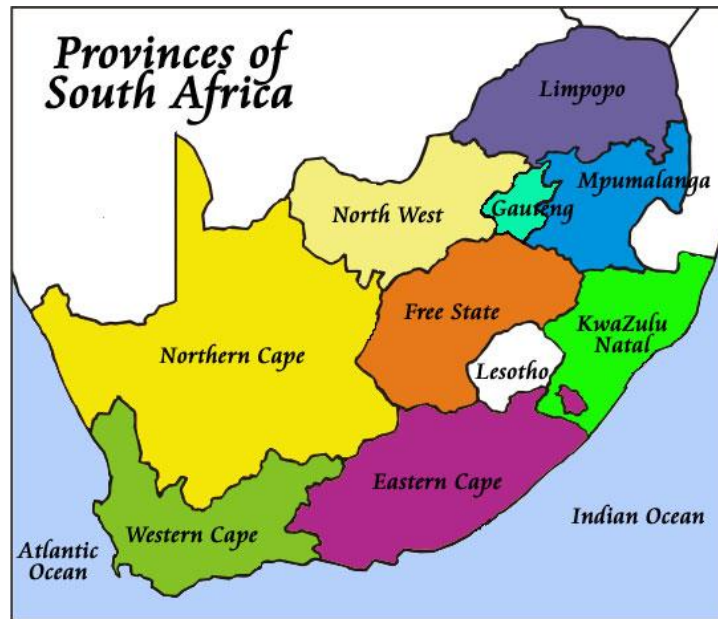
(SANC 2015:10). Several studies, for example Kantan and Ulker (2013:156) and Thomas (2012:59), have highlighted the vital role that employers play in providing a supportive environment for CPD to take place.

Onyango (2012:3) states that in a hospital setting, professional development should assume a partnership between the hospital and nurses and should be self-motivating, valued and perceived as mutually beneficial to the nurse, the hospital and the patients. Chaghari, Ebadi, Ameryoun and Safari (2016:499) acknowledge that unsuitable organisational management is an obstacle for the implementation and success of CPD programmes.

### **1.2.3 Setting of the study**

Grove, Gray and Burns (2015:37) state that there are three common settings for research to take place: natural, partially controlled and highly controlled settings. Natural settings are uncontrolled, real life settings while partially controlled and highly controlled settings have some degree of control and modification of the environment in which research takes place (Grove et al 2015:37). The study has taken place at a naturalistic setting in a selected public hospital in the KwaZulu-Natal (KZN) province in the Republic of South Africa (RSA). The researcher collected data while the respondents were on duty at their place of work.

The researcher has included a short narrative of the demarcation of the RSA into the provinces and a brief explanation of the delivery of public health care in South Africa. The RSA is a country on the southernmost tip of the African continent with a population of 56.5 million people as at mid-2017 (Statistics South Africa 2017:online). The RSA comprises nine provinces which are North West, Western Cape, Eastern Cape, Northern Cape, Gauteng, Limpopo, Free State, Mpumalanga and the KZN province. The KZN province which is the RSA's third smallest province is found on the eastern coastline of the RSA.



**Figure 1.1 Provinces of the Republic of South Africa**

(Google maps:online)

Van Rensburg (2012:552) states that public hospitals in South Africa are classified according to level, type of service and service provider. District hospitals form part of the primary level of care and provide services to the catchment area and population of a district; regional hospitals offer a secondary level of care by providing services that cannot be obtained at a district level; and academic hospitals provide services that comprise of sophisticated and specialist care that take place at tertiary level (Van Rensburg 2012:562). To understand the context in which the study has taken place, the researcher has provided a short discussion on district hospitals.

The White Paper on National Health Insurance (RSA 2015:37) defines district hospitals, which are level 1 hospitals, as the smallest type of hospital which provides generalist medical services and are limited to four areas namely obstetrics and gynaecology, paediatrics and child health, general surgery and family medicine. According to Van Rensburg (2012:563), district hospitals have a dual function: to support Primary Health Care (PHC) and to be a gateway to more specialist care at the regional hospitals. District hospitals are characterised by significantly less funding than their urban counterparts and a lack of adequate resources.

The study has taken place in a district level public hospital. The hospital is situated in the Ugu District of KZN and is one of five hospitals in the district. It is a 300-bedded

hospital with 288 usable beds (KwaZulu-Natal Department of Health 2017:online). The hospital is affiliated to two nursing colleges within the district but has established further partnerships with three nursing colleges outside the Ugu district. Formal training of nurses takes place using a decentralised approach while CPD is facilitated by the institutional human resource development department, one nurse educator and one clinical facilitator.

It is against this background that the researcher, a registered nurse educator employed at a public hospital in KZN has conducted a study to assess and describe the status of CPD of nurses in the selected hospital.

### **1.3 PROBLEM STATEMENT**

The lack of a mandatory CPD system for nurses in the RSA has led to the SANC developing such a system. The SANC is now in the developmental stages of a mandatory CPD system for nurses in South Africa. International studies such as Brekelmans, Maassen, Poell, Westrate and Guerdes (2016:15), have shown that skill development and continuing education for nurses is a challenge due to lack of time, lack of funding and inability to access training opportunities. Similar challenges are faced in the RSA and important questions arise as to whether public hospitals will be able to provide an enabling environment for CPD for nurses. Although CPD remains the responsibility of the individual nurse, employers have a responsibility to create enabling environments to support the provision of CPD (Kotze, Armstrong, Geyer, Mngomezulu, Potgieter, Subedar & Vasuthevan 2013:236; SANC 2015:12). This study will focus on the assessment of the factors that enable CPD in a selected public hospital in KZN. The researcher anticipates that the findings of the study will provide a description of the status of CPD of nurses in the hospital and will provide a background to assist nurses and hospital management to improve on current practice.

### **1.4 PURPOSE OF THE STUDY**

The purpose of the study is to assess the CPD of nurses at a selected public hospital in KZN.

### **1.4.1 Research questions**

In order to achieve the purpose, the researcher wished to answer the following questions:

- What is the status of the CPD of nurses in the selected hospital?
- What are the factors that enable CPD in the selected hospital?
- What are the processes involved in the CPD of nurses in the selected hospital?

### **1.4.2 Research objectives**

The objectives of the study are to:

- describe the status of the CPD of nurses in the selected hospital
- assess the enabling factors affecting the context in which CPD is implemented in the selected hospital
- describe the processes involved in the CPD for nurses in the selected hospital

## **1.5 SIGNIFICANCE OF THE STUDY**

The study will provide information on the status of CPD in the selected hospital. It will provide a background on the factors enabling CPD and the current processes of CPD in the selected hospital. This information will empower nurse leadership and educators to plan and implement actions to improve the mechanism of CPD in the hospital so that it has positive outcomes for the individual nurse, patient care and the organisation. The researcher envisions that the findings of this study will aid both nurses and the hospital management to improve current practice to comply with the pending mandatory CPD system to be implemented by the SANC.

## **1.6 THEORETICAL FRAMEWORK**

This study is based on the European Framework of Quality Management (EFQM) Model (EFQM 2012: online). Brink, Van der Walt and Van Rensburg (2012:26) define a model as a symbolic depiction of reality which provides a schematic representation of certain relationships between phenomena, using symbols or diagrams to represent an idea.

According to Brink et al (2012:26), the purpose of a framework in a research study is “to help the researcher organize the study and provide a context in which he/she examines a problem and collects data”.

### **1.6.1 History of the EFQM**

Post-World War II (1939-1945), Japan identified the need to reorganise its economy as Japanese products were recognised as being of inferior quality (Smit 1999:3). Consultation with quality specialists such as Deming, Juran and Ishikawa (Smit 1999:3) led to a reformation of the Japanese economy. According to Smit (1999:3), by the early eighties Japanese goods were making significant progress in the American market which led to a cause of concern for the USA. Recognising that USA's productivity was declining, President Reagan in 1982 mandated that a national study on productivity be done. The final report on this study recommended that a National Quality Award be awarded annually to successful organisations who met the requirements of the award. The US Malcolm Baldrige National Quality Improvement Act was signed into law (Public Law 100-107) on August 20, 1987 (Evans & Lindsay 2011:112).

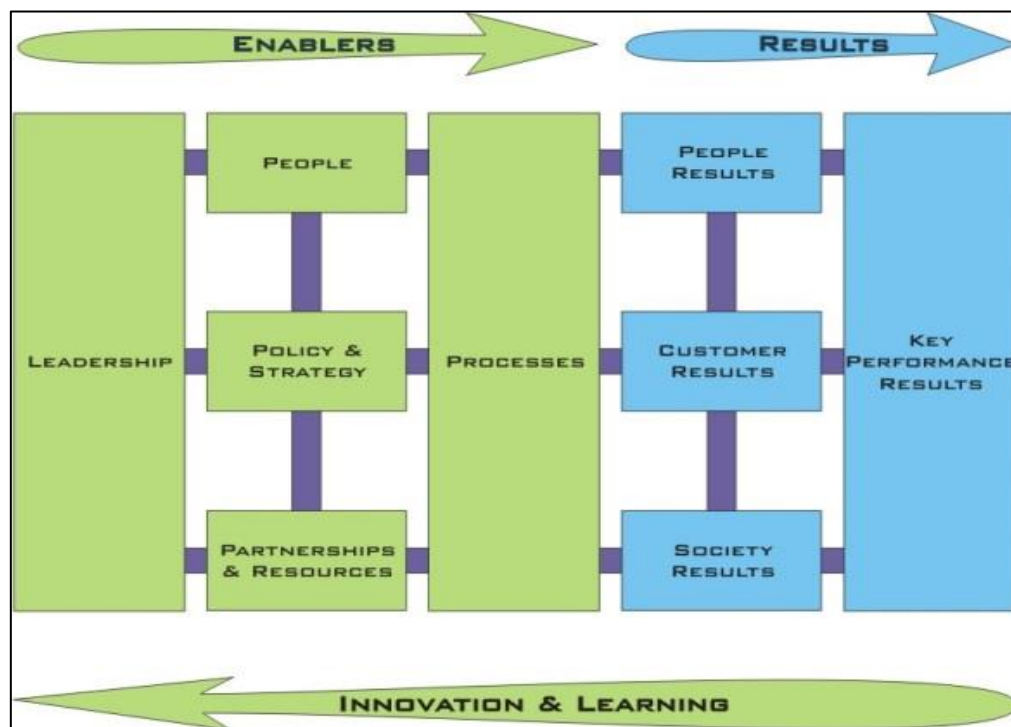
According to Smit (1999:03), the Western European countries took their cue to encourage their own countries to improve quality to compete in the global market. On 15th September 1988, 14 European business leaders met with Jacques Delors and signed a "Letter of Intent" to form a European Foundation dedicated to increasing the competitiveness of European businesses (EFQM 2012:online). The founding members established the EFQM in 1992 and their approach was that performance had to meet the expectations, demands and needs of the stakeholders (Nabitz 2006:98). The essence of the EFQM is that for an organisation to remain competitive in a dynamic environment it has to continually improve.

While the focus of the foundation is on European organisations, it has been widely used due to its practicality and non-prescriptive framework (EFQM 2012:online). Nabitz (2006:99) concludes that the EFQM approach provides a broader and more generic framework and is suited for utilisation in health care. Ferreira (2003:80) credits the model as a practical tool to help organisations improve by measuring where they are on the path to excellence, helping them to identify gaps and finding solutions to these gaps. A systematic literature review (1991–2015) on quantitative research on the EFQM

excellence model conducted by Suarez, Calvo-Mora, Roldan and Perianez-Cristobal (2017:8) found that the most significant effects of the implementation of the EFQM model is the improvement of image, greater client satisfaction, increased commitment and satisfaction of employees.

### 1.6.2 Application of the criteria of the EFQM model

In Figure 1.2 a diagrammatic presentation of the EFQM model depicting the nine criteria it represents. The criteria comprise of enablers and results. The “enabler” criteria cover what the organisation does and the “results” criteria covers what an organisation achieves. The “enablers” consists of leadership, people, policy and strategy, partnerships and resources and processes. The “results” criteria consist of people results, customer results, society results and key performance results (EFQM 2012:online).



**Figure 1.2 The EFQM Model**

(European Framework of Quality Management 2012:online)

In this study the enabling criteria were applied to assess the current CPD practices in the selected hospital. The influence of leadership in terms of support, motivation and personal involvement in the promotion of educational practices was examined. The

formulation of personnel development policy, the availability of resources for training, and the actions and procedures that constitute educational practices were described.

According to the EFQM (2012:online), the results criteria include results achieved in terms of the customer, people, society and business. Excellent organisations achieve and sustain outstanding results that meet the expectation of its stakeholders. Uygur and Sumerli (2013:980) state that the EFQM model is an assessment tool that helps organisations question their own activities and results of activities and determine strong and weak points. In the application to this study, the results criteria describe the outcomes of CPD as it relates to patient care, nursing knowledge and skills, the transfer of training and the satisfaction of nurses regarding the status of CPD in the selected hospital.

A detailed discussion of the application of criteria of the EFQM model is discussed in Chapter 2 (see section 2.5).

## **1.7 RESEARCH METHODOLOGY**

The study employed a quantitative, descriptive, non-experimental design with a cross-sectional approach. The chosen approach enabled the researcher to assess and describe at a specific point in time, the CPD of nurses in the selected hospital.

### **1.7.1 Research design**

Wood and Ross-Kerr (2011:115) state that the research design is a blueprint for the research and serves to provide a plan for answering the research question.

#### ***1.7.1.1 Quantitative design***

Polit and Beck (2012:14) define a quantitative design as an investigation of a phenomenon by means of precise measurement and quantification. Hedges and Williams (2014:112) add that quantitative research methods are a highly formal, objective, systematic process and rely on statistical procedures for analysis. According to Bachman and Schutt (2011:16), quantitative designs are used when the motives for research are explanation, description or evaluation.



### **1.7.1.2 *Descriptive design***

Polit and Beck (2012:725) state that descriptive designs are used in research where the main objective is the accurate portrayal of people's characteristics and/or the frequency with which certain phenomena occur. Grove et al (2015:212) state that descriptive designs may be useful to identify problems with current practice, to justify current practice and to determine trends in similar situations.

### **1.7.1.3 *Non-experimental design***

De Vos, Strydom, Fouché and Delport (2011:156) state that a non-experimental design is used in research where no manipulation of variables takes place and it does not include an experimental or a control group.

### **1.7.1.4 *Cross-sectional design***

De Vos et al (2011:156) state that a cross-sectional design examines several groups of people at one point in time and can be used to determine whether a problem exists within that group and what the level of the problem is. Cottrell and McKenzie (2011:197) add that the value of cross-sectional designs diminishes over time, as attitudes and situations change over time.

## **1.7.2 Research method**

Gravetter and Forzano (2016:164) state that a research method is an exact step-by-step description detailing exactly how the study will be conducted.

### **1.7.2.1 *Population***

According to Brink et al (2012:131), a population is the entire group of persons that is of interest to the researcher. The target population for this study comprised of registered nurses, enrolled nurses and enrolled nurse auxiliaries. The total nurse population at the selected hospital comprised of 282 nurses.

### **1.7.2.2 Sample**

A sample is a subset of the population that is selected for a study (Gray, Grove & Sutherland 2017:53). In this study the sample consisted of 200 nurses who met the eligibility criteria as outlined in Chapter 3 section 3.2.2.1.

According to Polit and Beck (2012:275), sampling refers to the process of selecting cases to represent an entire population and may be divided into probability methods which involve random selection and non-probability methods where cases are selected by non-random methods. The study utilised a non-probability method of sample selection, namely convenience sampling. According to Roller and Lavrakas (2015:184), convenience sampling is the practice of selecting a study environment or research participants that are simply available to the researcher by their accessibility.

### **1.7.2.3 Data collection**

Data collection includes the process of collecting data for answering questions or exploring a phenomenon (Parahoo 2014:352). The researcher utilised a self-designed structured questionnaire in a group administered approach for data collection. The structured questionnaire was used to obtain the following information:

- Section A: Demographic information (7 items)
- Section B: Leadership role in CPD (6 items)
- Section C: Policy and strategy of CPD (9 items)
- Section D: People development and CPD (5 items)
- Section E: Resources for CPD (10 items)
- Section F: Process of CPD (11 items)
- Section G: Results of CPD (10 items)

A detailed discussion of the data collection process is provided in Chapter 3 (see section 3.2.2.3).

#### **1.7.2.4 Data analysis**

De Vos et al (2011:249) regard data analysis as the process by which researchers use techniques to convert data to numerical interpretable form from which conclusions can be drawn. The researcher obtained the services of a statistician to assist in analysing the data collected. The results are presented as descriptive statistics by means of frequencies, percentages, graphs and tables. A detailed discussion of the results of the study is presented in Chapter 4 (see section 4.3).

#### **1.7.2.5 Validity and reliability**

According to Brink et al (2012:163), research results must be meaningful, must reflect reality and must be replicable. Polit and Beck (2012:745) define validity as a “quality criterion referring to the degree to which inferences made in a study are accurate and well founded; in measurement, validity refers to the degree to which an instrument measures what it is intended to measure”. Reliability is defined as the degree of consistency with which an instrument measures an attribute (Polit & Beck 2012:741). A detailed discussion on the application of the concepts of validity and reliability to improve the quality of the study is discussed in Table 3.5 (see section 3.2.2.5).

### **1.8 DESCRIPTION OF KEY CONCEPTS**

The *Oxford Mini Dictionary and Thesaurus* (2008:143) defines **continuing** as “keep happening or existing without stopping or to carry on in same direction”. **Professional** is defined as “belonging to a job that is requiring special training and formal qualification” (*Oxford Mini Dictionary and Thesaurus* 2008:519). **Development** is defined as “the action of developing a new stage in a situation”. Synonyms include growth, expansion and progress (*Oxford Mini Dictionary and Thesaurus* 2008:183).

**CPD** is described internationally by a variety of terms.

The SANC (2015:6) states that CPD means a “purposeful statutory process whereby practitioners registered with SANC, through personal commitment, engage in a range of learning activities to maintain and improve their knowledge, skills, attitudes and professional integrity to keep up to date with new science, innovation and health care

developments to enable them to practise safely, ethically, competently, and legally within their evolving scope of practice and to provide quality care to the South African community.”

The Australian Health Practitioner Regulation Agency (AHPRA) defines CPD as “the means by which health professionals maintain, improve and broaden their knowledge, expertise and competence and develop personal and professional qualities throughout their professional lives” (AHPRA 2016:4).

The American Nursing Association (ANA) defines CPD as a “lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice and support achievement of career goals” (American Nurses Association 2013:online).

In the UK, the Health and Care Professions Council (HCPC) describes CPD as “a range of learning activities through which healthcare professionals develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice” (HCPC 2016:online).

Common themes highlighted in the above definitions include maintaining competence, increasing knowledge and practising safely and professionally. Booyens (2015:230) point out that CPD is essential because the knowledge and skills of healthcare professionals become outdated with time and the demands for quality care are increasing so it becomes crucial that healthcare professionals keep updated with new knowledge.

CPD, in the context of this study, can therefore be defined as a continual action or participation in learning activities, both formal and informal, that are directly related to one’s profession for the explicit purpose of maintaining, growing and progressing in professional competence. The learning activities can include in-service education and continuing education in the form of formal studies, workshops, and seminars.

**Assessment** is to “make a judgement of the quality or importance about a person, thing or situation” (*Oxford Mini Dictionary and Thesaurus* 2008:38). In this study assessment refers to the collection and evaluation of information specific to the CPD of nurses.

**A nurse** is a “person trained to care for the sick or injured people” (*Oxford Mini Dictionary and Thesaurus* 2008:449). In this study a nurse refers to a person registered in a category under section 31(1) of the Nursing Act 33 of 2005 in order to practice nursing or midwifery who is employed on a full-time basis at the selected hospital.

**Public hospital:** The *Oxford Mini Dictionary and Thesaurus* (2008:527) defines the public sector as “part of the economy that is controlled by the state”. A hospital is defined as “an institution for the treatment of sick or injured people” (*Oxford Mini Dictionary and Thesaurus* 2008:325). In this study a public hospital refers to a hospital that is fully funded by the South African Government and is administered by the KZN Department of Health.

**In-service education** programmes are organised by the organisation for development purposes to inform, educate and train employees. It aims to increase employee competence and to keep updated with new developments (Kotze et al 2013:230). In this study in-service education refers to learning activities that are offered by the hospital with the purpose of improving the performance of the nurses. In-service education may take place at the immediate work environment or as workshops.

**Continuing education** is defined in Maguire (2016:online) as a “formal, planned learning activity built on the educational and experiential bases of the health practitioner”. It has an evaluation process and may award a printed certificate upon successful completion. In this study continuing education refers to formal education programmes, short courses and workshops that nurses engage in and from which they receive some form of certification.

Maguire (2016:online) acknowledges that in-service training and continuing education are not the same thing. According to Maguire (2016:online), in-service training differs from continuing education in that it is an informal process with no credentialing or formal evaluation. Brekelmans, Poell and Van Wijk (2013:313) find that in the nursing literature, continuing education and CPD are often used interchangeably but the authors argue that whereas CPD is self-directed learning and may include a broad range of activities, continuing education relates to participation in formal education and may be a component of CPD. In this study in-training and continuing education form part of a range of activities that constitute CPD.

**Learning:** Knowles, Holton and Swanson (2012:10) state that “learning is the act or process by which behavioural change, knowledge, skills and attitude are acquired”. In this study learning refers to the process whereby nurses gain knowledge and experience and apply it to their work environment.

**Nurse educator:** A nurse educator is a registered nurse with an additional qualification in nursing education and who is registered as such with the SANC (SANC 2014:1). In this study a nurse educator refers to a registered nurse with an additional qualification in nursing education and who functions as a clinical facilitator, in-service trainer or educator within the hospital setting.

**Training and development** are often used synonymously. However, Warnich, Carrell, Elbert and Hatfield (2015:342) state that training is focused on learning relating to a present job, is provided by the employer, and is short-term with an outcome in change in skills; while development is focused on learning experiences, is long term, may not be job related but is aimed towards change in attitudes. In this study training and development refer to the process of staff development for improving the performance of the nurse and the organisation.

## **1.9 ETHICAL CONSIDERATIONS**

Brink et al (2012:33) state that researchers involved in research with human respondents have special concerns related to the protection of human beings' rights. The Nuremberg Code consisting of ten characteristics for acceptable research is the most widely known document of ethics in research (Dhai 2014:179). The researcher has utilised these principles to ensure a high ethical standard is maintained. As stated by Dhai (2014:179), principles 2, 8 and 10 of the Nuremberg Code require that researchers protect the best interest of their subjects while principles 1 and 9 give the subject as much authority as the researcher to end participation before the conclusion of the research. The researcher has thus ensured that informed consent was obtained, anonymity was maintained, the benefits outweighed any risks and respondents were informed that they could withdraw from the study if they desired to. The researcher also complied with the ethical concepts of respect, justice, and beneficence as outlined by the Belmont Report (Jones, Grady & Lederer 2016:2393). The research design of this study was non- experimental and there were no anticipated risks or harm expected from

the study. The researcher ensured that data collection only commenced once approval from the Higher Degrees Committee of the Department of Health at the University of South Africa (UNISA), the KZN Provincial Ethics and Research Committee and the Chief Executive Officer of the selected hospital was obtained. A more detailed description of the ethical codes, ethical principles and its application to the study are discussed in Chapter 3 (see section 3.3).

## **1.10 OUTLINE OF THE STUDY**

This dissertation is divided into the following chapters:

- Chapter 1: Orientation to the study
- Chapter 2: Literature review
- Chapter 3: Research methodology
- Chapter 4: Data analysis and interpretation
- Chapter 5: Conclusions, limitations and recommendations

## **1.11 CONCLUSION**

This chapter has introduced the study. A discussion on the background to the research problem, significance of study, research objectives, theoretical underpinning and definitions related to CPD terminology has been included. The chapter also included a brief discussion on the methodology used in the study. The following chapter will focus on the literature reviewed in accordance with the theoretical framework used in the study. It provides an extensive discussion on the factors enabling CPD for nurses and includes leadership, policy, people development, processes of CPD, resources and results of CPD.

## CHAPTER 2

### LITERATURE REVIEW

*"Somewhere, something incredible is waiting to be known."*

Dr Carl Sagan

#### 2.1 INTRODUCTION

The aim of this chapter is to provide comprehensive information acquired through a search of the literature to find out what is known about CPD. Brink et al (2012:71) state that a literature review involves finding, reading, understanding and forming conclusions about the topic as well as presenting it in a logical manner. Brynard, Hanekom and Brynard (2014:40) state that the purpose of a literature review is to obtain a perspective on the most recent research findings related to the topic and to obtain an indication of the best methods, instruments for measurement and statistics which can be used.

This literature review presents the history of CPD in the health professions, the SANC CPD draft framework Version 2 and the application of the concepts of the theoretical framework used in the study.

#### 2.2 STRATEGIES USED TO SEARCH FOR LITERATURE

A preliminary review was done to develop a feasible research problem and methodology. The researcher utilised the University of South Africa (UNISA) tutorial letter (UNISA 301/0/2016:4) for sources of useful research publications. The UNISA library was also used to search for books and journals that related to the topic of CPD. Concurrently, electronic databases were used for an extensive search of literature relating to CPD. Brink et al (2012:76) state that the use of electronic databases gives researchers access to huge numbers and types of sources.

Table 2.1 outlines the key concepts and databases used by the researcher to search for literature on the research topic.



**Table 2.1 Sources of literature**

| <b>KEY WORDS AND PHRASES</b>  | <b>DATABASES</b>   |
|---|--|
| <ul style="list-style-type: none"><li>▪ Continuing professional development</li><li>▪ Nursing education</li><li>▪ Leadership role in continuing education</li><li>▪ Resources for continuing education</li><li>▪ Quality models</li><li>▪ Continuing education and outcomes</li></ul> | <ul style="list-style-type: none"><li>▪ ADL (African digital library)</li><li>▪ Sabinet SA ePublications</li><li>▪ Emerald Insight</li><li>▪ DOAJ (Directory of Open Access Journals)</li><li>▪ EBSCO host</li><li>▪ CINAHL Plus with full text</li><li>▪ Nursing and allied health database</li><li>▪ ProQuest dissertations and theses full text</li></ul> |

### **2.3 HISTORY OF CPD**

The history of CPD in the health profession began with Florence Nightingale (Institute of Medicine 2010:20). Florence Nightingale, in her “Notes on Nursing”, encouraged nurses to learn continually, not only through observation and experience but also by seeking new knowledge (Witt 2011:227). Probably the first advocate for CPD, she recognised that looking for new information and new ways of caring for patients was a professional responsibility of the nurse. Stein, as cited in the Institute of Medicine Washington, USA (2010:20) states that the first recorded continuing nursing education course dated back to 1894. The first courses consisted of on-the-job experience in speciality areas and by the mid-20<sup>th</sup> century the focus progressed to theory-based course instruction.

In medicine, CPD began after World War 1 (1914-1918) when academic staff became concerned with the need to develop the professional growth of doctors (Institute of Medicine 2010:20). To overcome this concern, the first professional body in South Africa that required CPD was the Interim Medical and Dental Council (IMDC) and this was implemented in January 1999 (Arunachallam 2009:10). The current professional body, the Health Professions Council of South Africa (HPCSA) requires compulsory CPD for the 12 professional bodies that it regulates. The SANC, since its inception in 1944 has not made mandatory CPD a requirement for nurses. Mandatory CPD was only prioritised in 2008 and in 2015 the SANC developed a draft CPD framework for nurses and midwives.

## **2.4 SANC'S CPD FRAMEWORK FOR NURSES AND MIDWIVES**

In this section, a brief discussion is provided on the SANC's CPD framework that was developed for nurses and midwives. The researcher has included wherever possible a comparison with the CPD framework for nurses currently used in Kenya, the UK, Australia, Malaysia and Lesotho.

### **2.4.1 Background**

The 14<sup>th</sup> SANC, inaugurated in June 2008, prioritised CPD in its five-year strategy as one of the projects to be introduced. This process commenced in early 2011 with funding obtained from Atlantic Philanthropies. According to SANC (2015:5), it was during this same year that South Africa was invited to participate in a new initiative, the African Health Professions Regulatory Collaboration (ARC). Funded through the President's Emergency Plan for AIDS Relief (PEPFAR) and supported by the ARC Faculty (Emory University) and Secretariat Commonwealth Nurses and Midwives Federation, the aim of the ARC was to strengthen nursing and midwifery in the African continent. This participation led to the appointment of the South African branch of the ARC, and to the development of a CPD toolkit (SANC 2015:5). Using this toolkit, South Africa established a 12-member CPD Technical Working Group consisting of representation from the SANC, professional associations, labour unions, public and private employers and CPD researchers.

Benchmark exercises with the HPCSA, the South African Pharmacy Council (SAPC) and the Engineering Council of South Africa (ECSA) were conducted by the SANC. Apart from these local exercises, international benchmark exercises were conducted in Washington State, USA. The cumulative effort of the desktop research and benchmarking exercises led to the CPD Framework's second draft in 2013. According to Manganye (2015:7), consultative provincial roadshows were carried out and a feasibility study was conducted in all nine provinces towards the latter part of 2013. A pilot study was then carried out in urban Gauteng province and rural Mpumalanga province to test the second draft CPD framework. A discussion on the results of the pilot study is provided in section 2.4.14 of this chapter.

## **2.4.2 Mandate**

As stated by the SANC (2015:7), the SANC has the authority to direct, approve and revise CPD for nurses based on the following policy and legislative directives:

- Constitution of the Republic of South Africa (Act No. 108 of 1996) Chapter 2, Section 27 (RSA 1996)
- National Health Act, 2003 (Act No. 61 of 2003) Section 52 (a & b) (RSA 2003)
- Nursing Act, 2005 (Act No. 33 of 2005), Section 39 & 59 (RSA 2005)
- Human Resource for Health South Africa: Human Resource for Health Strategy for the Health Sector 2012/2013-2016/2017 (RSA 2011:60)
- The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17 (RSA 2011:50)
- Skills Development Act, 1998 (Act No. 97 of 1998) (RSA 1998)

## **2.4.3 Principles of CPD**

The SANC (2015:7) states that CPD is:

- Based on the values of availability, accessibility, affordability and quality.
- Based on learning needs identified and prioritised by the individual and the employer through a rigorous and continuous self-analysis of practices against professional standards.
- Built around an individual's existing knowledge and skills, and links learning to practice.
- Self-directed, reflective and relevant to current and future professional practice.
- Planned in advance, structured and budgeted for, through an individual professional development plan.
- Based on adult-based education and learning principles and acknowledges varying learning styles.
- Inclusive of both formal and informal learning activities.
- Inclusive of clinical and non-clinical roles, including management, education, research, policy development, regulation, labour and industrial service.
- Linked to licensure to practice.

Megginson and Whitaker (2003:7) have the following additional principles:

- Development is a continuous process that applies throughout a practitioner’s working life.
- Learning is most effective when it is acknowledged as an integral part of work activity rather than an additional burden.

The Nursing Council of Kenya (NCK) supports the principle of integration as CPD should be viewed as part of a nurse’s professional work (NCK 2015:14). In addition, the NCK (2015:14) adds that all CPD activities should be evidence-based.

**2.4.4 Requirements for CPD**

The SANC (2015:8) outlines the requirements of CPD in terms of CPD allocation and CPD cycle. CPD allocation is a point-based system where points are allocated based on the level of complexity and participation.

**Table 2.2 CPD allocation criteria**

| PACKAGING POINT ALLOCATION (PPAS) | DEFINITION  | POINTS |
|-----------------------------------|---|--------|
| Observation and attendance        | Refers to a “situation where the practitioner is part of an audience or is receptive to knowledge or information” (e.g. theory & practice)                                  | 1      |
| Actioning                         | Refers to a “situation where the practitioner takes charge and leads the activity” (e.g. spot teaching)   | 2      |
| Development                       | Refers to a “situation where a practitioner develops a product or gives maximum input into a product to obtain maximum output.” This requires a maximum level of engagement | 3      |

(SANC 2015:8)

The SANC (2015:8) stipulates that the CPD cycle runs over a period of 12 months starting from July and ending in June of the following year. Practitioners are expected to accrue a minimum of 15 CPD points during the cycle and once they have been accrued, a declaration of compliance form can then be submitted to the SANC. CPD accrual with

the appropriate documentation will enable the practitioner to renew their annual practicing certificate for the following year.

A summary of the CPD requirements for the countries referenced in this section are provided in Table 2.3.

**Table 2.3 A summary of CPD requirements internationally**

| COUNTRY                | UNIT   | REQUIREMENT  | PERIOD            |
|------------------------|--------|--|-------------------|
| UK <sup>1</sup>        | Hours  | 35 hours   | Every three years |
| Australia <sup>2</sup> | Hours  | 20 hours for people registered as both a nurse and midwife. An additional 10 hours for registered nurses who hold endorsements as a nurse practitioner or hold an endorsement for scheduled medicines. | Annually          |
| Lesotho <sup>3</sup>   | Points | 12 points  | Annually          |
| Malaysia <sup>4</sup>  | Points | 35–40 points for registered nurses, 25–30 points for staff nurses  | Annually          |
| Kenya <sup>5</sup>     | Hours  | 40 hours   | Annually          |

(<sup>1</sup>Nursing and Midwifery Council 2017:online; <sup>2</sup>Nursing and Midwifery Board of Australia 2016:online; <sup>3</sup>Moetsana-Poka, Lebaka and McCarthy 2014:12; <sup>4</sup> Nursing Board of Malaysia 2008:5; <sup>5</sup>Nursing Council of Kenya 2015:8)

#### 2.4.5 CPD activities

The SANC (2015:20) recognises the following methods in CPD activities:

- Reflecting on feedback and keeping a practice journal
- Providing preceptorship, teaching, mentoring and supervising of nursing students
- Developing a policy, procedure or guideline
- Conducting and participating in clinical audits, reviews and committees.
- Writing and/or reviewing educational material, book chapters, journal articles and clinical or non-clinical project reports
- Attending mandatory in-service education that is directly related to clinical practice
- Undertaking volunteer work related to nursing or midwifery practice
- Journal clubs and discussion groups
- Active membership in a professional association
- Being an expert witness
- Planning and conducting workshops

- Involved in undergraduate and postgraduate studies
- Conducting research
- Participation in an accredited short course

In the UK, the Nursing and Midwifery Council (NMC) has added the use of social media as a method of delivery for CPD (NMC 2017:online). The learning activities are not confined to shared physical environments only but can take place in virtual environments such as online discussion groups and professional Twitter discussions. In view of this the NMC (NMC 2017:online) has published a guide to using social media to help nurses meet their CPD requirements.

#### 2.4.6 Scope of CPD

The SANC framework for CPD (SANC 2015:10) divides CPD activities into four areas, namely: ethical and legal domains, area of practice, leadership/management and teaching/research. These are referred to as themes of delivery. Each practitioner will be expected to accrue points in the four areas. The point allocation per area is determined by the scope of practice as indicated in Regulation 2598, 1984 (RSA 1984).

**Table 2.4 CPD grid: themes of delivery**

| CONTINUING PROFESSIONAL DEVELOPMENT GRID |   |                  |                        |                    |                  |
|--|---|------------------|------------------------|--------------------|------------------|
| NURSING CATEGORY                         | THEMES FOR DELIVERY AND REQUIRED CPD POINTS |                  |                        |                    |                  |
|  | Ethical and legal domains                   | Area of Practice | Leadership/ Management | Teaching/ Research | Total CPD Points |
| Professional nurse                       | 4   | 6                | 3                      | 2                  | 15               |
| Midwife                                  | 4   | 6                | 3                      | 2                  | 15               |
| Staff nurse                              | 4   | 6                | 3                      | 2                  | 15               |
| Staff nurse (Enrolled nursing)           | 3   | 9                | 1                      | 2                  | 15               |
| Auxiliary nurse                          | 3   | 10               | 1                      | 1                  | 15               |

(SANC 2015:10)

According to the SANC (2015:11) the themes of delivery are defined as follows:

**Ethical and legal domains:** The legal domain refers to legislation, policies and acts that control and influence nursing practice. The ethical domain refers to the ethical

codes that guide nursing practice. Examples include the Acts, SANC regulations and codes of practice.

**Area of practice:** Area of practice refers to the discipline or field of nursing in which the practitioner is working. Examples include medical nursing, surgical nursing, nursing education.

**Leadership/management:** Leadership refers to the process of directing the activities of the employees to meet organisational goals. Management refers to the process of working with or through people and other organisational resources.

**Teaching/research:** Teaching refers to the skills required to transfer knowledge and research refers to the studies to discover new or to collate old information through the use of scientific methods.

While the SANC CPD framework is limited to four thematic areas, in Kenya the NCK (2015:20) provides a broader range of 22 thematic areas which are non-exhaustive. The NCK (2015:20) further stipulates that CPD content can be cadre-specific which involves activities that focus specifically on the nursing profession or cross-cadre activities which cut across various health disciplines. The Nursing Board of Malaysia (NBM), however, does recognise courses not directly related to nursing but which promote personal development and self-improvement, and these are accepted as part of the CPD programme (NBM 2008:11). Examples of such courses are management courses and information technology courses. According to Summers (2015:337), in Australia the Nursing and Midwifery Board (NMBA) does not define a scope for CPD. The individual practitioners need to determine his/her developmental needs and seek out CPD that addresses those needs.

#### **2.4.7 Role of stakeholders in CPD**

According to the SANC (2015:10), the CPD framework specifies the roles and responsibilities of the practitioners, employers and CPD providers to ensure that CPD is supported for all practitioners so that they are able to meet their CPD requirements.

#### **2.4.7.1 Role of practitioners**

According to the SANC (2015:12), practitioners are expected to:

- Identify learning needs and develop a personal learning plan
- Take responsibility for identifying CPD activities
- Obtain approval from a supervisor to attend CPD activities
- Maintain a portfolio of evidence with relevant documentation for a minimum period of five years
- Submit a completed declaration of compliance on a prescribed form
- Submit supporting documentation in case of an audit

#### **2.4.7.2 Role of employers**

According to the SANC (2015:12), employers are expected to:

- Create an enabling environment for CPD activities
- Monitor employee compliance in CPD accrual
- Inform the SANC of non-compliant issues
- Facilitate CPD compliance and registration
- Keep CPD documentation for a minimum of five years

#### **2.4.7.3 Role of CPD providers**

According to the SANC (2015:12), CPD providers are expected to:

- Obtain SANC recognition as a CPD provider
- Always display the SANC recognition number in all correspondence
- Register and obtain a CPD allocation for each CPD activity
- Submit attendance registers to the SANC as required
- Maintain an electronic data base of training activities
- Keep CPD related documentation for a minimum of two years



The role of practitioners, employers and CPD providers remain consistent across the literature (Canadian Nurses Association 2004:online; NCK 2015:31), with the roles and responsibilities as stipulated by the SANC (2015:12).

#### **2.4.8 Documentation**

It is the responsibility of each practitioner to keep documentary evidence of CPD activities undertaken. The SANC has provided templates for the log sheet, declaration of compliance form and portfolio of evidence file. Practitioners will be required to maintain a log sheet form (see example in Annexure G) with all CPD activities attended and signed by a supervisor. The declaration of compliance form (see copy in Annexure H, Annexure I and Annexure J) is to be submitted at the end of the CPD cycle to verify that the practitioner has accrued the required CPD points for the cycle. Proof of all CPD activities and required documentation is to be kept in a portfolio of evidence (see copy in Annexure K) for a minimum of five years (SANC 2015:14).

#### **2.4.9 Compliance**

A practitioner will be deemed compliant on completion of the required CPD requirements and submission of the declaration form at the end of the CPD cycle (SANC 2015:14).

#### **2.4.10 Non-compliance**

The SANC (2015:15) states that a practitioner will be considered non-compliant in the following instances:

- A practitioner who has not achieved the required number of CPD points within a CPD cycle.
- A practitioner who fails to produce a portfolio of evidence within 21 days of request, if audited.
- A practitioner who produces a portfolio of evidence which does not adequately support the declaration of CPD.

A practitioner who is found to be non-compliant will be unable to renew his/her annual practicing certificate and the SANC may take action against the practitioner in the form of a financial fine, an extension of an additional three months to acquire the prescribed CPD points or removal from the Register (SANC 2015:25).

#### **2.4.11 Exemptions**

The SANC has made provision for exemption of CPD based on certain circumstances. These exemptions are not automatic and are decided by the SANC on an individual basis. The practitioner will be expected to pay an administrative fee and complete an exemption form (see copy in Annexure L) stating the reason why exemption is sought. The practitioners eligible for exemption according to SANC (2015:15) are:

- Practitioners who registered for a formal course of study at a recognised educational institution.
- Practitioners who are working for five or less months during a CPD accrual cycle.
- Retired nurses who are not working but who choose to maintain their registration.
- Those who wish to remain on the register but whose area of practice is not in the field of nursing.
- Practitioners who are on military or national assignments.

The SANC (2015:16) has also made provision for accrual of reduced CPD points and this applies to practitioners who have worked for less than nine months of the CPD cycle. Practitioners who have worked for six to nine months of the accrual cycle are expected to accrue only eight CPD points across the four areas.

This practice differs in Australia as, while the NMBA (2016:online) acknowledge that exemptions may be required, it does not provide a list of designated circumstances for which exemptions may be considered. Each case is considered on its merits and depending on particular circumstances. In addition, exemptions are not granted due to reduced work hours and practitioners are expected to complete the total amount of CPD relevant to their registration regardless of the number of hours worked during the CPD cycle.

#### **2.4.12 Monitoring and evaluation**

There are three levels of monitoring as determined by the SANC (2015:16):

- The first level is by individual practitioners who will monitor their own progress.
- The second level by the employers who will monitor, support and provide CPD opportunities for their staff.
- The third level is by the SANC through the audit process.

According to Moetsana-Poka, Lebaka and McCarthy (2014:11), in Lesotho, the CPD framework is evaluated biennially using a questionnaire survey to a random sample of 10% of all nurses to determine their engagement in the required CPD.

#### **2.4.13 Right to appeal**

The SANC (2015:16) states that practitioners who have grievances against any action imposed by the SANC CPD Committee may appeal to the Council in terms of section 57 of the Nursing Act no 33 of 2005 (RSA 2005:56).

#### **2.4.14 Results of the SANC CPD framework pilot study**

According to the SANC (2017:03), a six-month pilot study was conducted in Gauteng from August 2015 to January 2016 and in Mpumalanga province from September 2015 to February 2016.

##### ***2.4.14.1 Aim of the pilot study***

The aim of the pilot study was to evaluate the SANC CPD programme to:

- Inform national CPD rollout
- Ensure that the CPD programme is fit for purpose and appropriately resourced.
- Identify implementation challenges
- Determine the effectiveness of CPD communication challenges

#### **2.4.14.2 Method**

A total of 51 institutions with 2 772 nurses were piloted. The institutions represented included public and private hospitals, primary healthcare clinics, community centres, the Department of Correctional Services and pharmacies. According to the SANC (2017:06), the study design comprised of 20 focus group discussions, structured nurse questionnaires and CPD declaration forms. A total of 1 259 CPD declaration forms and 154 structured nurse questionnaires were collected.

#### **2.4.14.3 Data analysis**

Quantitative and qualitative data analysis was done. Descriptive statistics calculated for CPD declaration forms and structured questionnaires. Thematic analysis and coding was used to analyse data obtained from focus group discussions.

#### **2.4.14.4 Results**

According to the SANC (2017:14), the following findings were reported:

- Professional nurses and midwives were most likely to complete requirements (35%; n=495), followed by enrolled nurse auxiliaries (27%; n=382) and enrolled nurses (25%; n=353).
- Barriers to the completion of CPD points raised were staff shortages (73%; n=1 031), lack of time (69%; n=975), lack of organisational and supervisory support (27%; n=763) and timing of CPD activities (23%; n=325).
- Of the respondents, 68% (n=961) felt that their employer fully supported and was taking an active interest in CPD.
- CPD was perceived as valuable as respondents indicated that it improved knowledge (91%; n=1 286), improved practical skills (89%; n=1 258), impacted patient safety (81%; n=1 145), increased learner satisfaction (78%; n=1 102) and changed attitudes (73%; n=1 031).

#### **2.4.14.5 Challenges raised**

According to the SANC (2017:13), the following challenges were raised:

- The process was time consuming.
- The collection of evidence was a problem, especially the availability of attendance registers.
- There was uncertainty as to who should sign the portfolio of evidence forms.
- The communication strategy for cascading CPD information was poor.

#### **2.4.14.6 Conclusions of the study**

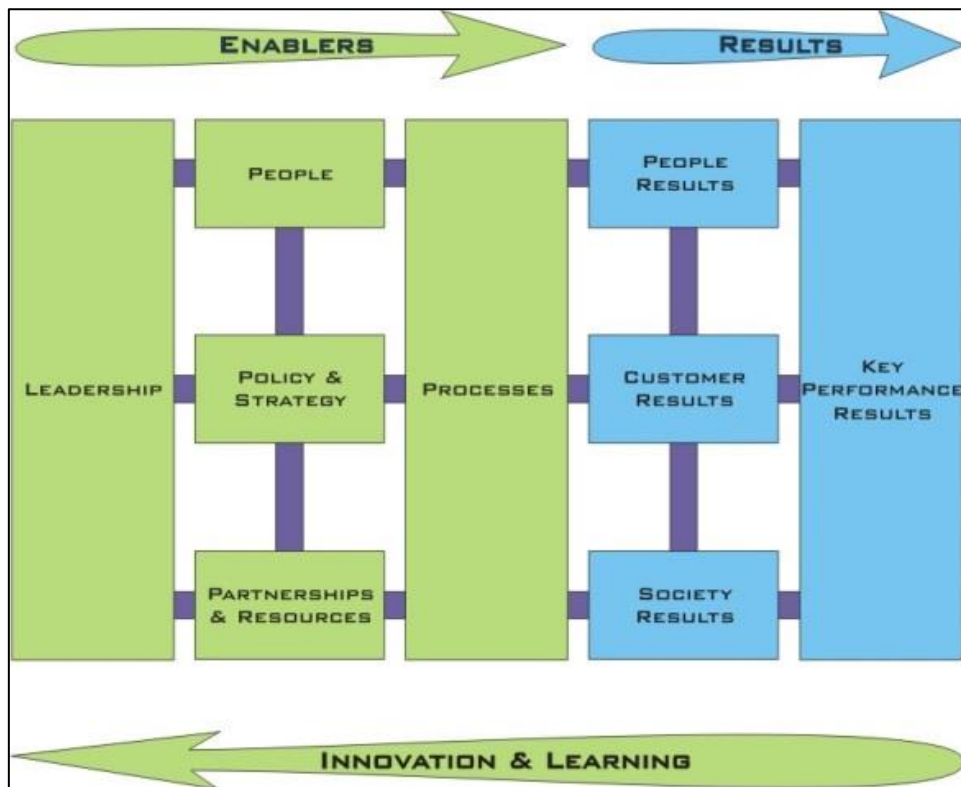
The SANC (2017:25) drew the following conclusions from the study:

- Most of the respondents did not complete the required CPD points, despite favourable attitudes towards CPD.
- Qualitative findings suggested the need to revise the existing roll out and communication strategy.
- The study found that there was a need to clarify certain CPD rules and thematic areas, and to address concerns regarding equitable access to CPD activities.
- Consideration needs to be given to adjusting the allocation of CPD points by thematic area and nursing cadre.

## **2.5 THEORETICAL FRAMEWORK**

This study is based on the EFQM model which suggests that for an organisation to remain competitive in a dynamic environment it has to continually improve. Jaeger and Matyas (2016:281) advocate that organisations use the EFQM model as a strategy to improve overall efficiency.

In Figure 2.1, a diagrammatic presentation of the EFQM model is once again provided followed by a detailed discussion of the application of the criteria of the model as it relates to the CPD of nurses in an organisation.



**Figure 2.1 The EFQM Model**

(European Framework of Quality Management 2012:online)

### **2.5.1 Enablers of CPD**

The *Oxford Mini Dictionary and Thesaurus* (2008:220) defines “enable” as “give the means or authority to do something”. Synonyms include permit, equip, empower and facilitate. The SANC (2015:12) outlines the roles and responsibilities of employers and states that employers should create “an enabling environment” to ensure that CPD is supported for all nurses so that they meet their CPD requirements. Green and Huntington (2017:55) add that to enable clinical competence, nurses should be offered regular professional development to support their skill and knowledge development.

#### **2.5.1.1 The role of leadership in CPD**

Longest (2017:9) defines organisational leadership as the decisions and actions of leaders with the intention to influence followers to agree or accept what the leader wants them to do. Booyens (2015:206) states that leadership is a dynamic and interactive process which involves three aspects, namely the characteristics of the

leader, the attitudes and needs of the follower and the characteristics of the organisation. Recent studies in the UK (Bharwani, Kline, Patterson & Craighead 2017:25; Elton 2016:416) support the notion that leadership cannot be achieved by the leader alone. Leadership is not seen as a single endeavour but must include a strong team of others with needed knowledge and skill.

Leaders play a crucial role in continuing professional development of personnel because they support them in the fulfilment of their personal and professional learning goals and needs (Jooste 2012:262). Leaders, by virtue of their experience, can also serve as mentors for personnel who are engaged in continuing education. According to Jooste (2012:252) a leader can serve as a mentor that offers support, guidance and leadership as the mentee develops skills and grows. Leaders have a responsibility to create an environment that maximises the development of human potential (Marquis & Huston 2015:415). In addition, Adeniran, Smith-Glasgow, Bhattacharya and Yu (2013:444) argue that leaders that want better outcomes for their patients must create environments that encourage nurses' participation in professional development.

In a study among 1673 nurses across three Australian states, Roche, Duffield, Dimitrelis and Frew (2015:61) found that nurses identify positively with leadership that engages, supports, motivates staff and promotes professional development. This is further supported by a South African study conducted by Viljoen, Coetzee and Heyns (2017:73) which emphasises the importance of involving nurses in decision-making relating to CPD. The study found that a top-down leadership approach was a major reason for unsatisfactory attendance at CPD programmes.

Bezuidenhout (2014:149) states that the leadership style adopted in an organisation determines the work climate. The author defines the work climate or organisational climate as a measure of the individual feelings and perceptions of the organisation. It is how the employees see or perceive the organisation. Bezuidenhout (2014:149) further adds that the effectiveness of organisational leaders and the opportunities for growth and development are among the criteria used to assess the organisational climate. Jenkins, Gunst, Blitz and Coetzee (2015:3) in their study on retention of healthcare professionals working in rural district hospitals in South Africa, revealed that a culture of support from management was the third main reason that kept healthcare professionals working in rural district hospitals. Receiving feedback from managers with a view to

developing people indicated a leadership style that promoted a culture of support. Wong and Laschinger (2013:956) highlight the effect of work environments that empower and enable nurses in their work. The study revealed that the biggest challenge for establishing empowering workplaces may reside in the role of effective leadership.

Despite the evidence that leadership impacts on CPD, McMahon (2017:1075) states that in practice few healthcare leaders have embraced the development of their employees as an organisational responsibility and opportunity.

The National Strategic Plan for Nurse Education, Training and Practice 2012/2013–2016/2017 (RSA 2011:26) further highlights the lack of management capacity as a key obstacle to health delivery in South Africa. The steady decline in formal nursing leadership roles has led to the loss of direction and the declining morale of nurses. The National Department of Health (RSA 2011:12) recommends that leadership roles in nursing be revitalised and promoted on an ongoing basis.

### ***2.5.1.2 People development***

Jehanzeb and Bashir (2013:243) acknowledge that employees are an important resource in organisations and that the success or failure of an organisation relies on the performance of its employees. Investment in employee development yields increased employee satisfaction and performance which leads to increased organisational performance.

Kanten and Ulker (2013:156) found that creating positive work environments, which care about its employees and their needs, is essential to promote job satisfaction. Marquis and Huston (2015:415) surmise that aligning equal importance to employee needs results in increased motivation for employees to develop their full potential. The need to belong and to feel useful is an important aspect in motivating employees. Sharing information and involvement in decision-making are practical means of meeting these needs.

The Performance Management Development System (PMDS) is a human resource strategy implemented in the South African healthcare system to provide a means of



assessment and improvement of both individual and organisational performance against predetermined objectives (Adejoka & Bayat 2014:9). The PMDS is a cyclic process of setting objectives, providing feedback, reviewing results and providing rewards based on performance (Du Plessis 2015:7). A reward system such as monetary rewards, recognition and acceptance of employees is also a means to motivate and improve performance (DeSimone & Werner 2012:43). Despite the implementation of the PMDS since 2011, a study by Du Plessis (2015:7) found that nurses have poor knowledge of the performance development system and recommends that nurses be provided education on the application of the PMDS system to enable professional development. The National Strategic Plan for Nurse Education, Training and Practice 2012/2013 – 2016/2017 (RSA 2011:52) has further made recommendations that the PMDS be linked to CPD to enhance career pathing.

Kotze et al (2013:228) discuss the Professional Excellence and Career Advancement in Nursing (PECAN) model and state that participation in CPD is influenced by human capital factors, social capital factors, system capital factors and external support.

- Human capital factors include knowledge, skills and personal attributes such as competence, confidence, self-regulation and intrinsic motivation.
- Social capital factors include the relationships that take place in CPD interaction such as mentoring, networking, collaboration and partnerships.
- System capital factors refer to the organisational attributes of the workplace such as support from management, access to education and tuition support.
- External support refers to the support nurses receive from family members.

According to Kotze et al (2013:228), the above factors influence the participation of nurses in CPD. In a qualitative study by Burrow, Mairs, Pusey, Bradshaw and Keady (2016:139) which explored the motivations of healthcare professionals in CPD, the following themes emerged in response to motivations towards CPD: personal and professional drivers; the influence of management and availability of funding; balancing competing demands' and sources of support. The findings suggest congruence with the PECAN model as described by Kotze et al (2013:228).

An advance in technology, communication and globalisation has led to changes in patterns of work life. Job opportunities have increased, and people will not work for

undesirable organisations (Bezuidenhout 2014:265). As a result, employers must focus on developing and retaining exceptional employees (Zinni, Mathis & Jackson 2011:320). Marquis and Huston (2015:239) outline several responsibilities that organisations have towards career development of employees:

- The development of career paths so that employees can progress through a sequence of job positions.
- Identification of needs to match jobs with the skills and abilities of present employees.
- Dissemination of career information so employees can make informed decisions on career pathing.
- Advertising of job vacancies.
- Assessment of employees through an appraisal system.
- Providing support and encouragement in career development.
- Providing education and training for employees.

Webb, Diamond-Wells and Jeffs (2017:25) state that the benefit of providing career development opportunities for nurses includes job satisfaction, organisational commitment, increased retention and achievement of career goals. This is supported by Vagharseyyedin (2016:111) in an integrative review of 33 studies in Iran, which found that providing opportunities for continuing education was associated with increased organisational commitment.

### ***2.5.1.3 Policy and CPD***

Marquis and Huston (2015:156) define policies as plans reduced to statements that direct organisations in their decision-making. In South Africa, policy development in issues pertaining to nurses' CPD is influenced by the National Department of Health, the SANC and the Skills Development Act 97 of 1998 (RSA 1998).

The National Department of Health has developed a strategy for the revitalisation of the nursing profession and this culminated in the development of the National Strategic Plan for Nurse Education, Training and Practice 2012/2013 – 2016/2017. The origins of the strategic document commenced in 2011 when the National Department of Health convened the National Nursing Summit (RSA 2011:9). According to the Department of

Health (RSA 2011:9) the problems facing nursing in South Africa were highlighted under seven themes:

- Nursing education and training
- Resources in nursing
- Professional ethos and ethics
- Governance, leadership, legislation and policy
- Positive practice environments
- Compensation, benefits and conditions of employment
- Nursing human resources for health

This resulted in a programme of action with recommendations for each of these seven themes. The National Strategic Plan Nurse Education, Training and Practice 2012/2013–2016/2017 (RSA 2011:11) proposed a CPD system linked to licensing and professional progression for all nurses and midwives as one of the recommendations. At the time of the study the Department of Health was the principal custodian, responsible for the administration, implementation, monitoring and evaluation of the National Strategy for Nursing Education, Training and Practice 2012/2013–2016/2017.

The SANC provides for the regulation, accreditation and policy development for issues pertaining to nursing and midwifery practice in South Africa (SANC 2017:online). At the time of the study, the SANC is in the developmental stages of the policy for mandatory CPD, linking licensure to practice, for nurses and midwives in South Africa. The draft framework has been discussed in section 2.4 of this chapter.

The Skills Development Act 97 of 1998 (RSA 1998) was promulgated to develop and improve skills of the South African workforce. The act outlines the following obligations (RSA 1998:10):

- To develop the skills of the South African workforce to improve productivity, quality of work life and improve delivery of services.
- To invest in quality education in the labour market and improve return on the investment.
- To assist employers to use the workplace as a learning environment in order that employees gain new skills.

- To provide opportunities for employees to participate in education and training.
- To address the needs of those previously disadvantaged.

At an organisational level, employers have a responsibility to develop personnel policies relating to career development (Marquis & Huston 2015:240). Policy formulation is usually performed by top level management; however, feedback from employees is crucial to successful implementation (Marquis & Huston 2015:156).

Rispel and Bruce (2015:120) state that the role of the nurse in policy formulation in South Africa needs some research. A policy analysis study was conducted to analyse the dynamics, strengths and weaknesses of nurse's participation in four national health policies (Rispel & Bruce 2015:120). The study found that although there has been some improvement since democracy, nurse's participation in policy development is both disputed and complex. According to Rispel and Bruce (2015:120) there was a marked disparity between nursing leadership and frontline nurses in the levels of awareness of the policies. The reasons cited by the study respondents for their lack of policy awareness, ranged from inadequate feedback from those involved to deliberate exclusion by managers from the policy table. This trend is also seen in international studies (Brekelmans et al 2016:17) which revealed that nurses want to have more influence on nursing policy development, specifically regarding mentoring of the young and inexperienced nurses.

#### ***2.5.1.4 Resources for CPD***

Lalonde, Hall, Price, Andres, Harris and MacDonald-Rencz (2013:51) indicate that the availability of resources is an important factor in nurses' participation in CPD. In a qualitative study of CPD for medical, nursing and midwifery cadres in Malawi, Tanzania and South Africa conducted by Feldacker, Pintye, Jacob, Chung, Middleton, Iliffe and Kim (2017:8), it was found that for CPD to be effective, resources such as human, financial and clinical resources were a key requirement.

##### *2.5.1.4.1 The human resource development team*

According to DeSimone and Werner (2012:286) all human resource development teams have three roles to play with respect to continuing education – enablers, resource

providers and monitors. The authors suggest that as an enabler, the human resource development team must ensure that there are policies and procedures in place that will ensure an effective and fair allocation of CPD opportunities within the organisation. The human resource development team fulfils its role as a resource provider by provision of support in terms of finance, study leave and funded professional meetings or seminars (DeSimone & Werner 2012:286). The third role as explained by DeSimone and Werner (2012:286) is the human resource development team as a monitor of professional development. Evaluation of professional development is a critical part of human resource development and will be discussed in greater detail in section 2.5.1.5 of this chapter.

#### *2.5.1.4.2 The nurse educator*

The SANC (2014:1) defines a nurse educator as a Professional Nurse with an additional qualification in nursing education and who is registered as such with the SANC. A nurse educator can function as lecturer, clinical educator, education manager, researcher and specialist. Studies (Dickerson 2016:483; Shinnars & Franqueiro 2017:45) have revealed that nurse educators contribute substantially to and are critical assets of the clinical education departments in hospitals. Dickerson (2016:486) adds that ongoing education and support will significantly improve delivery of quality education. Bleich (2016:11) supports the development of nurse educators as the educator role is one of constant giving to others with few opportunities for self-renewal and development. The National Strategic Plan Nurse Education, Training and Practice 2012/2013–2016/2017 (RSA 2011:40) makes provision for nurse educator development by ensuring that designated funding be made available for a nurse educator framework as well as funding for scholarly activities such as educational programmes, study leave, research support and CPD for nurses.

According to the SANC (2014:3), the key competencies for a nurse educator as related to learning and development are:

- Shows enthusiasm for teaching, learning and nursing and motivates learners.
- Displays proficiency in the utilisation of information technologies to support the learning process.
- Exhibits skill in oral, written and electronic communication.

- Utilises personal attributes such as caring, confidence, patience, integrity and flexibility that facilitates learning.
- Promotes a positive learning environment by maintaining collegial working relationships with other personnel.
- Is knowledgeable in contemporary professional practice.
- Acts as a role model with regards to professional activities, including but not limited to engagement in lifelong learning and community engagement.
- Participates in professional development activities to pursue continuous improvement in the nurse educator role.
- Demonstrates a commitment to lifelong learning.

Findings from a Delphi study by recognised experts in nursing education (Davis, Taylor & Reyes 2014:441), state that nurses who are engaged in lifelong learning actively seek and appreciate new knowledge to gain new perspectives in both their personal and professional life. Davis et al (2014:444) point out that the characteristics of lifelong learning are reflection, appreciating the dynamic nature of education, questioning, actively seeking new learning opportunities and being able to convert new knowledge into the ability to deliver high quality care. Govranos and Newton (2014:656) acknowledge the importance of lifelong learning and link it to adult learning.

Billings and Halstead (2012:221) summarise Knowles Theory of Adult Learning by stating that adults are problem centred, they need and want to learn useful information that can be applied to their lives and they need to learn in an environment that enables them to assume responsibility for their learning. Blevins (2016:60) adds that a nurse educator must be able to apply the principles of adult learning to teaching strategies.

Knowles et al (2012:4) outline six principles of adult learning.

- Adult learners need to know why, what and how to learn.
- The self-concept of the adult learner is important. Adult learners are autonomous and responsible for their own decisions and need to be seen by others as capable of self-direction. The teaching-learning transaction should be a mutual responsibility of both educator and learner.
- Adult learners value prior experience in their learning. Their depth and range of experience becomes a valuable resource of learning.

- Adult learners display a readiness to learn that is developmental task- and life-related.
- Adult learners' orientation to learning is problem centred and contextual. Connecting learning to real life experience is typical of adult learners.
- Adult learners are responsive to intrinsic motivation (personal growth, development) rather than extrinsic motivation (praise, rewards).

Gravett (2005:8) gives the opinion that the concept of an adult learner is a myth as each learner will bring unique characteristics to the teaching learning environment. Spies, Seale and Botma (2015:1494) acknowledge that learners are unique but also contend that the dynamics surrounding the adult learner warrant special attention as adults have specific needs and requirements as learners. Spies et al (2015:1494) state that adult learners share at least four common attributes: financial independence, full time employment, having dependants and studying part-time.

#### *2.5.1.4.3 The learning resource centre*

Billings and Halstead (2012:335) state that modern learning resource centres serve as a multifunctional teaching and learning centre. According to the authors these centres should be readily available and have resource staff, equipment, books, and journals, learning packages, online access and specialised work stations. The availability of such learning resource centres supports the delivery of continuing education. According to the authors, health care institutions especially those that are academic related, now have World Wide Web and social media network sites that provide online programmes for continuing education.

#### *2.5.1.4.4 Funding for CPD*

The Skills Development Act 97 of 1998 (RSA 1998:21) makes provision for funding for human resource development in South Africa. The act states that "each public service employer in the national and provincial spheres of government must budget for at least one per cent of its payroll for the training and education of its employees" (RSA 1998:22). The Sector Education and Training Authorities (SETA) were developed in accordance with the Skills Development Act 97 of 1998 (RSA 1998:13). SETAs are financed from the skills development levies collected in its sectors, grants, donations,

income earned on money invested and money received from the National Skills Fund (RSA 1998:13). The Health and Welfare Sector Education and Training Authority (HWSETA) is the authority primarily responsible for the development in the health sector (Liphosa 2013:41). The HWSETA is responsible for approval of the workplace skill plans submitted by organisations in the health sector. Workplace skills plans (WSPs) document the skills needed in an organisation and describes the range of skills interventions that an organisation will use to address these needs (Meyer 2012:231). These plans are developed annually in accordance with the fiscal year and submitted to the SETA with which the organisation is registered. In this study, nursing CPD falls within the health sector, so funding for CPD activities is controlled by the HWSETA.

The role of funding in CPD has become a common theme in many scientific studies. Salas, Tannenbaum, Kraiger and Smith-Jentsch (2012:74) point out that in the US organisations spend billions of dollars a year on the development of employees. The authors state that these organisations understand that investing in employees yields greater results. Haywood, Pain, Ryan and Adams (2012:138) identified a lack of funding as the main barrier to participating in CPD activities.

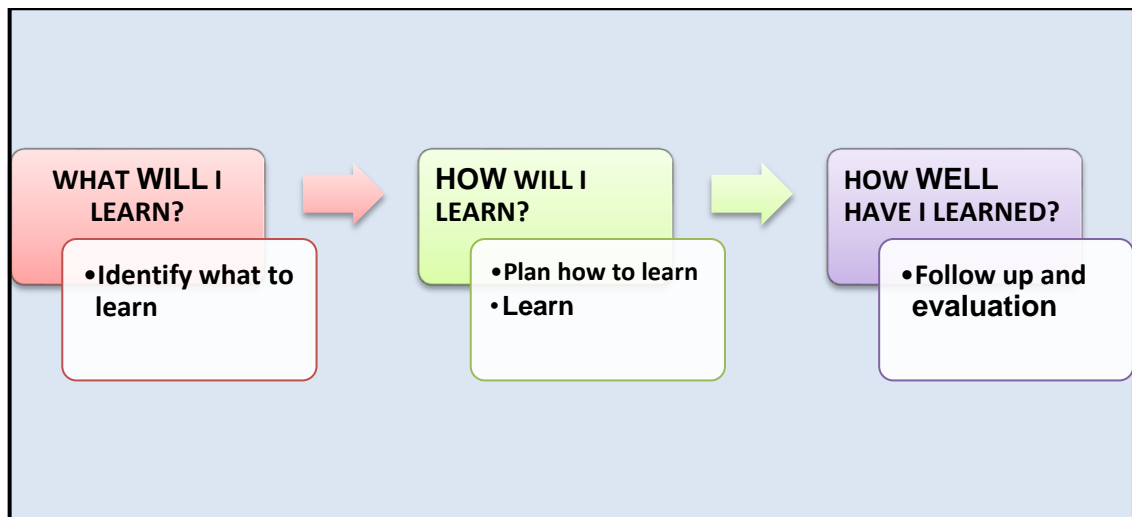
#### ***2.5.1.5 Processes of CPD***

Felipe, Silva, Stulting and Golnik (2014:136) researched CPD practices in several countries including the United Kingdom, Australia, Canada, New Zealand and Scotland, to ascertain best CPD practices. The study concluded that CPD practices can be conceptually organised around three fundamental questions:

- What will I learn?
- How will I learn?
- How well have I learned?

The authors describe the relation between these three processes as the CPD cycle as reflected in Figure 2.2.





**Figure 2.2 Generic CPD Cycle**

(Felipe et al 2014:136)

*Identification of learning needs*

Felipe et al (2014:136) are of the opinion that learning needs are gaps between current personal competencies and the desired state. These needs, according to Felipe et al (2014:136) can be identified during direct patient care, in interactions with the clinical team, in non-clinical activities (readings, scientific conferences), in quality management and risk assessments (audits, patient satisfaction surveys), in specific needs assessments (self-assessments) and in peer review.

Meyer (2012:153) states that identification of learning needs has traditionally been that of the human resource or training department and this is usually done through the development of a workplace skills plan. However, the authors add that the identification of training needs should include a variety of other stakeholders. The table below indicates the stakeholders who should be involved and the rationale for doing so.

**Table 2.5 Stakeholder involvements in learning needs analysis**

| STAKEHOLDER                      | RATIONALE FOR INCLUSION IN NEEDS ANALYSIS   |
|----------------------------------|---|
| Employees                        | Employees will be more committed to learning if they are involved in identifying what they are going to learn   |
| Managers                         | Managers will be in an ideal position to identify gaps in training through their supervisory capacity. Managers are also responsible for ensuring that opportunities are provided for transfer of learning back to the workplace. |
| Top management                   | They are responsible for the final approval of human resource development policy and resource acquisition and therefore their support is needed.  |
| HRD officers and nurse educators | They serve as the frontline staff for provision of training and are in a good position to identify learner's needs.   |
| Customers and clients            | Customers give feedback through satisfaction surveys and complaints mechanisms and training needs can be identified in these forums.  |
| Professional bodies              | Professional bodies may stipulate specific themes of development, e.g. the SANC stipulates themes such as ethics, professional practice, teaching.  |
| Past participants                | Feedback for previous participants can be a valuable source on specific needs.  |

Meyer (2012:160)

While various stakeholders may contribute to the identification of learning needs, Alsop (2013:7) and Doss-McQuitty (2016:97) agree that the ultimate responsibility for identification of professional development needs remains the duty of the nurse.

### *Planning of learning*

Once learning needs have been identified, learning activities should be planned and undertaken. Filipe et al (2014:137) suggest that CPD activities should be chosen according to the type of need identified. The authors distinguish needs into two categories: knowledge and skills updating for improving factual knowledge and competency assurance for boosting confidence in a particular skill.

Bezuidenhout (2014:259) discusses the planning of learning under four aspects namely:

- Training objectives: The learning/training needs identified will determine what the desired outcomes or objectives will be. The training objectives therefore describe the knowledge, skills and attitudes that are required or that need to be changed.
- Readiness and motivation of learners: Learners who are self-disciplined, goal directed and conscientious are more likely to apply knowledge and skills gained in training to work performance.

- Characteristics of instructors: The skills, knowledge and personal manner of those delivering training will influence the success of the training. Desirable characteristics of effective instructors include knowledge of the subject, adaptability, sincerity, sense of humour, interest, clear instructions, individual assistance and enthusiasm.
- Principles of learning: These are psychological principles which help learners grasp new material and apply it to their job. Some of the principles include goal setting, modelling, accommodation of individual differences, active practice and repetition, feedback and reinforcement, comfortable physical surroundings and a congenial atmosphere.

### *Implementation of learning*

Once planning has been done, the actual delivery of training can take place. Kyndt and Baert (2013:273) introduce the concept of workplace learning and state that learning occurs mostly in the workplace. Alsop (2013:75) agrees that the workplace provides a rich source of learning opportunities for ongoing and professional development. Ni, Hua, Shao, Wallen, Xu and Li (2014:596) in their study which explored Chinese nurses' perceptions of CPD, found that nurses' indicated workplace learning as the main way to meet CPD requirements.

DeSimone and Werner (2012:224) and Warnich et al (2015:353) differentiate between on-the-job and off-the-job learning. Janssens, Smet, Onghena and Kyndt (2017:93) add that the boundaries between work and private life are becoming more obscure as a result of flexible hours and flexible workplaces and there is uncertainty as to what exactly constitutes the workplace. Janssens et al (2017:93) further state that the distinction between on-the-job and off-the-job learning seems to be outdated and advocates that the differentiation between formal and informal learning seems more valuable.

Manuti, Pastore, Scardigno, Giancaspro and Morciano (2015:3) define formal learning as structured learning that takes place outside of the work environment. Alsop (2013:70) points out that learning in the workplace is dictated by the organisation's goals and not by academic expectations. Conversely, informal learning, as pointed out by Alsop

(2013:70) refers to learning that is not pre-planned but may occur unexpectedly at any time in the workplace.

Cacciattolo (2015:245) states that 80% of work related learning occurs informally and holds the view that workplace learning is predominantly informal. Alsop (2013:70) argues that formal learning tends to benefit the individual rather than the organisation, so it may not necessarily be supported by the organisation. Collin et al (2012:158) argue that both types of learning reinforce each other, underlining the importance of including different forms of learning activities when aiming for CPD. In a research review on formal and informal workplace learning, Manuti et al (2015:14) conclude that in all learning, elements of both formal and informal learning are present. The authors state that the most significant issue is not the boundaries between these types of learning but the interrelationships between these types of learning where often formal and informal learning practice overlap.

Using the above two methods of delivery of training, CPD can assume a variety of formats. Table 2.6 provides a comprehensive list of informal and formal learning activities based on the framework of the HCPC in the UK.

**Table 2.6 List of CPD activities based on the framework by the HCPC, UK**

| <b>INFORMAL LEARNING</b>   | <b>PROFESSIONAL ACTIVITY</b>   | <b>FORMAL</b>  | <b>SELF-DIRECTED LEARNING</b>   |
|--|--|--|---|
| <ul style="list-style-type: none"> <li>• Learning by doing</li> <li>• Case studies</li> <li>• Clinical audit</li> <li>• Discussion with colleagues</li> <li>• Ward rounds</li> <li>• Job rotation</li> <li>• Journal club</li> <li>• Study groups</li> <li>• In-service training</li> <li>• Supervising staff or students</li> <li>• Quality assurance activities</li> <li>• Performance development</li> <li>• Developing protocols, guidelines and policies</li> </ul> | <ul style="list-style-type: none"> <li>• Involvement in a professional body</li> <li>• Membership of a specialist interest group</li> <li>• Lecturing</li> <li>• Mentoring</li> <li>• Being an examiner</li> <li>• Organising journal clubs or other specialist groups</li> <li>• Being an expert witness</li> <li>• Giving presentations at conferences</li> <li>• Organising accredited courses</li> <li>• Supervising research</li> </ul> | <ul style="list-style-type: none"> <li>• Courses</li> <li>• Workshops</li> <li>• Further education</li> <li>• Undertaking research</li> <li>• Attending conferences</li> <li>• Writing articles or papers</li> <li>• Distance learning</li> <li>• Online learning</li> <li>• Courses accredited by a professional body</li> <li>• Planning or running a course</li> <li>• Delivering training</li> </ul> | <ul style="list-style-type: none"> <li>• Reading journals/articles</li> <li>• Conducting a literature search</li> <li>• Online discussion groups</li> <li>• Reviewing books or articles</li> <li>• Updating knowledge through internet or television</li> <li>• Keeping record of progress</li> </ul> |

| INFORMAL LEARNING   | PROFESSIONAL ACTIVITY   | FORMAL | SELF-DIRECTED LEARNING |
|---|---|--------|------------------------|
| <ul style="list-style-type: none"> <li>• Undertaking a project</li> <li>• Work shadowing</li> <li>• Participating in a committee</li> <li>• Peer review</li> <li>• Self-reflected learning</li> </ul> | <ul style="list-style-type: none"> <li>• Being a national assessor</li> </ul> |        |                        |

(Adapted from the Health Professions Council UK 2016:online)

### *Barriers to CPD*

Alsop (2013:38) states that implementing of learning in the CPD process has its own challenges such as organisational support, funding, time and resources.

In a study by Summers (2015:338) which examined the barriers and support for CPD in Australia, it was found that funding, lack of time, availability of information, lack of computer and internet access, CPD activities being oversubscribed and the poor attitude of nurses towards CPD constituted the main barriers to CPD. Feldacker et al (2017:5) in their qualitative study which evaluated the CPD of healthcare professionals in Malawi, Tanzania and South Africa, identified the barriers to CPD under three levels, namely system, implementation and individual levels as outlined in Table 2.7.

**Table 2.7 Barriers to CPD in Malawi, Tanzania and South Africa**

| LEVEL                | BARRIERS  |
|----------------------|---|
| System level         | <ul style="list-style-type: none"> <li>▪ Inadequate funding for CPD activities</li> <li>▪ Gaps in CPD regulation such as poor standardisation, lack of clear guidelines for CPD development and accreditation</li> <li>▪ Inadequate human resources negatively impact participation in CPD courses</li> </ul>   |
| Implementation level | <ul style="list-style-type: none"> <li>▪ Rural challenges are more profound due to lack of basic services, geographical isolation and lack of access to technology</li> <li>▪ The study found a general agreement across all three countries that CPD was developed, organised and delivered centrally without much input from the healthcare professional</li> </ul>   |
| Individual level     | <ul style="list-style-type: none"> <li>▪ Lack of self-motivation because of unfair managerial procedures, training does not match job content and not being selected to attend CPD courses</li> <li>▪ Lack of personal finance to engage in CPD on own time</li> <li>▪ Country specific challenges such as funding issues in Malawi, inclusion of private practitioners in CPD regulation in Tanzania and the issue of labour union involvement in CPD-related decisions in South Africa</li> </ul> |

Feldacker et al (2017:5)

## *Evaluation of learning*

Salas et al (2012:90) state that evaluation is a systematic collection of post-training data that allows the organisation to continue conducting training that works and to discontinue training that does not work. Meyer (2012:235) states that the objective of evaluation is to assess the strengths and weaknesses of the training activity and that this can be done by means of evaluation forms, changes in job behaviour following training and organisational change as a result of training.

Felipe et al (2014:137) state that evaluation completes the CPD cycle and involves two components:

- Finding opportunities in clinical practice to apply new skills.
- Dissemination of new learning to colleagues in the clinical setting.

Bezuidenhout (2014:265) provides recommendations by which employees who have attended CPD can apply and disseminate new learning to other colleagues:

- Employees who have benefited from training can provide a feedback in the form of a written report on what was learned.
- Employees can present an in-service training session to demonstrate new skills learned so that others can learn as well.
- The incorporation of the new knowledge and skills in the employees' performance agreement and job description. The performance agreement could provide evidence of how the training has benefited the employee and the organisation.

In a recent study, Garafalo (2016:103) introduces the concept of "value added education". The results of the study revealed that, even though high volumes of nurses are educated, there is no evaluation of the impact on practice and quality outcomes. Garafalo (2016:103) also states that experts in continuing education have cited Kirkpatrick's Four Level Model of Evaluation (Kirkpatrick & Kirkpatrick 2009:26) as an influential framework for training evaluation. Dorri, Akbari and Sedeh (2016:494) concur that the popularity of this model is because it provides a system for demonstration of training results and different data that can be used for evaluation. According to

Kirkpatrick and Kirkpatrick (2009:26), training can be evaluated using four levels as indicated in Table 2.8.

**Table 2.8 Kirkpatrick’s four level model of evaluation**

| LEVEL | CONCEPT   | MEANING   | APPLICATION   |
|-------|-----------|---|---|
| One   | Reaction  | The degree to which participants find the training favourable, engaging and relevant to their jobs.                             | Feedback sheets, oral discussions, checklists.                  |
| Two   | Learning  | The degree to which participants acquire the intended knowledge, skills, attitudes, confidence and commitment to participation. | Tests and portfolios.   |
| Three | Behaviour | The degree to which participants apply what they have learned during training when they are back on the job.                    | Observation, interviews, critical incident technique.           |
| Four  | Results   | The degree to which the training has impacted on the organisational goals of productivity, quality and job satisfaction.        | Workplace metrics such as production and cost benefit analysis. |

(Kirkpatrick & Kirkpatrick 2009:26)

Garafalo (2016:104) posits that the results obtained from evaluation programmes are used to guide future programmes and that CPD should be planned with the goals and strategic plan of the organisation in mind.

## **2.5.2 Results of CPD**

The American Nurses Credentialing Center on Accreditation (2014:online) outlines that the ultimate result of CPD is to improve the professional practice of nursing and care provided to patients.

### **2.5.2.1 Transfer of learning**

According to Sankey and Machin (2014:241), CPD is only effective when employees learn during activities and apply what they have learned in the workplace. Massenberg, Spurk and Kauffeld (2015:165) define training transfer as the effective and continuing application of newly gained knowledge and skills into practice.

In a study examining the voluntary or mandatory enrolment in training and the motivation to transfer training among 97 employees in a Portuguese insurance

company, Curado, Henriques and Ribeiro (2015:98) found that respondents who voluntarily enrolled in the training showed a higher impact in motivation to transfer training to practice than those that were mandatorily enrolled. Sankey and Machin (2014:253) further highlight that employees are more likely to make a commitment to transfer learning when the intrinsic benefits of the learning are highlighted and when they are proactively supported in their personal interests. In a study among 194 workers in two companies in Germany, Massenberget al (2015:161) found that peer and supervisor support were important predictors of training transfer.

According to Salas et al (2012:91), transfer of learning can be capitalised by:

- ensuring a supportive post-training environment
- providing opportunities to practise new skills
- using real on-the-job experiences to reinforce lessons learned
- removing obstacles to transfer such as time constraints
- providing support to managers so that they can reinforce and promote on-going learning

#### ***2.5.2.2 CPD outcomes relating to patient care, nursing knowledge and skills***

Several studies by various authors such as Theilan, Leonard, Jones, Ardill, Weitz, Agrawal and Simpson (2013:218); Kelly, Forber, Conlan, Roche and Stasa (2014:724); and Lahti, Kontio, Pitkanen and Valimaki (2014:846) found that educational programmes have a positive impact on patient outcomes. A mixed method review of literature (Connell, Endacott, Jackman, Kiprillis, Sparkes & Cooper 2016:133), using 23 peer reviewed studies published between 2002 and 2014, revealed that most (21) of the educational programmes were found to be effective. The review reported considerable positive impacts on the knowledge and performance of learners, patient outcomes and the activation of rapid response systems in organisations. While the overall result of this review indicated a positive impact of education on learner, patient and organisational outcomes, Connell et al (2016:143) acknowledge that due to the complexity of uncontrolled variables, it would be irrational to equate these positive outcomes with education alone.



Clark, Draper and Rogers (2015:388), as well as Duff, Gardner and Osborne (2014:104) point out that while there has been a substantial global investment in CPD, there is little evidence to suggest a noticeable impact on practice and patient outcomes. Clark et al (2015:389) state that in the presence of limited resources and confounding variables it becomes difficult to assign a clear causal relationship between CPD and practice. The authors embrace the view that the process affecting how CPD is planned, delivered, engaged and applied is important in determining the overall impact of CPD on practice. According to the authors, the process of CPD includes the importance of the organisational context, the engagement of leadership and the influence of a strong relationship between education and practice. The authors conclude that having an insight into the processes of CPD will afford a better understanding of how to improve the impact of CPD on practice.

## **2.6 CONCLUSION**

The purpose of this chapter was to obtain a perspective on the literature related to the CPD of nurses. The chapter commenced with the history of CPD in the health professions followed by the SANC's CPD framework for nurses and midwives' version 2 in terms of the mandate, principles, scope, requirements, role and responsibility, documentation, exemptions and monitoring and evaluation. It is evident from the discussion that mandatory CPD for nurses in South Africa is imminent. It is clear from the research reviewed that the CPD for nurses is influenced by organisational factors such as leadership, people development, policies and resources. Along with this, the organisational and individual processes involved further impact on the CPD of nurses. While the literature supports that CPD has positive outcomes for nursing practice there is also an acknowledgment that positive outcomes cannot be associated with education alone. The next chapter will focus on the research methodology used in the study.

## CHAPTER 3

### RESEARCH METHODOLOGY

*"Design is not just what it looks like and feels like. Design is how it works."*

*Steve Jobs*

#### 3.1 INTRODUCTION

The purpose of this chapter is to describe and justify the methodology of the study. The chapter provides a report on the research design and research methods including population, sample and sampling, data collection and analysis and the validity and reliability of the study as well as the ethical considerations and the limitations of the study.

The concepts of methodology of research are often used in an overlapping manner in research (Bryman & Bell 2015:48; Cronin, Coughlan & Smith 2015:16; Gray et al 2017:192). The authors differentiate between these concepts but acknowledge that collectively the methodology which includes design and methods represents the researcher's plan for conducting the study. Cronin et al (2015:16) state that methodologies offer a broader philosophical overview of the research which can be subdivided into approaches that describe how the research should be undertaken. The authors further state that the description of how the research should be undertaken is the method.

#### 3.2 RESEARCH METHODOLOGY

Research methodology, as defined by Gray et al (2017:38), refer to the type of research selected to answer the research question. According to the authors, the researcher's desired output determines a study's methodology. Gray et al (2017:8) conclude that decisions related to methodology represent the single most important step of the research process, namely designing the study.

### **3.2.1 Research design**

A research design is defined as an overall plan or blueprint for addressing a research question including conditions for maximising control over factors that could interfere with the study's desired result (Lo-Biondo Wood & Haber 2017:150). The choice of a design depends on many factors, including research problem, purpose, aims, researcher expertise and on the researcher's desire to generalise the findings (Brink et al 2012:55; Hedges & Williams 2014:112). Roller and Lavrakas (2015:73) suggest that the following four factors should be considered during selection of a research design:

- The scope, depth and nature of the research topic.
- The heterogeneity or homogeneity of the population of interest.
- The level of analysis and interpretation required to meet the research objectives.
- Practical constraints such as availability and access to participants, budget and time constraints.

The premise of the study was to improve the understanding of how CPD takes place in the hospital. Based on these factors the study employed a quantitative, descriptive, non-experimental, cross-sectional design. The chosen approach enabled the researcher to describe at a specific point in time the context in which CPD in the selected hospital takes place.

#### **3.2.1.1 Quantitative design**

Creswell (2014:32) defines quantitative research as an approach that involves the investigation of phenomena by examining the relationship among variables. Quantitative researchers have assumptions about testing theories deductively, preventing bias, ensuring strict control and objectivity and being able to generalise and replicate the findings (Creswell 2014:32). Hedges and Williams (2014:112) agree that quantitative research methods are a highly formal, objective, systematic process and rely on statistical procedures for analysis. Leavy (2017:24) summarises the quantitative approach as one that values breadth, statistical descriptions and generalisability and is primarily focused on achieving objectivity, control and precise measurement. The final report of a quantitative research study has a set structure consisting of an introduction, literature review, methodology, results and design (Creswell 2014:32).

A summary of the characteristics of the quantitative approach is provided in Table 3.1, as adapted from Leedy and Ormrod (2015:99).

**Table 3.1 Characteristics of a quantitative approach**

| <b>QUESTION</b>                                     | <b>QUANTITATIVE</b>   | <b>APPLICATION TO STUDY</b>   |
|---|---|---|
| What is the purpose of the research?                | Quantitative researchers tend to seek explanations and predictions that can be generalised to other persons and places.   | The purpose of the study was to make an assessment of the current status of CPD in the selected hospital and these findings were generalised to the nurse population at the selected hospital.  |
| What is the nature of the research process?         | Controlled and systematic. Quantitative researchers choose methods that allow them to objectively measure the variables, they remain detached from the phenomena and respondents in order to minimise the chance of collecting biased data. | The researcher maintained control by selecting nurses according to the inclusion criteria as discussed in section 3.3.1. The study was systematic as the researcher progressed logically through a series of steps according to a specified plan. The researcher maintained objectivity by using a self-administered questionnaire and the same information was given to all. |
| What are the data like and how are they collected?  | Quantitative research uses numerical data, samples are usually large to ensure representativeness and standardised instruments are used.  | The researcher collected numerical information by means of a structured questionnaire where the respondents were asked the same questions, in the same order and with the same set of options. The sample size corresponded to a precision of 3.1% which was more than adequate for the study.  |
| How are the data analysed to determine its meaning? | Statistical procedures are used to analyse data. Emphasis on objectivity in data analysis.  | Data analysis was carried out using SAS Version 9.4 for Windows.  |
| How are the findings communicated?                  | Data are reduced to summarising statistics and results are typically presented in a report that uses a formal, scientific style with impersonal language.   | Descriptive analysis of the data was summarised by frequency and percentage tabulation and illustrated by means of bar charts.  |

(Adapted Leedy & Ormrod 2015:99)

Parahoo (2014:165) classifies quantitative research onto the following types: descriptive studies, correlational studies and causal studies.

### **3.2.1.2 Descriptive design**

Leedy and Ormrod (2015:154) state that descriptive research involves examining a situation as it is without changing the situation under investigation. The authors state that descriptive research is not intended to define cause and effect relationships. Gray et al (2017:28) state that descriptive research provides for the following:

- Discover new meaning
- Describe what exists
- Describe the frequency with which something occurs
- Categorise information

Gray et al (2017:28) state that descriptive research is usually conducted when little is known about the subject. Studies by Brekelmans et al (2013:321), Burrow et al (2016:144) and Govranos and Newton (2014:659) reveal that CPD for nurses requires further study. Descriptive research is appropriate for this study as the focus is on describing the context in which CPD in the selected hospital takes place, with the purpose of gaining a new understanding.

### **3.2.1.3 Non-experimental design**

In a non-experimental design, no manipulation of variables takes place and it does not include an experiment or control group (De Vos et al 2011:156). Grove et al (2015:212) state that the focus of non-experimental designs is on examining variables as they naturally occur in environments and not on the implementation of a treatment by the researcher. Ó Dwyer and Bernauer (2014:56) add that when engaging in non-experimental research, researchers aim to avoid influencing the context in which the research is being conducted. This study employed a non-experimental design.

### **3.2.1.4 Cross sectional design**

Bryman and Bell (2015:62) state that a cross sectional design entails the collection of data on more than one case and at a single point in time in order to collect a body of quantitative or qualitative data. The researcher utilised a single data collection period which was from 01 May 2017 to 12 May 2017 to collect the data.

### 3.2.2 Research methods

Gray et al (2017:38) distinguish between design and methods in that a research design refers to the researcher's way of answering a research question with respect to several considerations including the number of subject groups, timing of data collection and researcher intervention, while research methods refer to specific ways in which the researcher chooses to conduct the study within the chosen design. According to the authors these ways include population and sample selection, the choice of setting, the manner in which the research intervention is strategised, the ways in which data is collected, the choice of the statistical tests used and quality control measures.

#### 3.2.2.1 Population

Grove et al (2015:250) differentiate between the concepts of population, target population and accessible population as outlined in Table 3.2.

**Table 3.2 Definitions of population and related concepts**

| CONCEPT               | DEFINITION  | APPLICATION TO STUDY   |
|-----------------------|---|--|
| Population            | Refers to a group of individuals, elements who are the focus of the study.                  | All nursing personnel who were employed at the selected hospital.                          |
| Target population     | Refers to the entire set of individuals who meet the sampling criteria.                     | All nursing personnel who were scheduled to be on duty during the month of May 2017.       |
| Accessible population | Refers to a portion of the target population to which the researcher has reasonable access. | All nursing personnel who were present on the days that the researcher collected the data. |

(Grove et al 2015:250)

Once the population is identified, researchers must stipulate criteria that define who is in the population. The criteria that specify population characteristics are the eligibility criteria or inclusion criteria (Polit & Beck 2012:274).

The inclusion criteria used in the study were:

- Nurses who were employed on a full-time basis at the selected hospital.
- Nurses who were scheduled to be on duty during the data collection period, namely 1-12 May 2017.
- Both male and female nursing personnel.

The exclusion criteria used in the study were:

- All nurses who were not available during the data collection period, namely 1–12 May 2017 such as those on vacation, sick and study leave.
- Any nurse who was not employed on a full-time basis by the hospital.

### **3.2.2.2 Sample**

A sample is a subset of the population that is selected for a particular study (Gray et al 2017:53). The purpose of a sample, as stated by Brynard et al (2014:56) is used to simplify the research, to save time, to reduce costs and to determine specific properties of the whole.

According to Polit and Beck (2012:275), two key considerations in assessing a sample in a quantitative study are its representativeness and size. Wang and Park (2016:107) identify a representative sample as one whose key characteristics match those of the population and can be achieved by reducing systemic selection biases in the sampling process. The authors advocate that a selection method which relies on random chance is considered as having no systemic selection biases. Although Polit and Beck (2012:275) acknowledge that certain sampling procedures are less likely than others to result in biased samples, a representative sample can never be guaranteed. Parahoo (2014:277) is of the opinion that representativeness is not necessarily guaranteed with random sampling. Rubin and Babbie (2016:376) corroborate this as the authors state that there will always be some degree of sampling error.

Salkind (2014:195) states that a larger sample is needed to represent the population accurately when there is greater variability within groups and when the difference between the groups gets smaller. Increasing variability implies that the data points are more diverse and a larger number of data points will be needed to represent all of them. Similarly, as the difference between the groups gets smaller, a larger sample is needed to reach the critical mass where the groups can differ (Salkind 2014:196). Brynard et al (2014:58) support this viewpoint as the authors' state that heterogeneous populations require a larger sample and larger samples in turn ensure representativeness. Polit and Beck (2012:285) postulate that in nursing studies, there is a fair degree of heterogeneity.

## *Sampling*

Sampling is defined as a technique employed to select a small group of people, events, behaviours or any other elements with which to conduct a study with a view to determining the characteristics of a large group (Brynard et al 2014:56).

A *sampling frame* is a complete list of the sampling elements in the target population and from which a sample is selected (Fowler 2015:14). The sampling frame for the study was obtained from the human resource division and included a list of nursing personnel employed at the hospital on a full-time basis. A second list was obtained from the deputy nurse manager responsible for nurse allocation and this list provided the names of all staff that were scheduled to work during the period 1–12 May 2017. Nurses that were present on both lists were invited to participate in the study.

The method of sample selection may be based on a probability (random) or non-probability (non-random) approach (Grove et al 2015:255). The study utilised a non-probability method of sample selection, namely convenience sampling. According to Roller and Lavrakas (2015:184), convenience sampling is the practice of selecting a study environment or research participants that are simply available to the researcher by virtue of its accessibility. Convenience sampling is criticised as it may yield samples that are not representative of the population (Bryman 2016:187) and it may increase the risk of sampling bias (Cronin et al 2015:95). Despite this, Polit and Beck (2012:276) acknowledge that most studies in nursing rely on non-probability approaches.

## *Sample size*

A sample size of 200 nurses (N=200) was used in this study to ensure representativeness of the population so that more accurate conclusions can be drawn. Based on worst-case (for sample size) estimates of 50%, 5% precision and the 95% confidence level, and a population size of 200, a sample size of 132 would have been required. The actual sample size of 166 (less where there is missing data) corresponds to a precision of 3.1% rather than 5.0%, which is adequate for the purposes of this study.



With the support of a statistician, sample size for prevalence was determined using the formula:

$$n = \frac{m}{1 + \frac{m-1}{N}} \quad \text{Where}$$

$$m = \frac{Z^2 P(1 - P)}{d^2}$$

n = sample size,

N = population size,

Z = Z-statistic for the chosen level of confidence,

P = expected prevalence or proportion

d = precision

### **3.2.2.3 Data collection**

Data collection includes the process of collecting data for the purpose of answering questions or exploring a phenomenon (Parahoo 2014:352). In this study, a self-designed structured questionnaire was used to collect data from the respondents.

#### *The questionnaire as a data collection instrument*

Rubin and Babbie (2016:611) define a questionnaire as a document that contains questions and other types of items that are intended to yield information suitable for analysis. In a structured questionnaire, respondents are asked to respond to the same questions, in the same order and with the same set of response alternatives (Polit & Beck 2012:297).

Table 3.3 outlines the relative merits of using a structured questionnaire in research.

**Table 3.3 Advantages and disadvantages of questionnaires**

| <b>ADVANTAGES</b>                             | <b>DISADVANTAGES</b>   |
|---|--|
| Cheaper and quicker to administer             | Researcher cannot prompt or probe  |
| Absence of interviewer bias                   | The questionnaire can be read as a whole so that none of the questions asked is truly independent of the other |
| No interviewer variability                    | Greater risk of missing data   |
| Convenient                                    | Requires a high literacy level   |
| Useful when sensitive information is required | Use of closed ended questions may not produce in-depth understanding of phenomena                              |

(Bryman 2016:222; Fowler 2015:63)

Gerrish and Lathlean (2015:423) state that a further disadvantage of a questionnaire is that data are almost exclusively retrospectively based and are gathered by asking a respondent to report on a concept by considering the recent past. Such accounts rely on memory which can sometimes be unreliable and yield incorrect data.

#### *Development of the questionnaire*

Lo-Biondo Wood and Haber (2017:248) point out that the success of a study depends on the fidelity of the data collection methods and that the process of selecting an instrument for measurement is of critical importance for the potential success of the study.

Brink et al (2012:147) grant that without high quality data collection techniques, the accuracy of research conclusions can easily be challenged. It is therefore imperative that researchers are familiar with the development of quality data collection instruments. Hair, Celsi, Money, Samouel and Page (2015:270) list the following criteria for the development of a questionnaire:

- Careful planning and a logical approach are necessary to ensure collected data is precise.
- Clear definition of concepts and how they might be communicated and measured are prerequisites for a good questionnaire.
- Deliberation must be given to readability, presentation, structure and length as this may affect response rates.
- Care must be taken in the type of questions used and their wording.

In this study, the researcher developed the questionnaire based on an extensive literature review of CPD (see Chapter 2) and on the theoretical framework of the EFQM model (see Chapter 1). Support, guidance and feedback were obtained from the study supervisor and the statistician, both of whom possess expertise in instrument construction.

### *Structure of the questionnaire*

Hair et al (2015:233) suggest that the outcome of a well-constructed questionnaire is reliable and valid data. In this study, the researcher developed a structured questionnaire based on an extensive literature review and support from experts in the research field. The questionnaire included closed ended questions, Likert agreement scales and Likert importance scales which offered response options from which the respondents had to choose. The items included in the questionnaire were based on the concepts of the theoretical model used and were carefully chosen to address the specific research objectives.

The questionnaire consisted of seven sections:

- Section A: Demographic information (7 items)
- Section B: Leadership role in CPD (6 items)
- Section C: Policy and strategy of CPD (9 items)
- Section D: People development and CPD (5 items)
- Section E: Resources for CPD (10 items)
- Section F: Process of CPD (11 items)
- Section G: Results of CPD (10 items)

### *Pre-testing of the questionnaire*

Rubin and Babbie (2016:610) convey that a pre-test involves testing a data collection instrument to see if the target population will understand it, as well as to identify any needed modifications.

According to Hair et al (2015:268), pre-tests are needed when:

- The research topic is new.
- The instrument will be used with a different group of respondents.
- The questionnaire is long.
- The mode of administration has changed.

The researcher conducted a pre-test study with twelve nursing personnel that were purposively chosen so that each nursing category was represented, namely registered nurse, enrolled nurse and enrolled nurse auxiliary. These respondents did not participate in the final study. The data collected during the pre-test was carefully analysed to determine if there were any flaws in the questionnaire such as ambiguous questions or wordings and to test the practical aspects of the study such as a time limit for questionnaire completion. Amendments were made to the questionnaire based on the feedback from the pre-test study.

#### *Administration of the questionnaire*

The researcher utilised a self-administered questionnaire in a group administered approach for data collection. Donley (2012:28) concedes that this method works best in an institutional setting.

Table 3.4 outlines the relative merits of the group administered approach.

**Table 3.4 Advantages and disadvantages of a group administered approach**

| <b>ADVANTAGES</b>   | <b>DISADVANTAGES</b>  |
|---|---|
| A large sample can be obtained in a short amount of time as potential participants are in a central location and time spent on recruiting participants is lessened.                       | Proximity to each other can prevent respondents from answering sensitive questions honestly.                        |
| Because the researcher is typically in the room while questions are being filled out, respondents can ask questions about unclear questions which could thus lead to higher data quality. | Not suitable for questionnaires that require a lot of time as respondents may have to get back to work commitments. |
| Due to the researcher being in the room, participation rates are usually high.  | Having the researcher present may pose problems as participants may feel pressured to participate.                  |
| The method is convenient and relatively inexpensive.  |   |

(Donley 2012:28)

Fowler (2015:66) supports the viewpoint that the most positive aspect of the group administration method is the high response rate thus ensuring large samples. This motivated the researcher to utilise this method as studies from large samples have more representativeness. This is supported by Grove et al (2015:252).

Two hundred questionnaires were passed out to nurses at the selected hospital who met the inclusion criteria as stipulated in section 3.2.2.1 of this chapter. Respondents filled out the questionnaire (see Appendix F) in a classroom setting. Each respondent received a pen, a questionnaire, a consent letter and an information letter outlining the aim of the study. The aim and objectives of the study as well as the rights of the respondents were explained orally as well as in written form at the commencement of each session (see Annexure E). The respondents were granted anonymity and confidentiality and were told that the session would take more or less half an hour. Respondents were asked to read the information letter and complete the informed consent before commencing the questionnaire. Respondents were also advised that they had a choice not to participate in the research and would not be prejudiced against if they so wished. Two clearly marked boxes labelled “Consent forms” and “Questionnaires” were provided and respondents were advised to place completed questionnaires and consent forms in these boxes on completion. The researcher conducted multiple sessions of data collection during the week. A similar strategy was used to collect data from staff on night duty except that only one session per night was conducted as the researcher did not want to remove nurses for long periods from the clinical setting because of minimal staff being scheduled on night duty. Data was collected for a period of 12 days from the 1-12 May 2017.

#### **3.2.2.4 Data analysis**

Rubin and Babbie (2016:505) state that quantitative data analysis refers to the techniques by which researchers convert data to numerical form and subject it to statistical analysis. Wood and Ross-Kerr (2011:249) state although descriptive analysis includes a wide range of choices for planning the analysis of data from simple to complex, all descriptive methods contain one aspect in common which is summarisation of the data.

The first step in the process of data analysis is coding. Coding is the way in which information is quantified (Donley 2012:33) or in a simpler sense, coding is to change the respondent's answers into numbers so that it can be analysed by a statistical programme (Wang & Park 2016:174).

The coding, checking and organising of the data was performed by the researcher. A statistician assisted in providing a descriptive analysis of the questionnaire responses. A total of 166 completed questionnaires were analysed representing a response rate of  $166/200 = 83\%$ . Rubin and Babbie (2016:385) acknowledge that a response rate of more than 80% is very good and that the overall response rate is one indication to the representativeness of the sample respondents. The authors recommend that if a high response rate is achieved, then there is less chance of significant non-response bias than if a low rate is achieved.

Descriptive analysis of the data was carried out with the support of a statistician. Likert agreement scale item responses were categorised as agree/neutral/disagree. Likert importance scale item responses were categorised as very important/ somewhat or not important/ not sure. For question 36 and 44, any number of reasons from one to three was accepted. Responses listing more than three reasons were excluded from the study.

The association between nurse rank (enrolled / registered) and whether or not any courses in Q41 had been attended or not was determined by Fisher's exact test. Questionnaire responses (all categorical) were summarised by frequency and percentage tabulation and illustrated by means of bar charts. Data analysis was carried out using the SAS Version 9.4 for Windows.

### ***3.2.2.5 Validity and reliability***

Salkind (2014:178) states that the measurement process is an incredibly important aspect of a research study as using measurement tools without the appropriate levels of validity and reliability will render the study futile.

Gerrish and Lathlean (2015:416) report that the validity of a questionnaire refers to whether the questionnaire measures what it is supposed to measure and if it measures it accurately. The authors state that there are different types of validity.

Two aspects of validity were used in this study as indicated in Table 3.5 below.

**Table 3.5 Types of validity applied to study**

| TYPE OF VALIDITY | DEFINITION   | APPLICATION TO STUDY   |
|------------------|--|--|
| Face validity    | Is the subjective assessment that the items in a scale appear to be clear, relevant and unambiguous? | <ul style="list-style-type: none"> <li>▪ The questionnaire was subjected to a pre-test to examine the presentation, wording, order and layout to ensure feasibility and readability.</li> </ul>  |
| Content validity | Refers to whether the questionnaire items fully represent the concept to be measured.                | <ul style="list-style-type: none"> <li>▪ To achieve content validity the researcher conducted an extensive literature review on CPD, including previous questionnaires used in CPD research.</li> <li>▪ The questionnaire was reviewed by research experts to evaluate the content validity of the instrument.</li> <li>▪ The questionnaire included a variety of questions intended to assess the current state of CPD in the selected hospital.</li> </ul> |

(Gerrish & Lathlean 2015:416)

Reliability refers to the consistency, stability and repeatability of a data collection instrument (Wood & Ross-Kerr 2011:209). Bryman and Bell (2015:49) agree that reliability is concerned with the question of whether the results of the study are repeatable. Tappen (2015:140) adds that reliability is related to the question of consistency and is of high concern especially when a new measure is being developed. Reliability relates to the precision and accuracy of the instrument. In the study the researcher engaged in careful phrasing of each question to prevent ambiguity. Further, a pretest was conducted to ensure reliability of the items and this was achieved by noting that each item consistently conveyed the same meaning every time it was read by respondents. Any inconsistencies and misinterpretation of items was duly corrected. The data collection instrument and instructions were standardised which ensured further reliability.

Polit and Beck (2012:335) identify two factors that affect the reliability of a measurement instrument, namely, the length of the instrument and the heterogeneity of the sample. The authors state that reliability is enhanced by a longer questionnaire (items related to similar concepts) and by having a more heterogeneous sample. The researcher addressed the factor of length by adding multiple items relating to the same concept (see section 3.2.2.3 in this chapter). The sample was fairly heterogeneous, as it included nurses of various age groups, genders, specialities, educational and professional backgrounds.

### **3.3 ETHICAL CONSIDERATIONS**

This section includes a brief discussion on the three fundamental ethical principles and how ethical issues were addressed in the various phases of the study (see Table 3.6). According to Wang and Park (2016:97), ethics are about the principles of doing right or wrong. Tappen (2015:193) equates research ethics to the standards of conduct that distinguish between acceptable and unacceptable behaviour in research.

Salkind (2014:149) states that ethical principles guide researchers in the treatment of the respondents so that their dignity is maintained despite the research outcomes. According to Brink et al (2012:32) a researcher is responsible for conducting research in an ethical manner and failure to do so undermines the scientific research process and may have negative consequences.

Hedges and Williams (2014:225) state that researchers must meet two important obligations when conducting research:

- The first obligation is to the integrity of knowledge, with the aim of achieving high quality science that will add to the body of existing knowledge and benefit society.
- The second obligation is to treat research respondents with dignity, respect and confidentiality, while assuring that they are safe, fully informed, and are participating voluntarily.



There are three fundamental principles that guide researchers during the research process, namely, respect for persons, beneficence and justice (Polit & Beck 2012:151). Brink et al (2012:34) suggest that these principles are based on the human rights that need to be protected in research namely, the right to self-determination, privacy, anonymity, confidentiality, fair treatment and to being protected from harm.

### **3.3.1 Respect for persons**

Respect for persons integrates two basic ethical convictions: first, that the individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection (Polit & Beck 2012:151). Butts and Rich (2012:34) define autonomy as the freedom and ability of an individual to act in a self-determined manner. The authors stipulate that the autonomy of the individual should be respected in such matters as obtaining consent, allowing refusal of intervention, disclosing information, privacy and confidentiality. Pera and Van Tonder (2011:332) add that the autonomy of an institution should also be respected. In this study, the researcher complied by providing information to the selected institution which included the data collection tool, sampling process, researcher's qualification and relevant ethical clearance by professional bodies. The autonomy of individuals was respected by ensuring that the respondents voluntarily participated in the study. Respondents were given an informed consent form and an information letter that indicated the purpose of the study, benefits, voluntary participation and the right to withdraw.

### **3.3.2 Beneficence**

Butts and Rich (2012:34) define beneficence as the idea of doing good and benefitting individuals. In the Belmont Report (Polit & Beck 2012:152), beneficence is understood in a stronger sense, as an obligation: the obligation not to do harm, to maximise possible benefits and minimise possible harm. Leedy and Ormond (2015:120) state that researchers should not expose respondents to harm and that the risk involved in participating in a study should not be appreciably greater than the normal risks of day to day living. This study was non-experimental, so the risk of harm was minimal and the respondents were assured that the information provided will not be used against them.

### 3.3.3 Justice

Parahoo (2014:103) articulates that the principle of justice includes a respondent's right to fair treatment, deterrence from deception and their right to privacy. Babbie (2015:85) states that to comply with this principle, participation must be voluntary, respondents must be informed of all consequences and anonymity and confidentiality should be maintained. Babbie (2015:65) distinguishes between anonymity and confidentiality in that anonymity is when the researcher cannot identify a given response with a given respondent, while confidentiality is when a researcher can identify a given person's response but promises not to do so publicly. In this study, the researcher ensured fairness by selecting respondents according to predetermined inclusion criteria. Anonymity was maintained by the use of questionnaires that did not require any identifying details. The researcher maintained confidentiality by neither disclosing the names of respondents or the institution in any written reports.

Brink et al (2012:32) and Creswell (2014:132) concur that a researcher is responsible for conducting research in an ethical manner from the conceptualisation and planning phases, through the implementation phase, to the dissemination phase.

Table 3.6 provides an overview of how the researcher addressed the ethical issues in the different phases of the study.

**Table 3.6 Ethical issues addressed in this study**

| <b>PHASE OF RESEARCH</b>      | <b>TYPE OF ETHICAL ISSUE</b>  | <b>HOW THE ISSUE WAS ADDRESSED IN THE STUDY</b>  |
|-------------------------------|---|--|
| Prior to conducting the study | <ul style="list-style-type: none"> <li>▪ Examine professional association standards</li> <li>▪ Seek approval from the educational institution and employing body</li> </ul> | <p>The researcher was guided by:</p> <ul style="list-style-type: none"> <li>▪ The SANC Code of Ethics for Nurse Practitioners in South Africa (SANC 2013:online).</li> <li>▪ University of South Africa Policy on research ethics (Unisa 2013).</li> </ul> <p>Prior to the study the researcher obtained permission from:</p> <ul style="list-style-type: none"> <li>▪ University of South Africa Research ethics committee: Department of Health Studies REC-012714-039 (NHERC) Ethics approval no HSHDC/645/2017 (Annexure A)</li> </ul> |

| PHASE OF RESEARCH              | TYPE OF ETHICAL ISSUE   | HOW THE ISSUE WAS ADDRESSED IN THE STUDY   |
|--------------------------------|---|--|
|                                |   | <ul style="list-style-type: none"> <li>▪ The KZN Provincial research and ethics committee ref KZ_2017RP52_799 (Annexure C)</li> <li>▪ The Chief Executive Officer of the selected site ref: GJC/HM9/2/3 (Annexure B)</li> </ul>  |
| Beginning the study            | <ul style="list-style-type: none"> <li>▪ Identify a research problem that will benefit the respondents</li> <br/> <li>▪ Provide information to relevant stakeholders</li> </ul> | <ul style="list-style-type: none"> <li>▪ In the staff satisfaction surveys of the selected hospital, nursing personnel reported low satisfaction levels regarding the current CPD system in place.</li> <li>▪ The researcher is a nurse educator at the selected hospital and CPD is a topic of interest to the researcher.</li> <li>▪ Letters were distributed to all nurse managers in the selected hospital informing them of the general purpose of the study and the plan for data collection.</li> </ul>   |
| Data collection phase          | <ul style="list-style-type: none"> <li>▪ Protection of human rights</li> </ul>  | <p>The researcher used the following procedures and mechanisms to ensure protection of human rights during this phase:</p> <ul style="list-style-type: none"> <li>▪ In order to obtain consent, the researcher provided comprehensive written information regarding participation in the study.</li> <li>▪ The researcher ensured that the respondents were not unduly influenced to participate, by providing an informed consent.</li> <li>▪ Anonymity was maintained by ensuring that questionnaires were returned without any identifying details and were stored in a safe place only accessible to the researcher.</li> </ul> <p>The study employed a non-experimental design which ensured a low risk-benefit ratio to respondents.</p> |
| Data analysis phase            | <ul style="list-style-type: none"> <li>▪ Selective retainment and/or manipulation of data</li> <li>▪ Fabrication, falsification or forgery</li> </ul>                           | <ul style="list-style-type: none"> <li>▪ The researcher included all data obtained from the study.</li> <li>▪ The researcher reported on the study as it had taken place.</li> </ul>   |
| Dissemination of results phase | <ul style="list-style-type: none"> <li>▪ Provide feedback to respondents regarding results of study</li> <li>▪ Scientific honesty</li> </ul>                                    | <p>The researcher provided feedback in the means of a report to the following:</p> <ul style="list-style-type: none"> <li>▪ The KZN provincial and research ethics committee</li> <li>▪ The management team and nursing personnel of the selected hospital</li> <li>▪ The researcher maintained</li> </ul>   |

| PHASE OF RESEARCH | TYPE OF ETHICAL ISSUE | HOW THE ISSUE WAS ADDRESSED IN THE STUDY   |
|-------------------|-----------------------|--|
|                   |                       | scientific integrity by utilising the Harvard referencing system for all sources consulted and by following the principles of scientific writing provided in MNUALL 301/0//2017. |

(Adapted from Creswell 2014:132)

### 3.4 CONCLUSION

This chapter reflected on the research methodology used in the study. It included an introduction, the design and the methods including population, sample, data collection and analysis and aspects of validity and reliability. The chapter concludes with a discussion on the ethical considerations that guided the study as well as the limitations of the study. The next chapter includes a discussion of the interpretation of the study findings.

## CHAPTER 4

### DATA ANALYSIS AND INTERPRETATION

*“Research is to see what everybody else has seen and to think what nobody else has thought.”*

Albert Szent-Gyorgyi

#### 4.1 INTRODUCTION

The previous chapter described the research methodology used in the study. In this chapter, data analysis and the interpretation of data will be discussed. The researcher has provided other relevant research results to support the study findings wherever possible.

#### 4.2 DATA COLLECTION

The data was collected by means of a structured questionnaire consisting of seven sections as related to the theoretical model used in the study. The sections were:

- Section A: Demographic information (7 items)
- Section B: Leadership role in CPD (6 items)
- Section C: Policy and strategy of CPD (9 items)
- Section D: People development and CPD (5 items)
- Section E: Resources for CPD (10 items)
- Section F: Process of CPD (11 items)
- Section G: Results of CPD (10 items)

#### 4.3 DATA ANALYSIS

Descriptive analysis of the data was carried out with the support of a statistician. The questionnaire responses (all categorical) were summarised by frequency and percentage tabulation, and illustrated by means of bar charts. Data analysis was carried out using SAS Version 9.4 programme.

### 4.3.1 Section A: Demographic data

The demographic information of the respondents was recorded, i.e. gender, age, designation, educational qualification, nursing experience, years of employment at the study hospital and current nursing department. Data collected on demographic variables were analysed to identify whether the sample characteristics were representative of the characteristics of the nurse population at the hospital.

#### 4.3.1.1 Gender

Due to the predominantly female population from which the sample was recruited, it was not surprising that 147 of the 166 respondents were female (88.6%) and only 19 (11.4%) were male. This is consistent with the SANC statistics (SANC 2017:online) which indicates that the South African nurse population comprises of 90.6% females and 9.4% males. MacWilliams, Schmidt and Bleich (2013:38) acknowledge that while women have made strides in male dominated professions, males still represent fewer than 10% of the registered nurse population. In a descriptive study by Roos, Fichardt, MacKenzie and Raubenheimer (2016:3) which examined the attrition rates of nursing students at selected South African universities, it was found that attrition rates among male students were twice as high as that among female students. Shakwane (2014:84) in a study on the socio-cultural perceptions of nursing and its influence on the recruitment and retention of male student nurses in nursing education institutions in KZN, found that if gender roles, responsibilities and the social status of men and women are not reviewed then nursing will remain a female dominated profession.

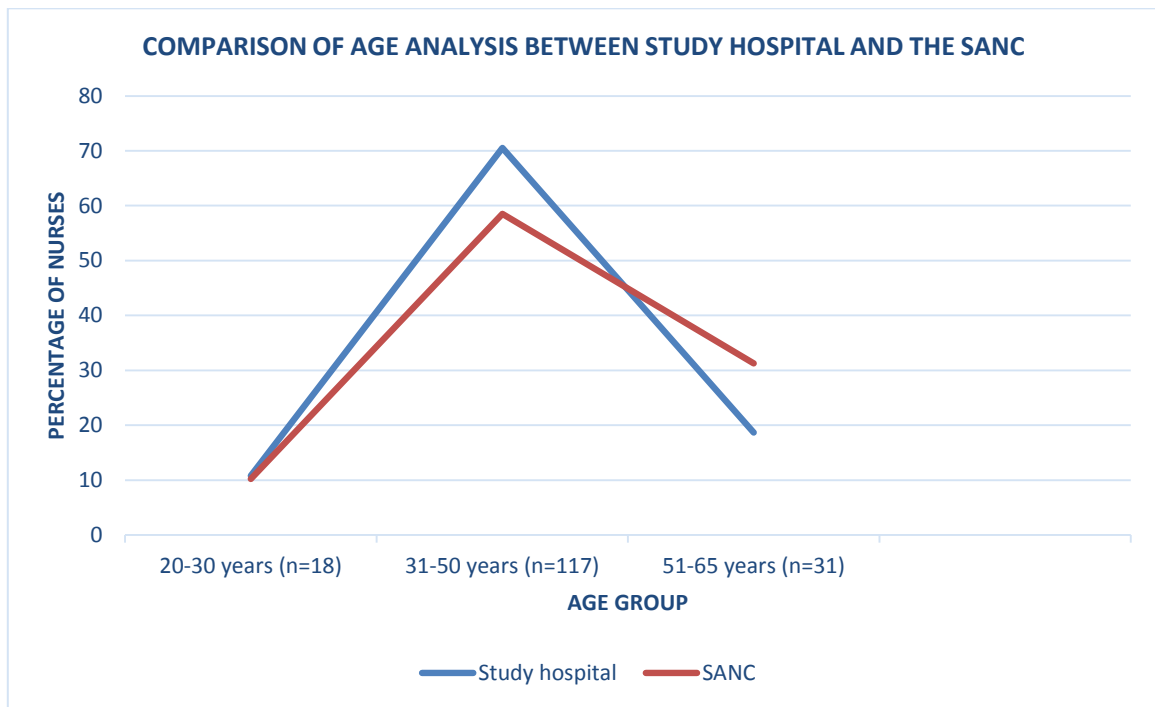
**Table 4.1 Gender distribution (n=166)**

| GENDER | FREQUENCY | PERCENTAGE |
|--------|-----------|------------|
| Female | 147       | 88.6%      |
| Male   | 19        | 11.4%      |

#### 4.3.1.2 Age

Of the respondents, 70.5% (n=117) were aged between 31 and 50 years, followed by 18.7% (n=31) who were in the 51–65 years age group while 10.8% (n=18) were in the 20–30 years age group. These findings are consistent with the South African nursing

statistics as indicated by the SANC (SANC 2017:online) namely that 58.5% of nurses are aged between 30 and 50 years, followed by 31.3% aged between 51 and 65 years and 10.2% aged between 20 and 30 years. Figure 4.1 below shows a diagrammatic representation of the age distribution in the study hospital and the findings of the SANC.

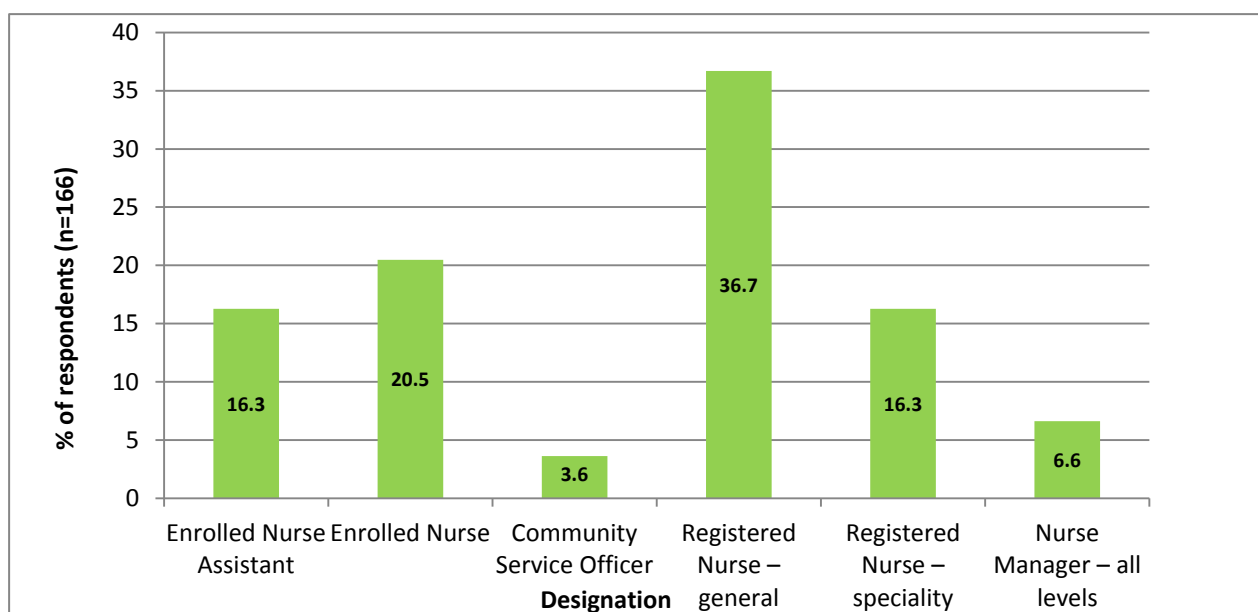


**Figure 4.1 Age distribution in comparison with the SANC statistics (n=166)**

A focus group study of 32 nurses conducted in the Netherlands by Pool, Poell and Cate (2013:34) found that there were significant differences in perception of CPD between younger and older nurses. In an article exploring the dilemma faced by education providers in supporting nurses' CPD in the UK, Ousey and Roberts (2013:78) indicate that age is an important variable in terms of planning CPD programmes as learning styles can be categorised by generations. In this study, the majority of the respondents were aged between 31 and 50 years which is largely indicative of the generation "Xers" (born 1965-1982). According to Ousey and Roberts (2013:78), generation "Xers" tend to learn quickly and want to focus on what will benefit them most.

### 4.3.1.3 Designation

Figure 4.2 depicts the designation of respondents at the hospital (n=166).



**Figure 4.2 Designation of respondents (n=166)**

Of the 166 respondents, 16.3% (n=27) were designated enrolled nurse assistant, 20.5% (n=34) enrolled nurses while 3.6 % (n=6) were community service officers. In addition, 36.7% (n=61) were general registered nurses, 16.3% (n=27) were specialised registered nurses and 6.6% (n=11) were designated nurse managers. Registered nurses in total (i.e. community service officers, general, speciality and nursing managers) made up 63.2% of the respondents while the enrolled categories made up 36.8% of the respondents. Similar findings by Liphosa (2013:104) in a study among 162 nurses in the Gauteng province, RSA, found that registered nurses comprised 69% of the population while 31% were in the enrolled categories.

### 4.3.1.4 Highest educational qualification

Of the 166 respondents, 54.3% (n=90) were in possession of a National Diploma in nursing sciences, followed by 34.3% (n=57) who completed certificate programmes in nursing. Only 10.2% (n=17) of the respondents were in possession of a Baccalaureus Curationis degree while 1.2% (n=2) of respondents had an Honours degree. None of the respondents was in possession of either a Masters or a Doctorate degree.

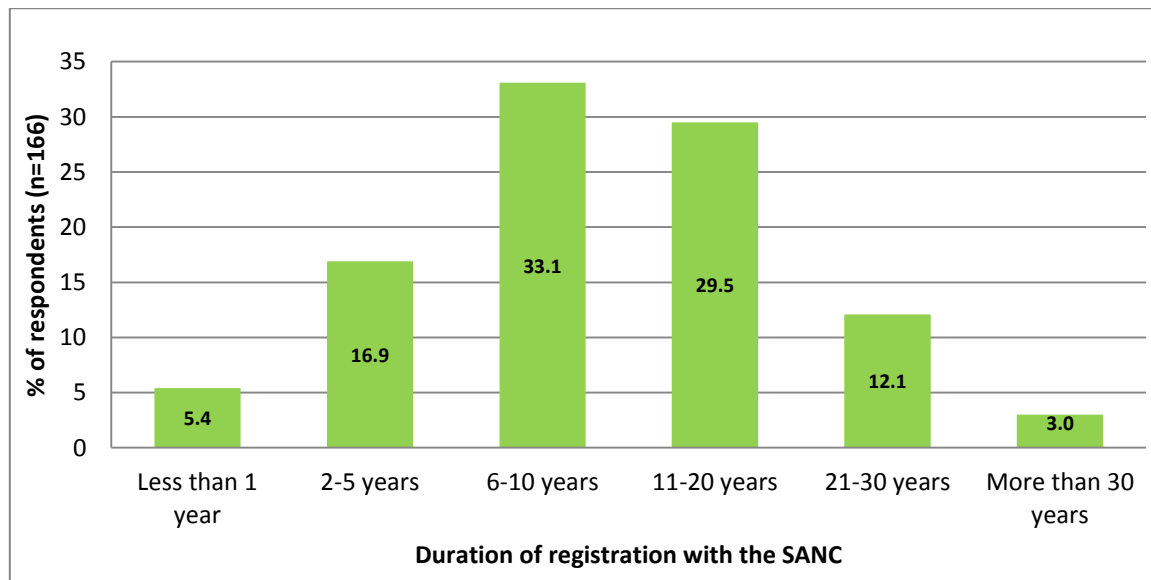


According to the SANC (SANC 2017:online), between 2007-2016 nurse education institutions produced a greater output of nurses with national diplomas, namely 22 572, than nurses with a Baccalaureus Curationis degree totalling 7 241 in the four year comprehensive programme. The Institute of Medicine recommends that 80% of nurses should obtain baccalaureate degrees by the year 2020 (Harris & Burman 2016:85; Hewitt 2016:29). In the Republic of South Africa (RSA), nursing education is in the process of transitioning to higher education as per the National Qualifications Framework Act No 67 of 2008 (RSA 2008:online). The implication thereof would be that all nurses graduating from the four-year comprehensive programme will do so with baccalaureate degrees (SANC 2017:online). Clark, Casey and Morris (2015:328) acknowledge that higher education in nursing has significant value and contributes to improved critical thinking and decision-making skills and improved leadership qualities to challenge poor practice. A retrospective observational study in 300 hospitals across nine European countries conducted by Aiken, Sloane, Bruyneel, Van der Heede and Griffiths (2014:1824), assessed whether differences in nurse staffing and nurse education were associated with a variation in mortality rates. The study, using a sample of 26 516 nurses and the discharge data of 42 2730 patients clearly demonstrated that an increase in the number of graduate nurses in the workplace resulted in a significant reduction in patient mortality.

#### ***4.3.1.5 Nursing experience***

Of the 166 respondents, 5.4% (n=9) had less than 1 year experience, followed by 16.9% (n=28) who had between two and five years' experience and 33.1% (n=55) who had 6–10 years nursing experience. In addition, 29.5% (n=49) indicated between 11 and 20 years' experience, followed by 12.1% (n=20) who had 21–30 years' experience and 3% (n=5) who had more than 30 years nursing experience. Overall there were 55.4% (n=92) of respondents who had less than 10 years of nursing experience and 44.6% (n=74) of respondents who had more than 10 years of nursing experience.

Figure 4.3 depicts the nursing experience of the respondents at the hospital (n=166).



**Figure 4.3 Nursing experience (n=166)**

A literature review by Pool, Poell and Cate (2013:301) consisting of 27 studies which examined the relationship between age and CPD, found that a longer work history may have two opposite effects. Firstly, that a long tenure of work experience may lead to an increased level of competence or secondly, a long work tenure may lead to deterioration of knowledge as obsolescence is associated with increase in age, leading to a higher need for CPD.

To determine the relationship between the levels of nurse competence and length of nursing experience, a study by Takase (2013:1400) among 599 nurses in Japan, found that competence is characterised by two distinctive phases: a rapid growth period which is during the first 10 years of clinical experience followed by a stable period which is after 10 years of clinical experience. According to Takase (2013:1407), the development of nurse competence can be significant during the first 10 years and how much they can improve their competence by the end of this growth period may determine the level of competence in the next 20 years of experience. This finding is supported by Numminen, Meretoja, Isoaho and Leino-Kilpi (2013:1420) in a comparative study on the professional competence among 2 083 practicing nurses in Finland, which found that surgical nurses' competence development remained unchanged after about 10 years of work experience. The implication for nurse leaders and educators then is ensuring that time specific educational investments are made to improve nurse competence.

#### 4.3.1.6 Years of employment at study hospital

Of the 166 respondents, 9.6% (n=16) indicated that they had worked at the hospital for less than a year, 34.3% (n=57) indicated between two and five years' service while 28.4% (n=47) indicated between six and 10 years' service at the hospital. In addition, 21.1% (n=35) indicated service of between 11 and 20 years, followed by 5.4% (n=9) indicating service of 21–30 years and 1.2% (n=2) with more than 30 years employment record at the hospital. Overall, more than half of the respondents, namely 56% (n=93) had worked at the study hospital for six years or more. Khunou and Davhana-Maselesele (2016:7) state that employees who remain employed for more than five years is an indication of a relatively stable workforce. Tshitangano (2013:8) found that nurse turnover is attributed to dissatisfaction regarding staffing, salary and resources.

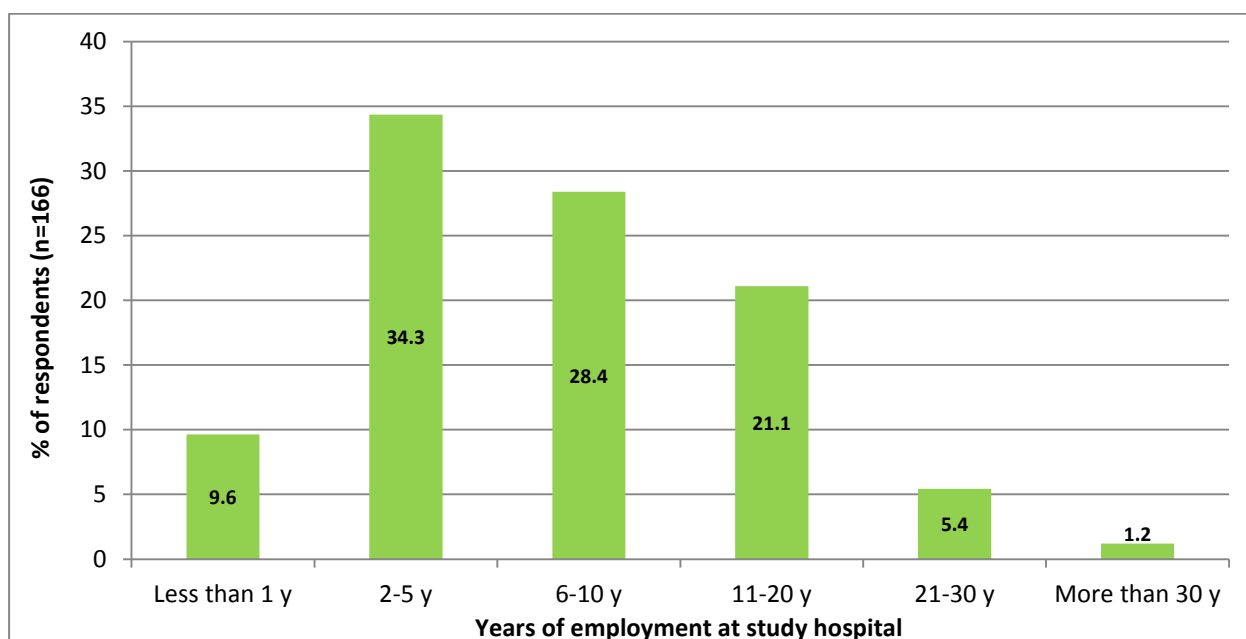
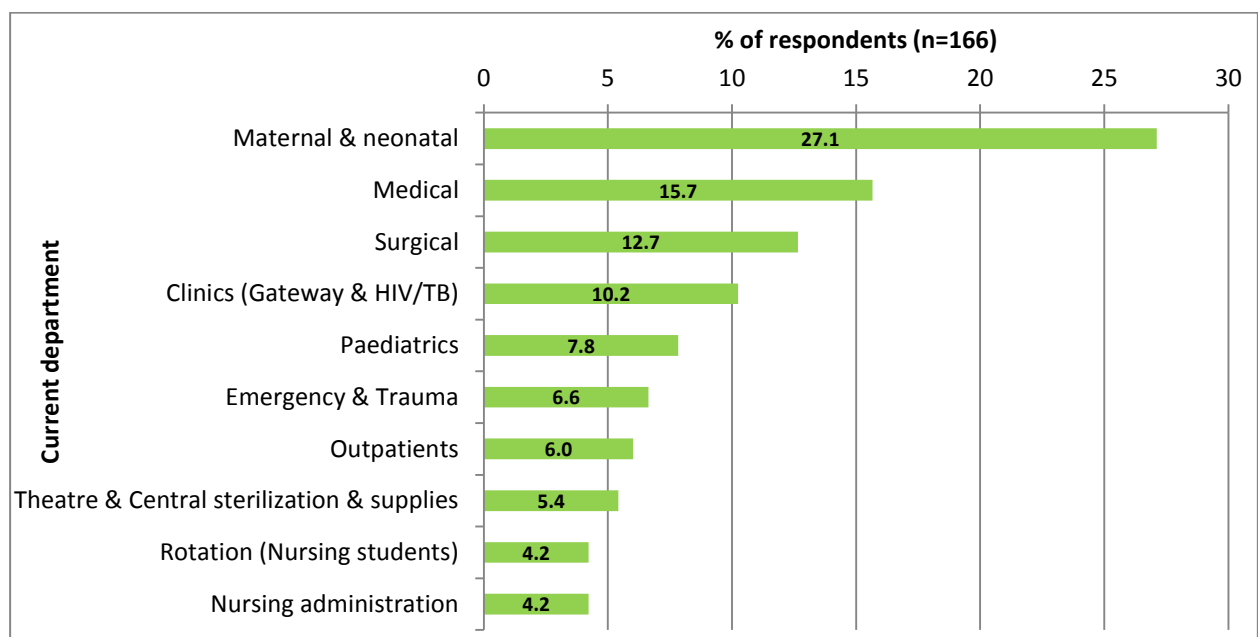


Figure 4.4 Years of employment at hospital (n=166)

#### 4.3.1.7 Nursing department

The respondents were primarily working in the maternal and neonatal department, namely, 27.1% (n=45); 15.7% (n=26) in the medical department; and 12.7% (n=21) in the surgical departments. Respondents also indicated placement in the following departments: 10.3% (n=17) in clinics, 7.8% (n=13) in paediatrics, 6.6% (n=11) in emergency and trauma, 6.0% (n=10) in outpatients, 5.4% (n=9) in theatre and the central sterilisation and supply department, 4.2% (n=7) on rotational basis and 4.2%

(n=7) in nursing administration. In a descriptive study on CPD among 600 nurses in a public hospital in Saudi Arabia, Aboshaiqah, Qasim, Abualwafa and Al-Bashaireh (2012:25) found similar findings in which 26% (n=156) of nursing staff were allocated to the maternal and child department and 11% (n=66) in the medical/surgical departments. In a study by Ly, Kouanda and Ridde (2014:4) which examined the staffing needs in maternity wards in West Africa, it was found that midwives were the best represented category within three facilities in Burkina Faso, a West African country. Globally there is an increased emphasis on matters relating to midwifery since maternal and neonatal health were made the focus of two of the Millennium Development Goals (World Health Organization 2013:804).



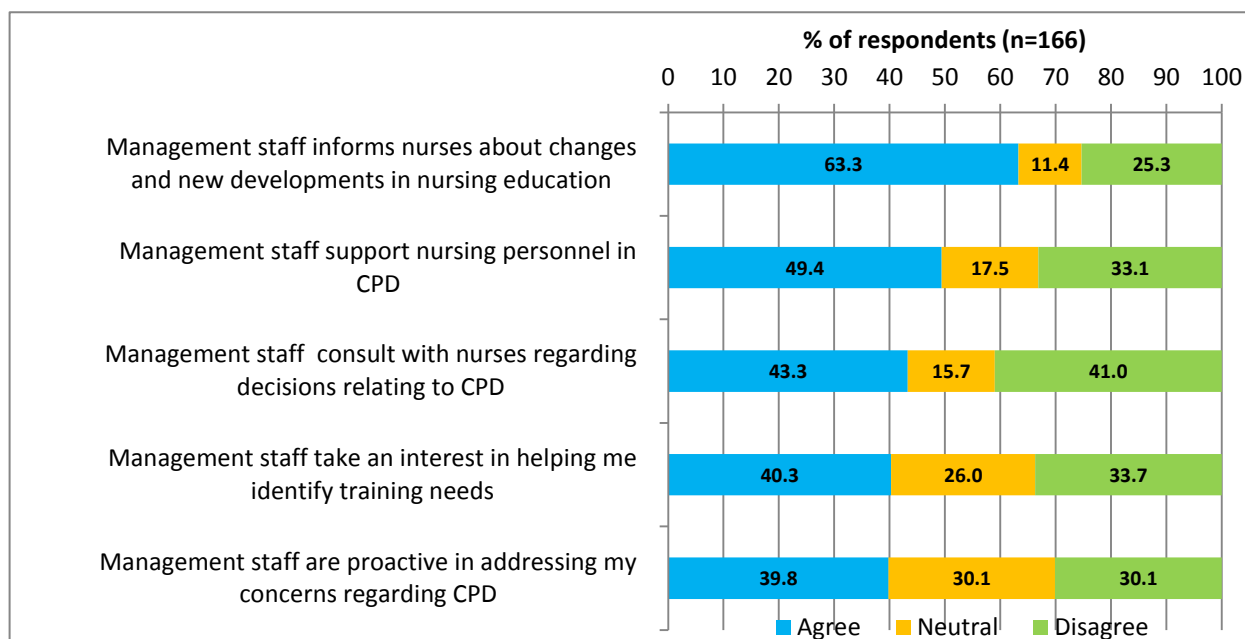
**Figure 4.5 Nursing department allocation (n=166)**

### 4.3.2 Section B: Leadership role in CPD

This section discusses the role of nursing management in terms of attitude and priorities regarding CPD.

#### 4.3.2.1 *Management's attitudes towards CPD*

Management attitude towards CPD is indicated in Figure 4.6.



**Figure 4.6 Management attitude towards CPD (n=166)**

More than half, namely 63.3% (n=105) of the respondents agreed that management staff informs nurses about changes and new developments in nursing education while 25.3% (n=42) disagreed with the statement. A further 11.4% (n=19) indicated a neutral response.

Approximately half of the respondents, namely 49.4% (n=82) expressed agreement that management staff supports nurses in CPD followed by 33.1% (n=55) who disagreed that management support is available and a further 17.5% (n=29) remained neutral. Overall the study indicates that nurses at the selected hospital experience a moderate level of management support. This finding is not consistent with a qualitative study exploring Iranian nurse's experiences of perceived support conducted by Sodeify et al (2013:191), which found that nurses experienced a lack of support from their workplaces, indifferent managers and low social identity. According to Thomas (2012:59) strong organisational support, such as paid study time, strong leadership and a positive attitude to CPD from both management and peers strengthens the promotion of CPD.

Less than half of the 166 respondents, namely 43.3% (n=72) indicated agreement that management consults with nurses regarding decisions relating to CPD while 41% (n=68) disagreed that consultation is done. A small proportion of respondents, namely 15.7% (n=26) indicated a neutral response.

Of the 166 respondents, 40.3% (n=67) indicated agreement that management staff take an interest in the identification of their training needs, while 33.7% (n=56) disagreed with this statement and a further 26% (n=43) indicated a neutral response.

Of the 166 respondents who responded to whether management staff were proactive in addressing their CPD concerns, 39.8% (n=66) indicated agreement, 30.1% (n=50) indicated disagreement and 30.1% (n=50) indicated a neutral response.

Overall, the highest level of agreement, namely 63.3% (n=105) was that management informs nurses about changes and developments in nursing education. This appears to be the easiest of the items to implement and requires less engagement with staff as cascading of information can be done through various communication channels without management staff getting involved. The least agreement was that management staff take an interest in identifying training needs (40.3%; n=67) and are proactive in addressing CPD concerns (39.8%; n=66). These items require the most personal engagement with staff.

In an integrative review of eleven international studies, Coventry, Maslin-Prothero and Smith (2015:2723) found that due to an increase in organisational priorities, nurse managers have distanced themselves from the clinical setting, leaving little time for them to act as advocates for their staff. This contributes to a demotivated workforce. In a study conducted by Roche et al (2015:57) which examined the role of leadership in nurse retention across eleven hospitals in Australia, it was found that nurses value “human” skills including their manager’s interest in their concerns, motivation, encouragement and interest in their development more highly than other leadership characteristics.

#### **4.3.2.2 Management priorities**

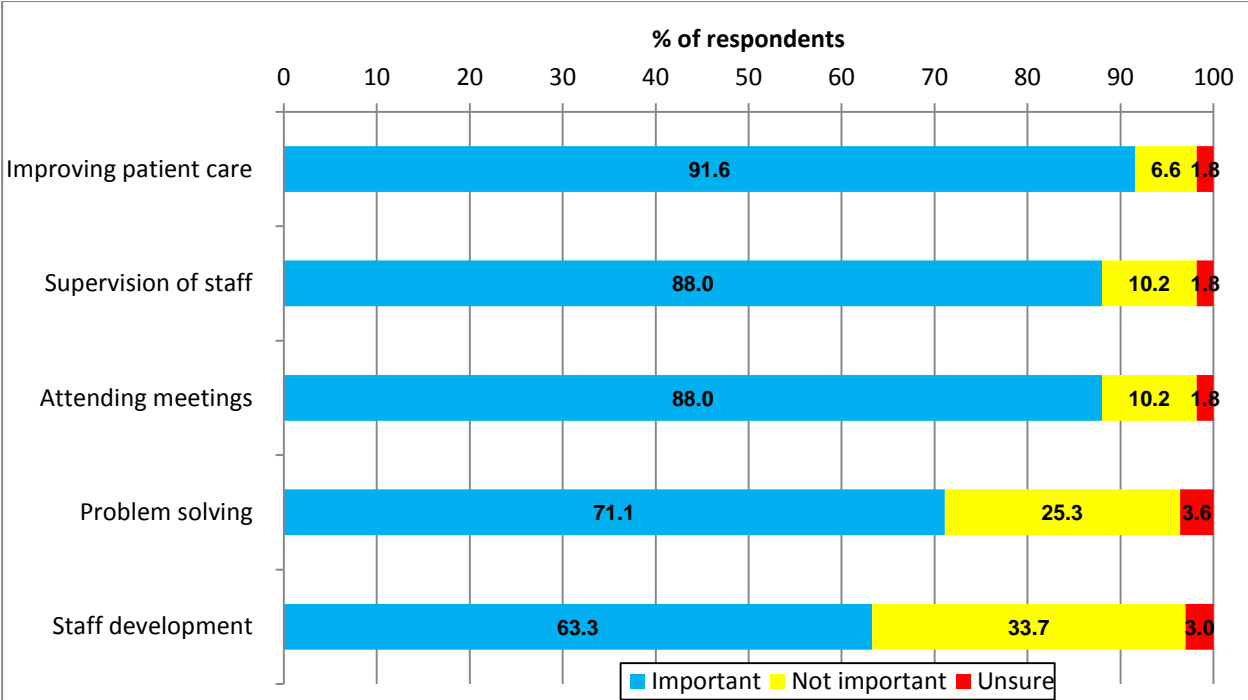
The respondents were asked to rate the importance level of priorities that managers consistently paid attention to.

Of the 166 respondents, 91.6% (n=152) indicated that improving patient care was important to managers while a minimal 6.6% (n=11) indicated that patient care was not important and 1.8% (n=3) indicated uncertainty.

Supervision of staff and attendance of meetings were equally identified as priorities with 88% (n=146) indicating the items as important, 10.2% (n=17) indicating the items as not important and 1.8% (n=3) were unsure.

Just over two-thirds of the respondents, namely 71.1% (n=118), indicated that problem solving was important to managers while 25.3% (n=42) indicated that problem solving was not important and a further 3.6% (n=6) were unsure.

Staff development came last in order of importance with only 63.3% (n=105) of respondents indicating it as important, while 33.7% (n=56) indicated it as not important to managers and 3% (n=5) indicated that they were not sure if staff development was important to managers or not.



**Figure 4.7 Management priorities (n=166)**

These findings are consistent with a study by Brekelmans et al (2016:17) in a study investigating the factors influencing nurse participation in CPD in the Netherlands, which found that scores on professional and personal development were the lowest indicating that CPD was deemed the least important area when compared to clinical practice, policy development and research. Udod, Cummings, Care and Jenkins (2017:36) in their study which explored the role stressors and coping strategies among nurse

managers in Canada, found that managers identified an increasing number and intensity of competing priorities as a significant role stressor.

**4.3.3 Section C: Policy and strategy for CPD**

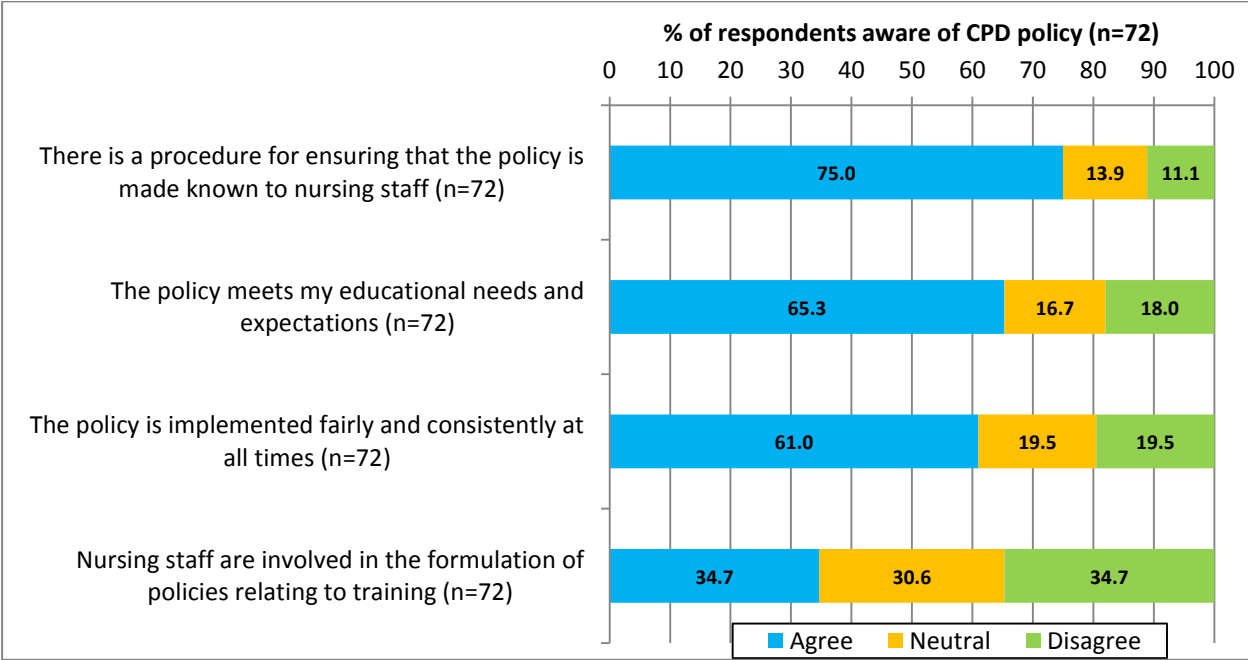
This section discusses the respondents’ awareness and perceptions of the hospital policy on CPD.

**4.3.3.1 Awareness of CPD policy**

Of the 166 respondents, 43.4% (n=72) indicated awareness of the CPD policy, 28.3% (n=47) indicated that they were unaware of the policy and a further 28.3% (n=47) indicated that they were unsure whether the hospital had a policy or not. Cheraghi, Ghiyasvandian and Aarabi (2015:16) acknowledge that while nurses value the development of health-related policies, a very few nurses, especially those in clinical settings, are aware and involved in policy formulation.

**4.3.3.2 Nurses’ perception of CPD policy**

Figure 4.8 indicates the respondents’ perception of the CPD policy currently practised in the hospital.



**Figure 4.8 Nurses’ perceptions of CPD policy (n=72)**



Of the 72 respondents who indicated that they were aware of the CPD policy, 75% (n=54) agreed that there is a procedure for making the CPD policy known to all staff, while 11.1% (n=8) disagreed that there is a procedure for communication of policy and a further 13.9% (n=10) indicated a neutral response. Although there was a high level of agreement that the CPD policy is communicated to all staff, this study found that more than half of the nurses at the hospital (56.6%; n=94) were unaware or unsure of the CPD policy in the hospital as indicated in section 4.3.3.1 of this chapter.

There was a moderate agreement of 65.3% (n=47) that the CPD policy meets the educational needs of nurses, followed by 18% (n=13) who disagreed with the statement and 16.7% (n=12) who remained neutral. This finding is not supported by Viljoen et al (2017:73) in a study exploring critical care nurses' reasons for poor attendance at CPD activities in Gauteng, RSA. The study found that one of the reasons indicated by nurses for poor attendance at CPD activities was that the CPD programme did not address individual needs. In a study conducted by McCafferty, Ball and Cuddigan (2017:268), which examined the continuing education needs of nurses in two rural Midwestern states in the USA, it was found that rural nurses identified emergent situations as their greatest need for learning. The authors further state that the assessment of the continuing education needs of nurses who work in rural settings is highly under-researched.

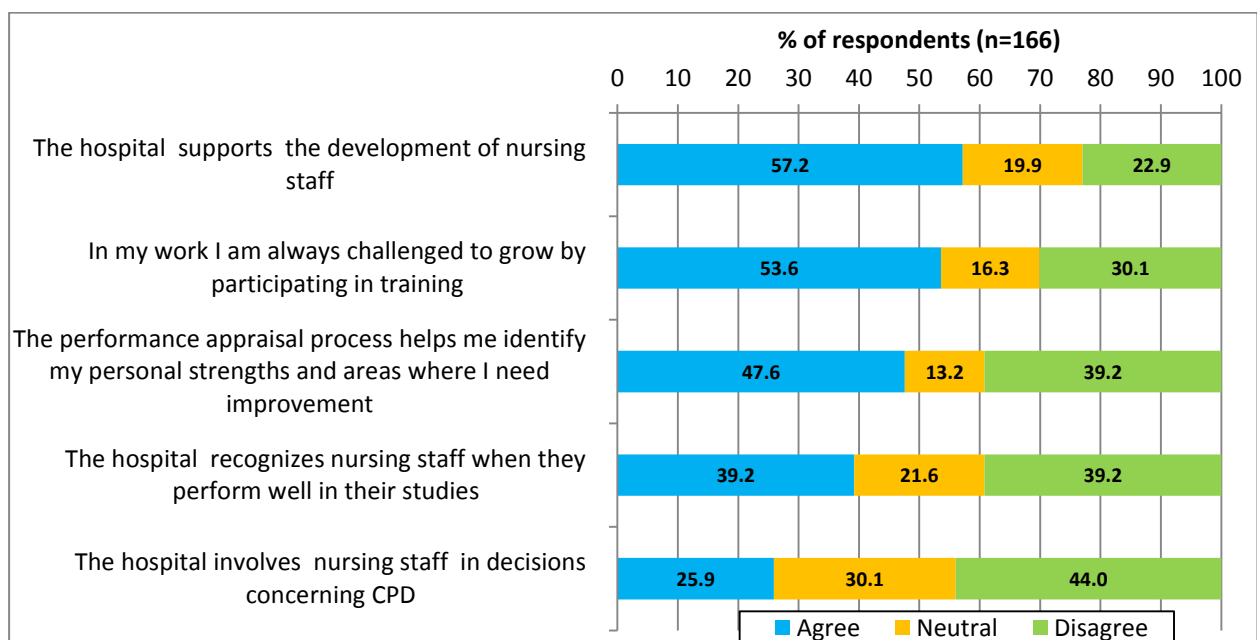
In this study it was found that fair and consistent implementation of the policy received 61% (n=44) agreement, 19.5% (n=14) disagreement while 19.5% (n=14) indicated a neutral response.

Nurse involvement in the formulation of policies received an equal consensus of agreement and disagreement of 34.7% (n=25) per item while 30.6% (n=22) chose a neutral response. It appears that the involvement of nurses in policy formulation is a matter of debate in the hospital. These findings are supported by various studies (Richter, Mill, Muller, Kahwa, Etowa, Dawkins & Hepburn 2013:52; Abu Al Rub & Foudeh 2016:20) which found that nurses' engagement in policy development is low. Juma, Edwards and Spitzer (2014:online) identified the following reasons for poor involvement of nurses in policy development: rigid hierarchical structures in nurse leadership, inadequate knowledge due to policy issues not being incorporated in

nursing curricula, and inadequate advocacy and research skills of nurses to influence policy. Arabi, Rafii, Cheraghi and Ghiyasvandian (2014:315) acknowledge that nurses have the ability to influence policy development, but they must be empowered with the required knowledge, advocacy, power and policy competence.

#### 4.3.4 Section D: People development

Respondents were asked to indicate their view on support they receive from management regarding CPD. Figure 4.9 depicts management support in people development in the hospital.



**Figure 4.9 People development (n=166)**

Of the 166 respondents in this study, 57.2% (n=95) agreed that the hospital supports the development of nursing staff, while 22.9% (n=38) disagreed that support is provided and a further 19.9% (n=33) indicated a neutral response. More than half of the respondents, namely 53.6% (n=89), agreed that they are challenged to grow by participating in training, while 30.1% (n=50) disagreed with this statement. A small number, namely 16.3% (n=27), indicated a neutral response. These findings are not consistent with the findings of Hosey, Kalula and Voss (2016:304) who found that lack of support and motivation was identified as the third highest barrier to CPD among 51.4% (n=35) of nurses from seventeen African countries. Maharaj (2013:347) adds

that a lack of employer support for CPD was more prevalent in the public sector (59%; n=49) compared to the private sector (25%; n=14).

Fewer than half the respondents, namely 47.6% (n=79) agreed that the performance appraisal process was useful for personal development, while an alarming 39.2% (n=65) disagreed with the statement and a further 13.2% (n=22) indicated a neutral response. A case study among 85 employees in a district hospital in KZN, RSA, conducted by Abdool (2016:105), revealed similar findings regarding the inadequacy of the performance appraisal process. The study found that 51.8% (n=44) of the respondents indicated that the performance appraisal process did not help them in identifying their developmental needs. Makhubela, Botha and Swanepoel (2016:9) in their study among 81 public sector employees in North West province, RSA, found that employees perceived the performance appraisal process to be ineffective in identifying their developmental needs. In a study among 300 employees across nine government hospitals in the RSA, Semakula-Katende, Schmickl and Pelsler (2013:9), found that reward was given more prominence than other drivers such as leadership, development and performance. The authors acknowledge that the performance appraisal process as a tool was originally designed to focus on employee development, but the focus has since gradually shifted to reward attainment.

Recognition of staff for good performance in studies received low agreement, namely 39.2% (n=65), while an equal 39.2% (n=65) disagreed that staff are recognised for good performance, and a high percentage, namely 21.6% (n=36), indicated a neutral response. Lack of recognition for good performance is also evident in a study by Awases, Bezuidenhout and Roos (2013:4) in Namibia, which found that an alarming 75.9% (n=110) of respondents indicated that hardworking nurses were not given recognition. A study by Sojane, Klopper and Coetzee (2016:4) which examined leadership, job satisfaction and nurses' intention to resign in South African healthcare facilities, found that nurses reported lack of recognition and praise as a factor adversely influencing retention.

The lowest level of agreement, namely 25.9% (n=43) was that the hospital involved nurses in decisions relating to CPD, while almost half of the respondents, namely 44% (n=73), disagreed that nurses were involved in decisions relating to CPD, and a further 30.1% (n=50) indicated a neutral response. This finding is supported by a qualitative

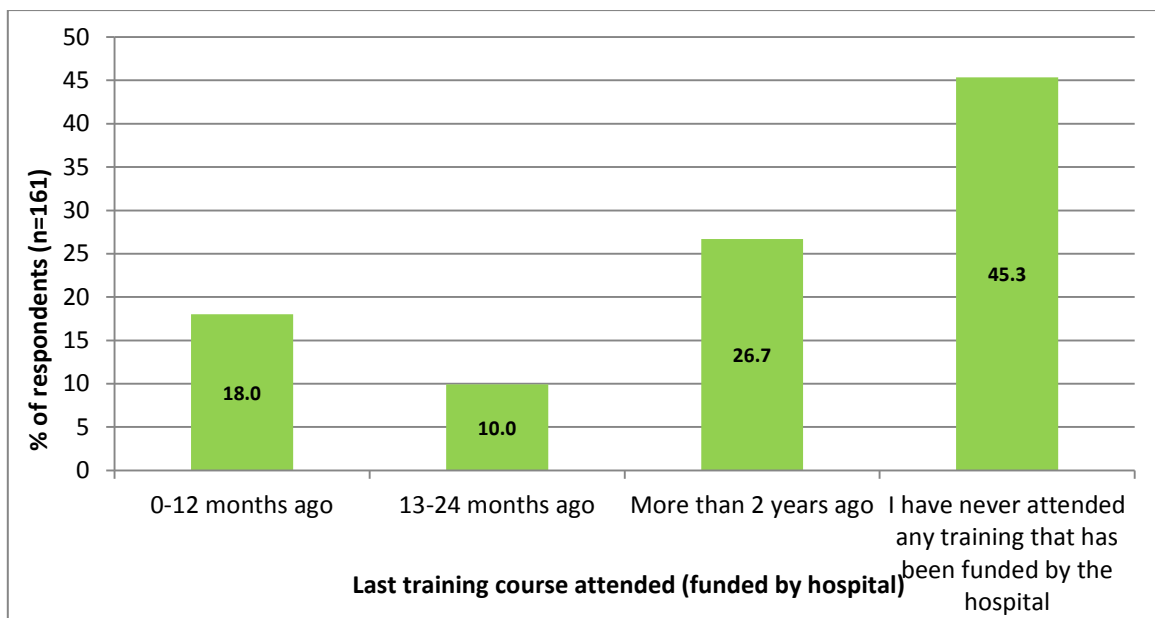
study among Iranian nurses (Sodeify et al 2013:193) which found that although nurses are given feedback by managers, they are rarely involved in any decision-making.

#### 4.3.5 Section E: Resources for CPD

This section discusses the resources available to the nurses that enable CPD in the study hospital.

##### 4.3.5.1 Last attendance of a funded CPD activity in the hospital

Respondents were asked to indicate when they had last participated in a funded CPD activity in the hospital, as depicted in Figure 4.10.



**Figure 4.10 Last attendance of a hospital funded CPD activity (n=161)**

In this section, five respondents refrained from answering the question.

Of the 161 respondents, 18% (n=29) indicated that they had attended a funded training within the last year, followed by 10% (n=16) who indicated attendance of training 1–2 years ago, while 26.7% (n=43) indicated that they had attended training more than two years ago. A further 45.3% (n=73) indicated that they had never attended any training funded by the hospital. Given that 56% (n=93) of the nurses had been employed at the hospital for more than six years, this is presumably a rather grim state of affairs.

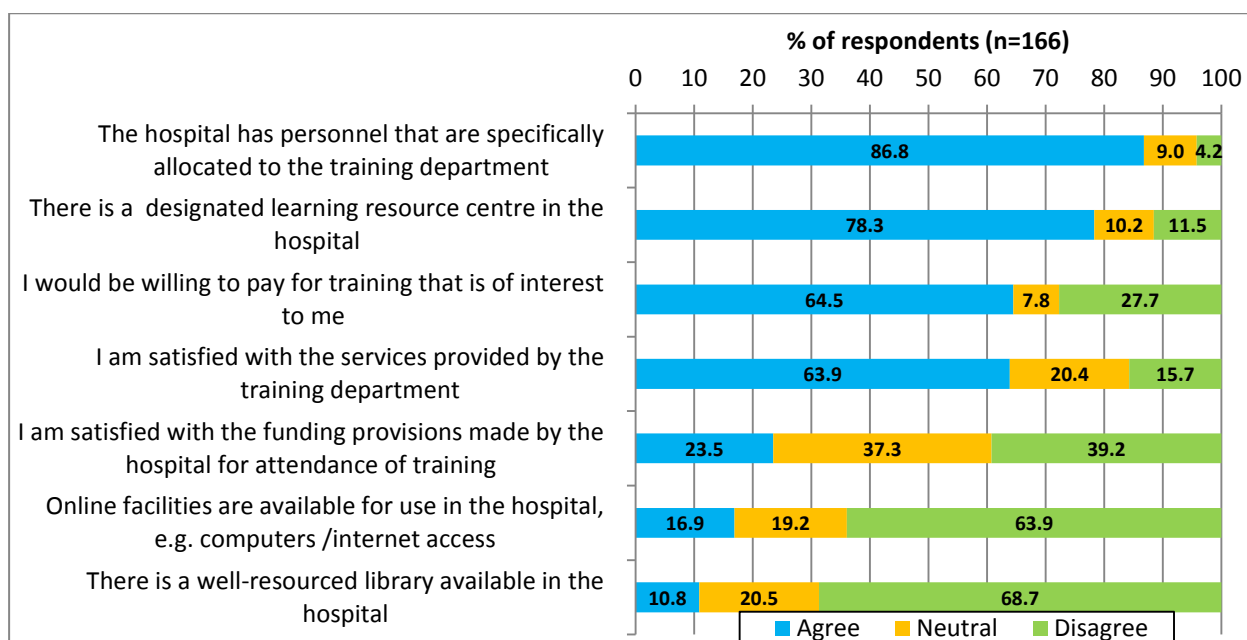
Lack of organisational funding is a common barrier to CPD for nurses and has become a recurrent theme in several studies (Aboshaiqah et al 2012:22; Burrow et al 2016:143; De Jager, Nolte & Temane 2016:265; Haywood et al 2012:138). In addition, Rogan (2014:41) adds that funding for CPD is not limited to the cost of the training programme alone but also has other financial implications such as cost of travel, time off from work, and the cost of replacing nurses to cover shifts when one or more nurses want time away for CPD. Beside the financial implications for the organisations, Viljoen et al (2017:74) found that nurses reported that attending of CPD activities affected time available for overtime and this negatively impacted on remuneration.

#### **4.3.5.2 Willingness to pay for own CPD activities**

Willingness to pay for own training was high, namely 64.5% (n=107), while 27.7% (n=46) indicated that they were not willing to pay for own training and a further 7.8% (n=13) remained neutral. Of the 166 respondents, 23.5% (n=39) indicated satisfaction with the funding provisions made by the hospital, while more than a third, namely 39.2% (n=65) indicated dissatisfaction with the funding provisions made by the hospital. A large portion of 37.3% (n=62) indicated a neutral response. These results are depicted in Figure 4.11. These findings may explain the low frequency of training reported in the study (see section 4.3.5.1). Liphosa (2013:124) reported similar findings in a study which indicated that more than half of the respondents would be willing to pay for own training.

#### **4.3.5.3 Available resources for CPD**

Respondents were asked about the resources available for CPD. Figure 4.11 depicts the resources available for CPD at the hospital.



**Figure 4.11 Resources available for CPD (n=166)**

Of the 166 respondents, 86.8% (n=144) agreed that the hospital has personnel allocated specifically to the training department, while a minimal 4.2% (n=7) disagreed with this statement and a further 9.0% (n=15) indicated a neutral response. A large portion of respondents, namely 78.3% (n=130) agreed that a learning resource centre is available, while 11.5% (n=19) disagreed with this statement and a further 10.2% (n=17) indicated a neutral response. Overall, the study found that nurses indicated a high satisfaction level regarding availability of training personnel and a resource centre. A qualitative study exploring the perceptions of CPD among nurses in Korea by Jho and Kang (2016:568), found that nurses were satisfied with programmes operated by hospitals that provided good services and facilities.

A moderate percentage of respondents, namely 63.9% (n=106) indicated satisfaction with the services provided by the training department, while 15.7% (n=26) indicated dissatisfaction with the services and 20.4% (n=34) remained neutral. Chaghari et al (2016:498) in a qualitative study exploring the in-service training of nursing personnel in Iran, found that nurses indicated dissatisfaction with the training opportunities because of organisational challenges, weakness in education management and unsuccessful mandatory education.

There was a low agreement of 16.9% (n=28) that online facilities are available for use accompanied by 63.9% (n=106) of the respondents who did not agree with the

statement and a further 19.2% (n=32) who indicated a neutral response. Ross et al (2013:5) confirm that lack of online facilities such as internet and computer access is a common barrier to CPD.

The lowest level of agreement, namely 10.8% (n=18) was that a library is available while 68.7% (n=114) disagreed with the statement and 20.5% (n=34) indicated a neutral response. Hosey et al (2016:304) found that a lack of libraries was reported as the fourth highest barrier to CPD for nurses in rural settings.

#### ***4.3.5.4 Application for study leave***

Of the 166 respondents, 41.6% (n=69) indicated that they had at some point applied for study leave while 58.4% (n=97) indicated that they had not applied for study leave.

Among the 69 respondents who had applied for study leave, 62.3% (n=43) indicated that their applications had been approved while 37.7% (n=26) indicated that their applications had been declined. In a qualitative review of 13 studies on CPD, Burrow et al (2016:144) found that workplaces were viewed as being supportive or unsupportive depending on whether or not study leave, and funding, were made available. A national study conducted by El-Jardali, Alameddine, Jamal, Dimassi, Dumit, McEwan, Jaafar and Murray (2013:09) on nurse's retention in 63 healthcare facilities in rural areas in Lebanon, found that the provision of study leaves to pursue further education was a strategy employed by many hospitals to improve the retention and recruitment of nurses in rural areas.

#### **4.3.6 Section F: Processes of CPD**

This section discusses the processes involved in CPD at the selected hospital and includes type of training, barriers to attending CPD at the workplace and in own time, the SANC mandatory CPD system, responsibility for CPD and specific CPD topics that nurses attend at the hospital.

### 4.3.6.1 Training in the last year

Respondents were asked to indicate whether they had participated in training provided by the hospital in the last year.

Of the 166 respondents, 60% (n=99) indicated that they had participated in CPD activities provided by the hospital in the last year while 40% (n=67) indicated that they had not participated in any hospital-provided CPD activities in the last year. The value of workplace CPD is highlighted in various studies (El-Jardali et al 2013:09; Dotson, Dave, Cazier & McLeod 2013:190) which reveal that access to professional development programmes strengthens both the recruitment and retention of nurses.

### 4.3.6.2 CPD format

The respondents, namely the 60% (n=99) who had indicated that they had participated in CPD activities in the hospital in the last year, specified the following CPD formats as depicted by Figure 4.12. This question was a multi-response item and more than one option was accepted.

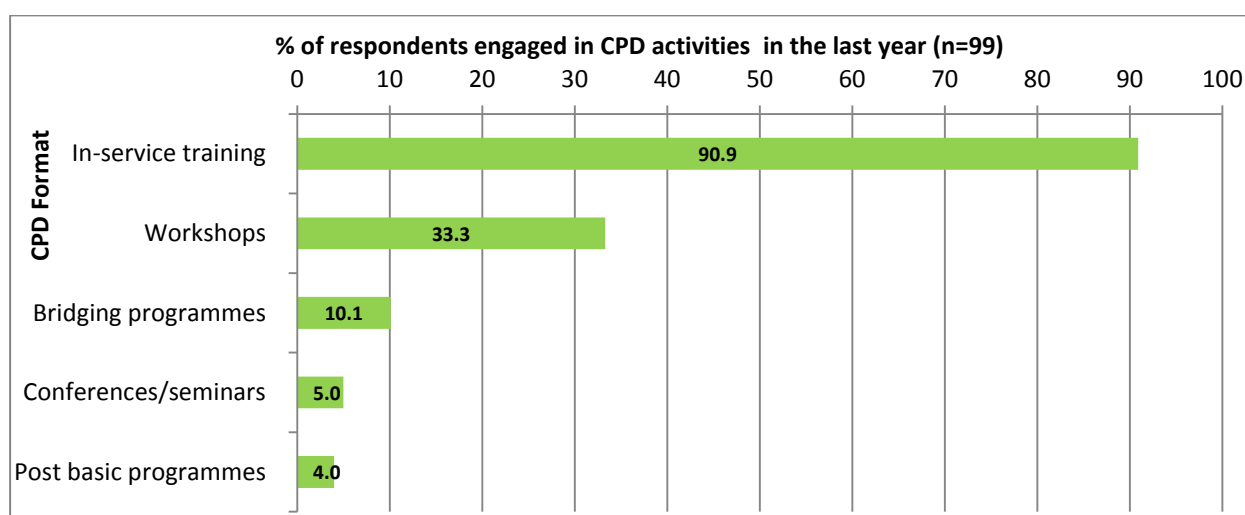


Figure 4.12 CPD format (n=99)

The 99 respondents who had attended training in the last year, indicated the following formats of CPD, namely, in-service training, workshops, conferences and post-basic programmes. In a study describing the CPD practices among 792 Malaysian nurses,



Chong et al (2014:03) found that participation in workshops, conferences and in-service training were the choice of CPD activities among nurses.

Of the 99 respondents, 90.9% (n=90) indicated attendance of in-service training in the last year. While 60% of the 166 respondents indicated that they had attended training in the past year (see section 4.3.6.1), only 18% (n=29) of the respondents had indicated that they had attended a funded training in the last year as indicated in section 4.3.5.1. Of the 90 respondents who had indicated in-service training, 48.5% (n=44) had had only in-service training. This discrepancy could possibly mean that some respondents do not recognise in-service training as a training course funded by the hospital. Evidence from an integrative literature review by Bluestone, Johnson, Fullerton, Carr, Alderman and BonTempo (2013:24) does not support this finding as the review concluded that in-service education represents a significant financial investment in developing and maintaining competence of the healthcare workforce. The discrepancy could further imply that nurses attend training provided by the hospital, but which is not funded by the hospital. In the hospital under study, 55 training sessions were conducted during the period April 2016 to March 2017. Of the 55 training sessions, 20% (n=11) were complimentary training conducted by industries supplying wound care and medical equipment to the hospital (Hospital information system 2017). Foskett (2011:46) states that collaboration between industry and the health service began in the 1990s and the role that industries play in providing educational events for nurses is becoming increasingly significant and feasible.

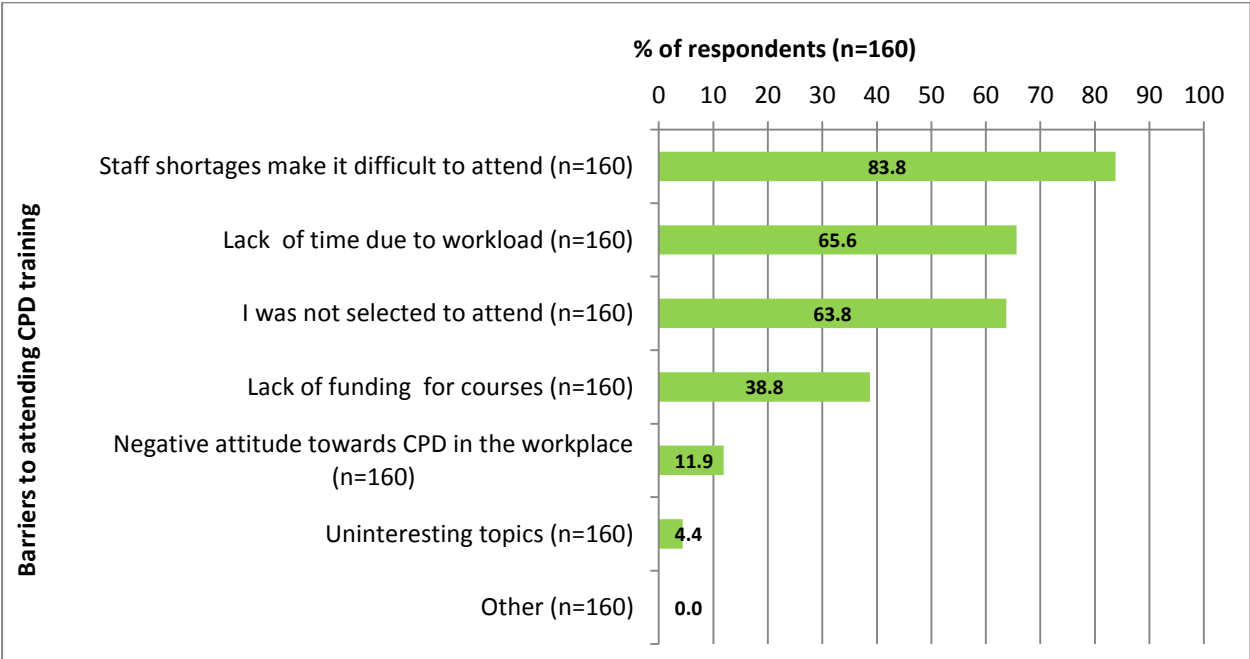
A third of the respondents, namely 33.3% (n=33) attended workshops followed by a minimal portion of 10.1% (n=10) who attended bridging programmes in the last year. In addition, only 5.0% (n=5) attended conferences while 4.0% (n=4) indicated that they had participated in post-basic programmes in the last year.

#### **4.3.6.3 Barriers to attending CPD in the hospital**

Respondents were asked to indicate not more than three key barriers to attending CPD in the hospital as indicated by Figure 4.13. Those that indicated more than three options were excluded. A total of 160 respondents indicated between one to three options in this question. The key barriers to attending CPD in the hospital were identified as staff shortages, (83.8%; n=134), lack of time due to workload (65.6%; n=105) and not being

selected to attend (63.8%; n=102). The SANC (2017:online) reported similar findings in a six-month pilot study among 1 413 nurses in Mpumalanga and Gauteng provinces in the RSA between September 2015 and February 2016. The findings revealed that staff shortages (73%; n=1 031), lack of time (69%; n=975) and lack of organisational and supervisory support (54%; n=763) were the main barriers to CPD.

Interestingly, even though almost half of the respondents (45.3%; n=73) in this study had indicated that they had never attended a hospital funded training (section 4.3.5.1), lack of funding was not mentioned as a key barrier (38.8%; n=62). Ross et al (2013:5) in a recent discourse on the mandatory CPD system in Australia, states that lack of funding and personal costs had been noted as a significant barrier to CPD. Other barriers identified were a negative attitude towards CPD in the workplace (11.9%; n=19) and uninteresting topics presented (4.4%; n=7).



**Figure 4.13 Barriers to attending CPD activities in the hospital (n=160)**

Several studies (Aboshaiqah et al 2012:22; Andrew & Theiss 2015:535; Hosey et al 2016:303; Maharaj 2013:346) have cited staff shortages, lack of time, lack of funding, lack of employer support and lack of individual motivation as barriers to attending CPD activities. This suggests that the barriers to attending CPD activities remain consistent across the literature.

#### **4.3.6.4 The SANC mandatory CDP system**

There was a fair awareness of 72.3% (n=120) on the mandatory CPD system to be implemented by the SANC. Within these 120 respondents, 74.2% (n=89) had attended an information session on the new CPD system. Table 4.2 indicates the results of the information session on the SANC CPD system.

**Table 4.2 Results of the information session (n=89)**

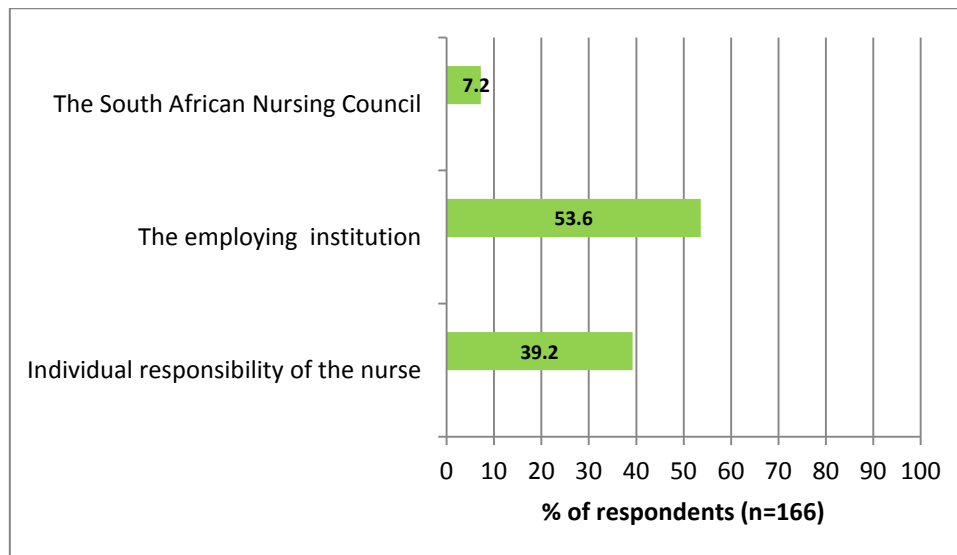
| GOOD UNDERSTANDING |           | NEED MORE CLARIFICATION |           | DON'T UNDERSTAND IT AT ALL |           |
|--------------------|-----------|-------------------------|-----------|----------------------------|-----------|
| Percentage         | Frequency | Percentage              | Frequency | Percentage                 | Frequency |
| 43.8               | 39        | 53.9                    | 48        | 2.3                        | 2         |

Among the 89 respondents who had attended an information CPD session, 43.8% (n=39) indicated that they had a good understanding of the new system, 53.9% (n=48) indicated that they required more clarification, while 2.3% (n=2) indicated that they did not understand the new CPD system at all. Thus, overall, the penetration of information about the new system to the point of good understanding is very low:  $39/166 = 23.5\%$ . This finding is supported by Ross et al (2013:2) in their study on mandatory CPD requirements for Australian nurses which found that although CPD was not a new concept, it was not a well understood concept among nurses in Australia. Viljoen et al (2017:74) acknowledge that a lack of awareness and understanding of CPD can be a barrier to the successful implementation of CPD for nurses.

#### **4.3.6.5 Responsibility for CPD**

Of the 166 respondents, 53.6% (n=89) felt this was the responsibility of the employing institution, followed by 39.2% (n=65) who felt it was the responsibility of the nurse, while 7.2% (n=12) indicated that it was the responsibility of the SANC.

Figure 4.14 indicates the responsibility towards CPD as indicated by the respondents.



**Figure 4.14 Responsibility for CPD (n=166)**

Takase (2013:1408) agrees that healthcare organisations and professional bodies have a part to play in assuring the continuing competence of nurses but the primary responsibility for competency development lies with the individual nurse. The SANC CPD framework (SANC 2015:10) places an obligation on practitioners to assume responsibility for meeting CPD requirements.

#### ***4.3.6.6 Specific topics on which respondents were trained in last year***

Respondents were asked to indicate if they had attended any training categorised by four topics (training specific to speciality, teaching and research, ethics and legal aspects of nursing and leadership) in the last year.

An important observation in the responses was the high percentage of missing data (6.0–7.8% missing data depending on item). This could possibly be because of a poor understanding of the question as it related to the themes of delivery of the SANC mandatory CPD system of which respondents had already indicated low levels of understanding (see section 4.3.6.4).

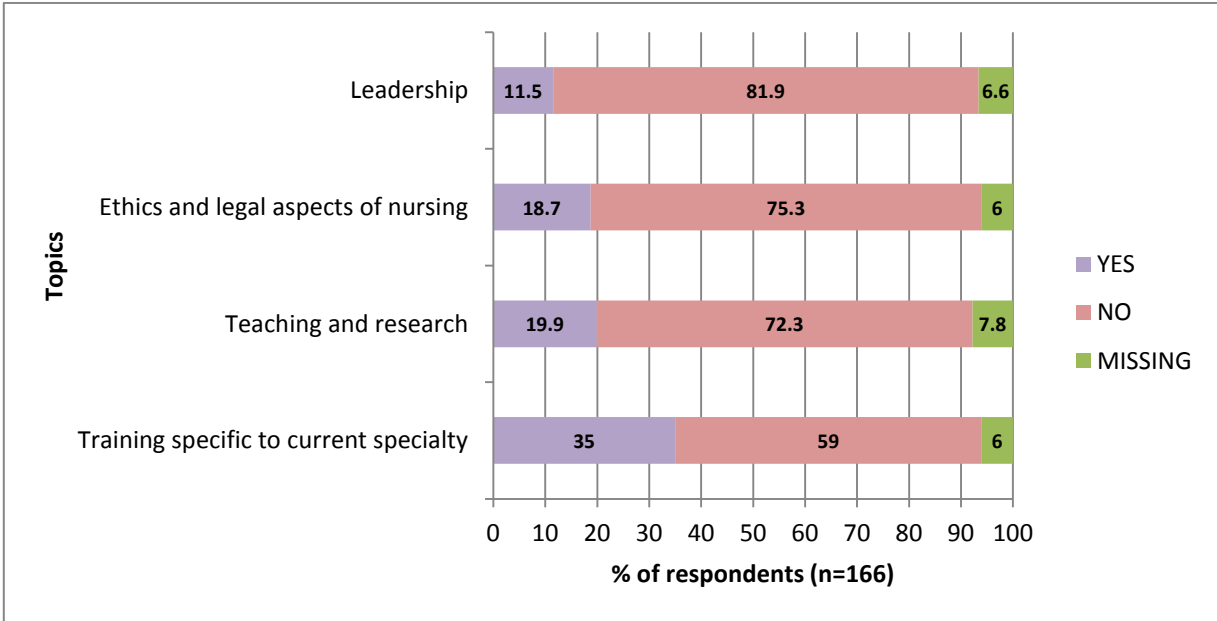
According to the SANC framework for CPD (SANC 2015:10), the new CPD system has divided the scope of CPD activities into these four areas of practice and nurses will be expected to obtain CPD points according to these four themes of delivery. The researcher used these four topics to determine if nurses were currently attending CPD activities in line with the proposed CPD system. The results revealed that all four topics

had a low coverage. Among the 163 respondents who answered this question at least partially, 55.4% (n=92) indicated at least one topic, which agrees roughly with the 60% (n=99) who had indicated that they had attended CPD training in the last year (see section 4.3.6.1). Presumably CPD in the hospital covers more topics that the four listed in this section.

**Table 4.3 Topics on which respondents were trained in the last year (n=166)**

| TOPIC                                   | YES       |      | NO        |      | MISSING   |     |
|---|-----------|------|-----------|------|-----------|-----|
|   | Frequency | %    | Frequency | %    | Frequency | %   |
| Training specific to current speciality | 58        | 35   | 98        | 59   | 10        | 6   |
| Teaching and research                   | 33        | 19.9 | 120       | 72.3 | 13        | 7.8 |
| Ethics and legal aspects of nursing     | 31        | 18.7 | 125       | 75.3 | 10        | 6   |
| Leadership                              | 19        | 11.5 | 136       | 81.9 | 11        | 6.6 |

Figure 4.15 shows a graphical representation of Table 4.3.



**Figure 4.15 Topics on which respondents were trained in the last year (n=166)**

The topic covered for most respondents was training specific to their speciality/department, namely 35% (n=58); followed by teaching and research (19.9%; n=33), ethics and legal aspects of nursing (18.7%; n=31) and leadership (11.5%; n=19). These findings are congruent with a study on CPD practices among Malaysian nurses (Chong et al 2014:4), which found that a higher percentage of nurses attended training

related to their clinical work as compared to training related to teaching, management and research. Katsikitis et al (2013:43) agree that nurses focus on training related to clinical work and suggest that nurses should be encouraged to explore CPD in research and leadership as this will present them with opportunities for advancement.

Of the respondents, 19.9% (n=33) had attended CPD activities related to teaching and research. This finding is of concern because nurses lacking teaching skills would compromise the advocacy of peer and patient education. Furthermore, a lack of research skills would compromise the delivery of evidence-based practice in nursing. Sim, Jang and Kim (2016:363) state that evidence based practice is fundamental to nursing because it provides the best outcome and high quality, cost effective nursing and gives potential benefits to patients, nurses and healthcare systems.

Only 18.7% (n=31) of respondents had attended CPD activities relating to ethics and legal aspects of nursing. A study conducted by Osiyaga, Nalwadda, Ngabirano, Wakida, Sewankambo and Nakanjako (2015:3) which assessed nurse's perceptions regarding continuing ethics education among 114 nurses in Uganda, found that, although 93% (n=109) of the nurses had positive perceptions towards continuing nursing ethics education, only 45% (n=51) had reported having attended at least one education session on nursing ethics during their professional career.

Among the respondents who had indicated at least one topic, 61.8% were registered nurses while 47.5% were of the enrolled categories. The association between nurse rank (registered/enrolled) and topics attended was not significant as determined by the Fishers exact test ( $p=0.10$ ). This finding is not supported by the CPD pilot study (SANC 2017:15) which found that registered nurses (35%; n=495) are more likely to meet the requirements than the enrolled categories (26%; n=367).

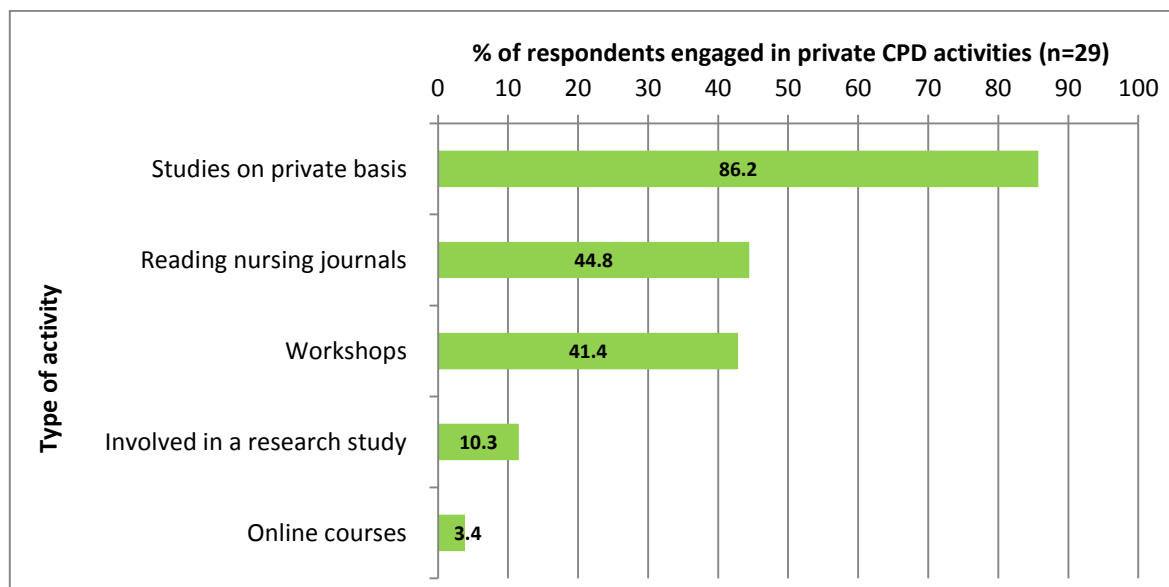
#### ***4.3.6.7 Participation in CPD activities in own time (not provided by hospital)***

Respondents were asked whether they participated in any CPD activities in their own time and to indicate the type of activity they participated in.

Of the 166 respondents, only 17.5% (n=29) indicated that they had participated in CPD activities in their own time while 82.5% (n=137) indicated that they had not participated

in any CPD activities in their own time. The implication thereof is that the majority of nurses rely solely on the hospital to provide opportunities to meet their training needs. Katsikitis et al (2013:42) argue that a predominance of workplace CPD may limit broader knowledge acquisition from other sources and on topics that develop a more upcoming image of practice and the profession. In the Western countries, where CPD is mandatory, the majority of nurses engage in CPD activities in their personal time and at their own cost to meet mandatory CPD requirements (Jones 2016:386; Ross et al 2013:5).

Figure 4.16 represents the type of activity engaged in by the 17.5% (n=29) who had indicated participation in CPD activities in their own time.



**Figure 4.16 Participation in CPD activities in own time (n=29)**

The most common activity indicated was private study, namely 86.2% (n=25), followed by 44.8% (n=13) who indicated reading nursing journals, while 41.4% (n=12) indicated attending of workshops in private time. In addition, 10.3% (n=3) indicated involvement in research studies and 3.4% (n=1) indicated participation in online courses.

The results reveal that there is an overall very low participation in reading nursing journals, research and online courses in the study hospital.

Rodriguez, Victor, Leonardi, Sulo and Littlejohn (2016:537) confirm that regardless of the effectiveness of nursing journals, nurses are not using them for continuing education.

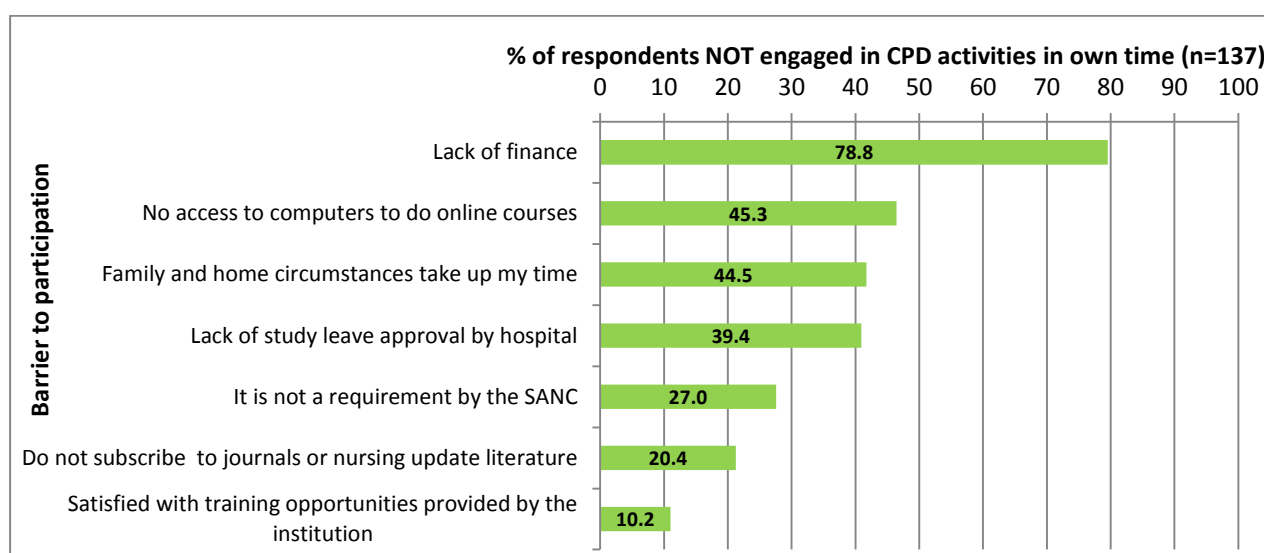
Dunning (2013:1) adds that most clinical nurses do not actively engage in or feel any professional responsibility towards nursing research. Chong et al (2014:3) concur, as their study among 792 Malaysian nurses found that 81.9% (n=649) indicated that they had never engaged in reading nursing journals while 95.5% (n=756) had never engaged in nursing research. By contrast, a study by Gaspard and Yang (2016:4) which investigated the training needs among 78 nurses in developing countries, found that research activities were ranked second on the priority list of needs identified. In a study among 150 registered nurses in Nigeria, Adamu and Naidoo (2015:44) acknowledge that while nurses have a positive perception and attitude towards evidence based practice, only a small proportion use this approach in their clinical practice. This is supported by Srijana, Subramaniam and Paudel (2016:171) in their study which examined the factors affecting research utilisation among nurses in Nepal. The study found that nurses (n=97) were aware of the importance and existence of research but could not devote the time to read research reports (34.9%; n=34) nor implement new ideas (60.3%; n=58).

The least indicated activity was participation in online courses (3.4%, n=1). This is not surprising as 89.2% (n=148) of the nurse population at the hospital was in the age group 31–65 years at the time of the study which is mostly indicative of generation “Xers” (born 1965–1982) and baby boomers (born 1946–1964). In a debate on the use of technology by nurses, Mather, Gale and Cummings (2017:4) argue that these generation cohorts are less likely to use online technology for communication or CPD purposes. Ousey and Roberts (2013:82) advocate that the use of online learning for nurses has the potential to ensure that education is available for all staff to access at a time that meets both personal and professional needs. A further advantage of online learning as identified by Ousey and Roberts (2013:82) is that online provision could also promote the internationalisation of courses as content can be accessed by students from anywhere in the world. Parkinson (2014:16) agrees that online education affords the benefit of flexibility; however, a major criticism of online learning is that a high level of digital literacy is required and thus this method may exclude nurses who do not possess the requisite skills and hardware.



#### 4.3.6.8 Barriers to participation in CPD activities in own time

Respondents who indicated that they did not participate in CPD activities on their own were asked to indicate the barriers preventing them from doing so. A total of 137 respondents indicated between one to three barriers. Figure 4.17 indicates the barriers to participating in CPD activities in their own time.



**Figure 4.17 Barriers to participating in CPD activities in own time (n=137)**

The main barrier to participation in private CPD activities was a lack of finance (78.8%; n=108), followed by a lack of computer access (45.3%; n=62), family and home circumstances taking up time (44.5%; n=61), a lack of study leave (39.4%; n=54) and a lack of subscription to nursing journals (20.4%; n=28). In addition, 27% (n=37) of respondents indicated that they did not participate in any additional private CPD activities since CPD was not a mandatory requirement by the SANC. Satisfaction with training opportunities (10.2%; n=14) provided by the institution was not a key factor in the decision not to participate in private CPD activities. The lack of funds, computer access and study leave has been previously noted as a barrier to CPD (see section 4.3.5.4 and section 4.3.6.3).

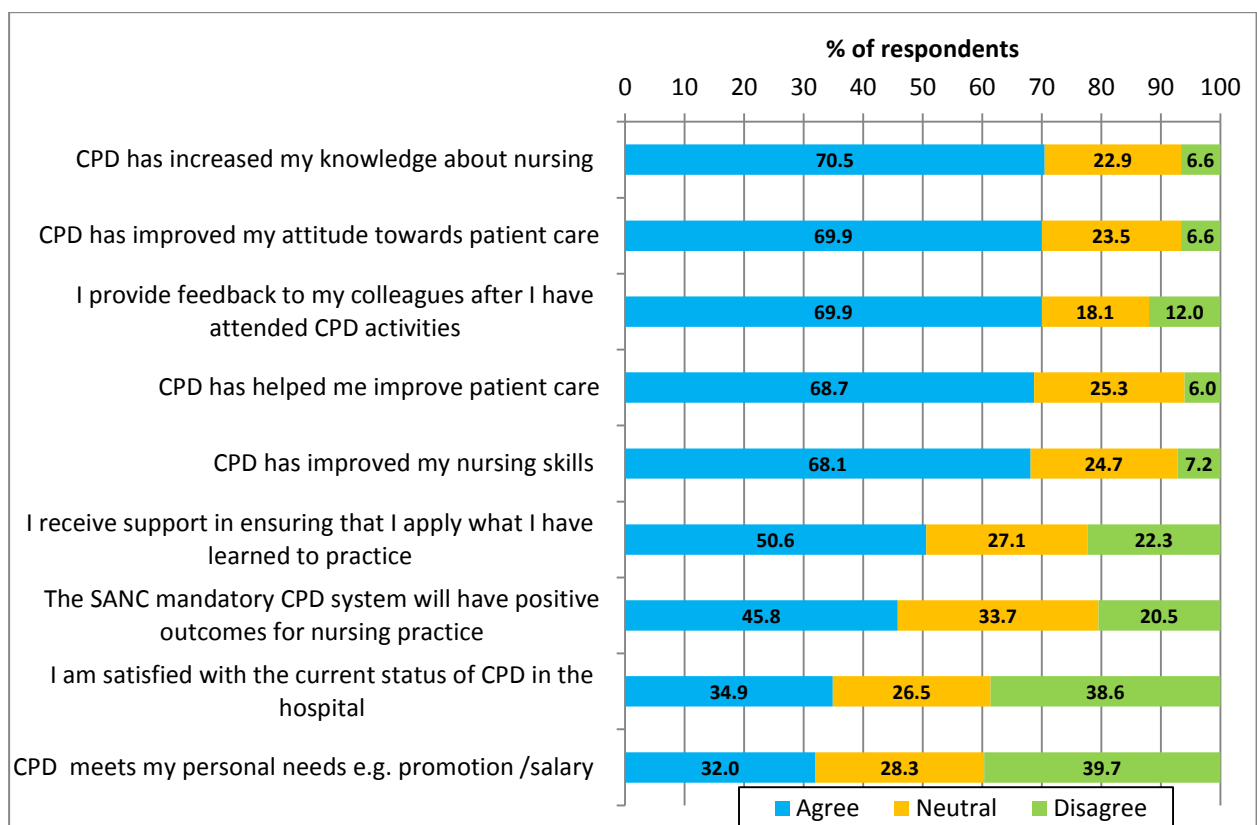
Coventry et al (2015:2715), in an integrative review of eleven international studies, found that six of the studies supported the view that family responsibilities compete with the time expected to participate in CPD. Burrow et al (2016:143) argue that the influence of family and home circumstance on nurses participating in part time study can be both positive and negative. The authors state that the pressures of combining

academic study with competing demands on the home front can serve as a barrier to CPD. On the other hand, supportive families can serve as a source of motivation for nurses participating in part-time study.

In this study, 27% (n=37) of respondents indicated that they did not participate in any additional private CPD activities since CPD was not a mandatory requirement by the SANC. This finding is supported by Jho and Kang (2016:569) in their study on Korean perceptions of CPD. They found that nurses focused on the fact that participation in CPD was essential to obtain annual education credits to legally maintain their licences, rather than being motivated by self-interest in learning new things.

#### 4.3.7 Section G: Results of CPD

This section focuses on the results of CPD as perceived by the respondents. It discusses the outcomes of CPD as related to patient care, nursing knowledge and skills. The section closes with the nurses' perception of mandated CPD and the overall satisfaction with the status of CPD in the study hospital. Figure 4.18 depicts the results of CPD as perceived by the nurses.



**Figure 4.18 Results of CPD (n=166)**

Respondents were asked about the results of attending CPD activities. Although all respondents answered the questions in this section, there was a moderate level of neutral responses indicating that respondents did not have an opinion about the item.

#### ***4.3.7.1 CPD outcomes relating to patient care, nursing knowledge and skills***

Among the 166 respondents, 70.5% (n=117) agreed that CPD increased knowledge about nursing, followed by 6.6% (n=11) who disagreed with the statement and almost a quarter (22.9%; n=38) who indicated a neutral response.

There was a high agreement, namely 69.9% (n=116), that CPD had improved attitudes towards patient care, with 23.5% (n=39) indicating a neutral response and 6.6% (11) disagreeing with the statement.

There was a high agreement, namely 68.7% (n=114), that CPD had improved patient care, 25.3% (n=42) indicated no opinion about it, while a minimal 6% (n=10) disagreed with the statement.

Of the 166 respondents, 68.1% (n=113) agreed that CPD had improved nursing skills, 24.7% (n=41) indicated a neutral response and 7.2% (n=12) disagreed that CPD had improved nursing skills.

These results are supported by the SANC pilot study (SANC 2017:14) which found that CPD improves knowledge (91%; n=1 286), enhances skills (89%; n=1 258), impacts patient safety (81%; n=1 145), increases learner satisfaction (78%; n=1 102), changes practice (73%; n=1 031) and redirect attitudes (73%; n=1 031). Owaka (2014:31) concurs in a study which examined the effects of CPD on performance of nurses in Kenya, as nurses indicated a high agreement that CPD had increased their skills, knowledge and job performance.

Using a pre-test/post-test experimental design, Becker (2017:125) examined the effects of continuing education on nurse's knowledge of paediatric asthma. The study which was conducted among 100 registered nurses across various states in the USA, found that there was a significant increase in paediatric asthma knowledge among the control

group from the pre-test to the immediate post-test. This supported the view that continuing education increases knowledge. However, the study found that there was a significant decrease in mean scores from the immediate post-test to the 5-week post-test. Becker (2017:125) suggests that the resulting decrease in the mean score at the 5-week post-test was due to a lack of reinforcement of asthma information in the control group. Bluestone et al (2013:23) support the view that repetitive exposure as well as interactive educational techniques are critical in ensuring that CPD positively impacts on nursing practice.

#### **4.3.7.2 *Transfer of training***

Feedback regarding CPD activities received an equally high agreement of 69.9% (n=116), while 18.1% (n=30) indicated a neutral response and 12% (n=20) disagreed that feedback is given. Half the respondents, namely 50.6% (n=84), indicated that they receive support in applying what they have learned to practice, 27.1% (n=45) indicated a neutral response while 22.3% (n=37) disagreed that support is available in applying learning to practice.

Ignatavicius and Chung (2016:141) in their study on assessing transfer of learning among nursing faculty in the USA, found that knowledge, skills and attitudes gained at CPD events can be successfully transferred and utilised in practice provided that the organisational culture allows change decisions to be made. Bhatti, Battour, Sundram and Othman (2013:273) in their study which highlighted the importance of selected environmental, situational and individual factors in the training transfer process, found that supervisor and peer support increased the motivation level of trainees to transfer learned skills to the workplace.

#### **4.3.7.3 *Perception of mandated CPD***

Hope for the pending mandatory CPD system was low as less than half of the respondents, namely 45.8% (n=76), indicated that it would have positive outcomes for nursing practice, while 33.7% (n=56) indicated a neutral response and 20.5% (n=34) disagreed that it would have a positive impact on nursing practice. This finding is supported by Chaghari et al (2016:501) in a qualitative study among 42 nurses in Iran, which found that the concept of unsuccessful mandatory education to be the main

concern of the participants. The Iranian study found that nurses perceived education as an obligatory subject rather than being useful and effective.

#### **4.3.7.4 *Satisfaction with the status of CPD in the hospital***

Satisfaction with the current state of CPD in the hospital received a low agreement of 34.9% (n=58), while 26.5% (n=44) indicated no opinion about it and more than a third, namely 38.6% (n=64), indicated that they were not satisfied with the current state of training in the hospital. These findings are not consistent with Marzuki, Hassan, Wichaikhum and Nantsupawat (2012:453) in their descriptive study on best practices in continuing education among nurses in Malaysia, which found that nurses in university hospitals expressed a high agreement and satisfaction with active continuing education programmes. The authors acknowledge that university hospitals have an accountability towards teaching and research and this could possibly have resulted in high satisfaction levels experienced by nurses. In a qualitative study of continuing education needs of rural nursing staff, Fairchild, Everly, Bozarth, Bauer, Walters, Sample and Anderson (2013:368) found that there are many challenges faced by nurses in rural settings and this hinders staff development.

The lowest level of agreement, namely 32% (n=53), was that CPD met personal needs, while 28.3% (n=47) indicated a neutral response and 39.7% (n=66) disagreed that CPD met their personal needs. Eslamian, Moeini and Soleimani (2015:384), in a qualitative study exploring nursing education challenges, found that the management and planning of continuing education needs to be modified to meet nurses' needs. Katsikitis et al (2013:34) argue that while CPD may serve nurses immediate skill needs, it may not contribute to professional satisfaction in meeting personal needs.

## **4.4 CONCLUSION**

This chapter provided an analysis of the study findings. The findings were discussed and justified with reference to the literature review and other studies. The next chapter presents the conclusions of the study, makes recommendations based on the findings and proposes a scope for further research.

## CHAPTER 5

### CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

*"I alone cannot change the world, but I can cast a stone across the waters to create many ripples."*

Mother Teresa

#### 5.1 INTRODUCTION

The previous chapter provided the interpretation of data and the link to previous research on CPD. This chapter addresses the study conclusions, limitations and recommendations for CPD practice and further research.

The purpose of the study is to assess the CPD of nurses in a selected public hospital in KZN.

The research objectives of the study are to

- describe the status of the CPD of nurses in the selected hospital
- assess the enabling factors affecting the context in which CPD is implemented in the selected hospital
- describe the processes involved in the CPD for nurses in the selected hospital

The findings are discussed according to the sections of the questionnaire and the theoretical framework used. The study conclusions are presented according to the following sequence: demographic data, leadership role in CPD, policy and strategy of CPD, people development, resources for CPD, process of CPD and results of CPD.

#### 5.2 RESPONDENTS DEMOGRAPHICAL PROFILE

The sample consisted of 200 nursing staff of which 166 nurses completed the questionnaire providing a response rate of 83%. The respondents were mostly female (88.6%; n=147) and were aged predominantly between 31 and 50 years (70.5%; n=117). The respondents were primarily registered nurses (63.2%; n=105) and

subsequently the predominant educational qualification was a national diploma in nursing (54.3%; n=90). Nursing experience varied between those with less than 10 years' experience (55.4%; n=92) and those with more than 10 years' experience (44.6%; n=74). In relation to the employment status, the study found that more than half of the respondents (56%; n=93) had worked at the hospital for more than six years. Although the respondents indicated a range of nursing departments, the three main departments in which the respondents were allocated were the maternity (27.1%; n=45), medical (15.7%; n=26) and the surgical (12.7%; n=21) departments.

### **5.3 LEADERSHIP ROLE IN CPD**

The results revealed that there is a moderate agreement (63.3%; n=105) that management staff informs nurses about changes and developments in nursing education. The least agreement (39.8%; n=66) was that management are proactive in addressing CPD concerns. The results revealed that the activities that required the most personal engagement between management and nurses scored the lowest levels of agreement. Management's priorities were further clarified when CPD was ranked the least important area (63.3%; n=105) when compared to patient care, staff supervision and attendance at meetings. This finding is important as it highlights the need for managers to establish an organisational culture that promotes engagement, where nurses are involved in decision making, their professional needs are considered, and concerns addressed. The findings also support the notion that nurse leadership in a hospital is integral to supporting CPD.

### **5.4 POLICY AND STRATEGY FOR CPD**

Although the findings indicated a high agreement (75%; n=54) that there is a procedure for making the CPD policy known to nursing staff, more than half of the nurses at the hospital were unaware or unsure of the CPD policy (56.6%; n=94). Of the 43.4 % (n=72) that were aware of the CPD policy, 61% (n=44) agreed that the policy was adequate and fair. However, there was low agreement (34.7%; n=25) that nurses are involved in the formulation of the CPD policies. These findings confirm that even though there is a procedure for communicating the CPD policy to nursing staff, the implementation thereof is lacking. It is also clear from the findings that nursing staff have little input in the formulation of the CPD policy in the hospital.

## **5.5 PEOPLE DEVELOPMENT**

There was a moderate agreement (57.2%; n=95) that the hospital supports the development of nursing staff. Less than half (47.6%; n=79) of the respondents indicated that the performance appraisal process was useful for personal development. This is a major concern as the purpose of the performance appraisal process is to manage and develop employee behaviour for the achievement of the organisational goals. Another area of concern raised by the study was the low agreement (39.2%; n=65) that nurses are given recognition for good performance. The findings suggest that the hospital shows a moderate investment in its nurses.

## **5.6 RESOURCES FOR CPD**

This section discusses the findings relating to funding, availability of study leave and human and material resources.

### **5.6.1 Funding for CPD**

The study found a gross lack of funding for training as almost half (45.3%; n=73) of the respondents indicated that they had never attended any training funded by the hospital. A further 18% (n=29) indicated that they had attended funded training in the last year. This finding is significant as the literature review reveals that the availability of funding determines whether the organisation is perceived as supportive of CPD or not.

### **5.6.2 Study leave**

The findings suggest that the hospital meets the need for study leave as, of the 41.6% (n=69) of respondents who had applied for study leave, 62.3% (n=43) indicated that their request for study leave had been approved.

### **5.6.3 Human and material resources**

There was a high agreement that the hospital has designated training personnel (86.8%; n=144) and a learning resource centre (78.3%; n=130). However, there was an extremely low agreement that online facilities (16.9%; n=28) and a library exist (10.8%;



n=18). It is clear that there is a need to improve access to online provision as a delivery style for the CPD of nurses in the hospital.

## **5.7 PROCESS OF CPD**

In this section the findings are discussed under CPD format, barriers to attending CPD in the hospital and in own time, the SANC mandatory system and participation in CPD in own time.

### **5.7.1 CPD format**

In-service training (90.9%; n=90) was the predominant CPD format that respondents engaged in, while 33.3% (n=33) indicated participation in workshops. The study noted a discrepancy in that of the 90 respondents who had indicated the attendance of in-service training, 48.5 % (n=44) had had only in-service training. Yet in Chapter 4 (see section 4.3.5.1), only 18% (n=29) had indicated attendance of a hospital funded training. This discrepancy suggests that nurses at the hospital may not perceive in-service training as a funded programme. This finding is significant as it lends itself to further research on nurses' perceptions regarding in-service training.

### **5.7.2 Barriers to attending CPD**

The key barriers to attending CPD in the hospital were staff shortages (83.8%; n=134), lack of time (65.6%; n=105) and not being selected to attend (63.8%; n=102). Despite the low satisfaction that the respondents expressed regarding availability of funding, lack of funding (38.8%; n=62) was not mentioned as a key barrier. This finding highlights the need for hospital management to address barriers to CPD to improve practice.

The key barriers to attending CPD in own time were lack of finance (78.8%; n=108), followed by lack of computer and online access (45.2%; n=62) and the competing demands of family life (44.5%; n=61). The findings suggest that computer and online access feature as necessary resources for CPD for nurses in this hospital. Given the technological advances of the day, it stands to reason that online access to CPD is the future trend.

### **5.7.3 The SANC mandatory CPD system**

There was a moderate awareness (72.3%; n=120) of the mandatory CPD system soon to be implemented by the SANC. Within these 120 respondents, 89 had attended an information session on the CPD system. Of these 89 respondents 43.8% (n=39) indicated that they had a good understanding of the new CPD system, followed by 53.9% (n=48) who indicated that they needed more clarification, while 2.3% (n=2) indicated that they did not understand the new CPD system at all. Overall, the penetration of information about the new system to the point of good understanding was very low (23.5%). This finding is significant as a lack of understanding of the new system could pose a potential barrier to its successful implementation.

#### ***5.7.3.1 Responsibility for CPD***

Responsibility for CPD was attributed to the employing institution (53.6%; n=89), followed by 39.2% (n=65) who felt that it was the responsibility of the nurse while 7.2% (n=12) who indicated that it was the responsibility of the SANC. Although CPD is a professional responsibility, this finding highlights the role of shared responsibility in meeting CPD requirements.

#### ***5.7.3.2 The SANC themes of delivery***

The study found that the topic covered the most was training specific to their speciality/department (35%; n=58), followed by teaching and research (19.9%; n=33), ethics and legal aspects of nursing (18.7%; n=31) and leadership (11.4%; n=19). This finding is significant for the nurse management and educators at the hospital as it will aid in the planning and implementation of training programmes that will meet the requirements of the SANC mandatory CPD system.

The study did not find any significant association between nurse rank and the topics attended (Fishers test p=0.10).

#### **5.7.4 Participation in CPD in own time**

A minimal number (17.5%; n=29) indicated that they had participated in CPD in their own time. The most common activity indicated was private study (86.2%; n=25) followed by reading nursing journals (44.8%; n=13) and workshops (41.4%; n=12). Only 10.3% (n=3) indicated involvement in research studies and online courses. The findings revealed that the majority of nurses (82.5%; n=137) rely on the hospital to provide opportunities to meet their training needs. This finding highlights the need for nurses to be encouraged to seek out CPD activities in their own time to meet CPD requirements. It also highlights the important role of the hospital in the provision of CPD activities for nurses.

### **5.8 RESULTS OF CPD**

This section focuses on the findings of the results of CPD as perceived by the respondents. CPD outcomes, application to practice, perception of mandated CPD and satisfaction with the status of CPD will be discussed.

#### **5.8.1 CPD outcomes relating to patient care, nursing knowledge and skills**

The study found that there was agreement that CPD had resulted in increased knowledge (70.5%; n=117), improved attitudes (70%; n=116), enhanced patient care (68.7%; n=114) and improved nursing skills (68.1%; n=113). This finding is important as it implies that nurses acknowledge the value of CPD.

#### **5.8.2 Transfer of learning and application to practice**

The study found that although the respondents indicated high agreement (69.9%; n=116) that feedback to colleagues about CPD activities took place, there was less agreement (50.6%; n=84) that support in applying learning to practice was received. This finding is significant as it reveals the need for the hospital to support nurses in transferring learning to practice.

### **5.8.3 Perception of mandated CPD**

The study found that although the respondents acknowledged that CPD resulted in increased knowledge, skills and patient care, there was less agreement (45.8%; n=76) that mandated CPD will have positive outcomes for nursing practice. The study revealed that hope for the mandated CPD system was not high. This could possibly be due to a lack of knowledge and fear of a mandated system that will impact on licensure to practice.

### **5.8.4 Satisfaction with status of CPD in hospital**

Overall, the study found that respondents indicated low satisfaction (35.9%; n=58) with the current state of CPD in the hospital, linked to low satisfaction with CPD meeting personal needs (32%; n=53). This finding is significant as it suggests that there is a need for improvement in current practices relating to the CPD of nurses.

## **5.9 LIMITATIONS**

The study presented the following limitations:

- A non-probability convenience sampling method was used. This method can be risky as some elements may be over represented or under represented which can make it difficult to generalise the findings to the population.
- The study was conducted in one district hospital in KZN and this limits the generalisability of the findings to other hospitals in KZN.
- Since mandatory CPD is a new concept in South Africa, the literature review on this subject in South Africa was limited. The researcher analysed international studies and articles relating to CPD to establish a literature review.
- Although 200 nurses participated in the study, only 166 completed the questionnaire in its entirety. The study presented a response rate of 83% and a sample size of 166. Although this is significant, the sample of 166 was only 58.9% of the total nurse population employed at the hospital.

## **5.10 RECOMMENDATIONS**

The researcher holds the opinion that CPD plays a pivotal role in meeting the competency needs of nurses to render quality care to the South African public. Based on the findings, the researcher makes the following recommendations for practice and further research.

### **5.10.1 Practice**

- Good leadership is an enabler of CPD. It is recommended that a policy be developed to ensure that managers and nurse leaders are trained for leadership positions before assumption of leadership roles. In-service training to empower managers in the recognition and praise of staff is highly recommended.
- Identification and consultation regarding learning needs is important to promote effective CPD. It is recommended that management create a platform to consult with nurses regarding their learning needs and concerns. Needs should be guided by patient needs to ensure that nurses remain updated with current practice.
- The length of nursing experience impacts on CPD participation. It is recommended that time specific educational investments are made to improve nurse competence.
- At the time of this study, the bulk of the nursing population was comprised of generation “Xers” (born 1965–1982). Educators need to take this into consideration in planning CPD programmes so that the specific learning needs of this generation are met.
- The organisational context post training can have an impact on transfer of learning. It is recommended that management create supportive practice environments that will promote the transfer of knowledge and skills learned to the clinical environment.
- Awareness of CPD policies is important to the successful implementation of a CPD programme. It is recommended that nurses are involved in the formulation of CPD policies and that the procedure for communicating the policy be fully implemented.

- Both personal and organisational factors serve as barriers to CPD. The hospital should address staff shortages, lack of time and selection procedures as these were indicated as key barriers to CPD.
- The purpose of the performance appraisal purpose is to manage performance and link it to development initiatives. It is recommended that management and staff be trained on using the system to identify employee strengths and areas of need.
- An availability of resources is essential to effective CPD. It is recommended that the hospital review the workplace skills plan and prioritise funding for nurse training. It is further recommended that the organisation consider the provision of a library and online access to assist nurses in meeting CPD needs.
- The implementation of the SANC mandated CPD system is imminent. It is recommended that the hospital plans for the successful operationalisation of the new system by considering the following:
  - The content of CPD programmes should be reviewed to include the four themes of delivery as indicated in the scope of the SANC mandatory CPD system.
  - A series of trainings on the new system should be rolled out to all nursing staff to ensure a good penetration of information.
  - Attention to other formats of training beside in-service lectures such as journal clubs and audits should be included in the training programme to meet CPD requirements.

### **5.10.2 Research**

Further research is suggested on the following topics:

- Nurses' perceptions of in-service training in public hospitals in South Africa.
- The implications of mandatory continuing professional development for South African nurses.
- Continuing professional development of nurses: assessing transfer of learning to the practice environment.
- Improving access to online provision as a method of delivery for continuing professional development for nurses in rural hospitals.

- The assessment of the continuing education needs of nurses in rural hospitals in South Africa.

## **5.11 CONCLUSION**

This chapter summarised the study findings, limitations and recommendations for practice and future research. The assessment of the CPD of nurses in a selected hospital in KZN revealed that while CPD takes place in the hospital there is room for improvement to meet the satisfaction and developmental needs of nurses. The role of good leadership, clear policies, adequate resources, people development and improved processes serve as enabling factors to a positive outcome of CPD. The researcher hopes that the recommendations outlined in this study will assist in improving CPD practices for nurses and ultimately contribute to quality patient care.

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## **ANNEXURES**

## ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE



**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES**  
**REC-012714-039 (NHRC)**

1 March 2017

Dear Mrs D Pillay

**Decision: Ethics Approval**

**RSHDC/645/2017**

Mrs D Pillay

Student: 5146-977-4

Supervisor: Prof S Hattingh

Qualification: D Litt et Phil

Joint Supervisor: -

**Name:** Mrs D Pillay

**Proposal:** The assessment of the continuing professional development of nurses in a selected public hospital in KwaZulu Natal.

**Qualification:** MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

*The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 1 March 2017.*

*The proposed research may now commence with the proviso that:*

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



University of South Africa  
Pretorius Street, Midrand, A. Ridge, Jurg. G. I. Swane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 420 3111 Facsimile: 127 12 428 4150  
www.unisa.ac.za

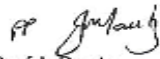
3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

4) [Stipulate any reporting requirements if applicable].

**Note:**

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,



Prof L Roets  
CHAIRPERSON  
[roetsl@unisa.ac.za](mailto:roetsl@unisa.ac.za)



Prof MM Moleki  
ACADEMIC CHAIRPERSON  
[molekmm@unisa.ac.za](mailto:molekmm@unisa.ac.za)



Approval template 2014

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## ANNEXURE B: LETTER SEEKING CONSENT FROM DEPARTMENT OF HEALTH

### ANNEXURE B: LETTER SEEKING CONSENT FROM DEPARTMENT OF HEALTH

Mrs Doshnee Pillay  
Cell: 0027747997  
Email: [pillayd72@gmail.com](mailto:pillayd72@gmail.com)

13 March 2017

Mrs SP Nyawo  
Chief Executive Officer  
G J Crookes Hospital  
Scottburgh, 4180

Dear Madam

#### PERMISSION TO CONDUCT A STUDY AT GJ CROOKES HOSPITAL

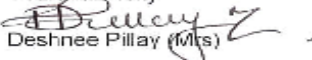
I, Doshnee Pillay, a student of the Master's Degree programme at the University of South Africa, wish to request permission to conduct my study at your hospital. My research topic is "**The assessment of the continuing professional development of nurses in a selected public hospital in Kwa Zulu Natal**".

The study will employ a quantitative, non-experimental, descriptive design. Data collection will be by means of a self-designed questionnaire using a cross sectional approach. The study population will include all categories of nursing personnel employed on a full time basis at the hospital, who are registered with the SANC and who have given their consent to participate.

All information collected during the study will be used for research purposes only and the anonymity of every respondent is guaranteed.

I have enclosed a copy of the research proposal, informed consent form, data collection tool and the ethics committee clearance certificate from UNISA. I am most willing to address any concerns or questions you may have regarding my research and can be contacted at my email address as stated above. My supervisor is Professor Susan Hattingh and she can be contacted on [hattingh.susan@yahoo.com](mailto:hattingh.susan@yahoo.com). I look forward to a positive response and hope to hear from you soon.

Yours faithfully

  
Doshnee Pillay (Mrs)

## ANNEXURE C: LETTER OF APPROVAL FROM DEPARTMENT OF HEALTH



**health**  
Department:  
Health  
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,  
Private Bag X9051 PMB, 3200  
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782  
Email: hrkm@kznhealth.gov.za  
www.kznhealth.gov.za

**DIRECTORATE:**

Health Research & Knowledge  
Management (HKRM)

Reference: HRKM120/17  
KZ\_2017RP52\_799

05 April 2017

Dear Mrs D Pillay  
(University of South Africa)

**Subject: Approval of a Research Proposal**

1. The research proposal titled '**The assessment of continuing professional development of nurses in a selected hospital in KwaZulu-Natal**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at GJ Crookes Hospital

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

**Dr E Lutge**

Chairperson, Health Research Committee

Date: 05/04/17

## ANNEXURE D: ASSESSMENT OF DATA COLLECTION TOOL



(CK 96/28545/23)

*Specialists in Data Management and Statistical Analysis*

P.O. Box 665, Wits, 2050

Tel: (011) 717-1686, Fax: (011) 403-2373, E-Mail: [dmsa@wits.ac.za](mailto:dmsa@wits.ac.za)

VAT Number: 4020171528

---

To whom it may concern

**Ms Deshnee Pillay: The assessment of educational practices utilized in the continuing professional development of nurses in a selected public hospital in Kwa Zulu Natal**

I have reviewed the research proposal and draft questionnaire, and will be assisting the student with the statistical analysis of the data, for the above project.

A handwritten signature in cursive script, appearing to read 'Petra Gaylard'.

**Dr Petra Gaylard**

Consulting Statistician

Pr. Sci. Nat. (reg. no. 400052/14)

Tel 011 486 4836 / 083 255 9961

Email [petra@dmsa.co.za](mailto:petra@dmsa.co.za)

---

Members

MJ Paiker PhD(Wits) Professor LP Fatti MSc, DIC (London), PhD (Wits), MJ Greyling MSc(Stats)

## **ANNEXURE E: INFORMATION LETTER AND CONSENT FORM**

Dear Respondent

My name is Deshnee Pillay and I am a registered nurse specializing in nurse education. I am currently studying towards a Master's degree at the University of South Africa and wish to invite you to participate in my research. The title of my study is:

### **The assessment of the continuing professional development of nurses in a selected public hospital in KwaZulu-Natal**

The research will involve an assessment of factors that enable continuing professional development in the hospital. The significance of the study is that it will highlight strengths and weaknesses of current practices. The aim will be to use these research findings to plan for the successful operationalization of the pending Continuing Professional Development System soon to be implemented by the South African Nursing Council.

This letter is aimed at giving you as much information as possible regarding your participation. Please take note of the following:

1. This research has been approved by the Higher Degrees Committee of the Department of Health Studies at UNISA.
2. Consent to conduct this research has been given by the Chief Executive Officer of this institution and KZN Provincial Research & Ethics Committee.
3. Your participation in this study is totally voluntary; you are under no obligation to participate. You have the right to withdraw at any time without repercussion or penalty.
4. You will be required to complete a questionnaire which will require about 20 minutes of your time. Your name or any identifying particulars will not be required.
5. All information collected will be stored in a secure place and will only be accessible to me. Anonymity will be maintained at all times.
6. There are no potential risks or harm that are anticipated as this study has a non-experimental design.
7. I am available for any questions or concerns you may have, my contact details are as follows: Cell : 0827747997 / Email : [pillayd72@gmail.com](mailto:pillayd72@gmail.com)



8. Please be aware that should the study be published in nursing literature, names of respondents or the hospital will not be mentioned.
9. If you wish to participate in this study, please complete the following consent form before answering the questionnaire.
10. Your participation in this study is valued and appreciated.



**CONSENT FORM**

I, .....(Name and surname) have read and understood the above information letter. I understand that my participation is voluntary and that I may refuse to participate or withdraw at any time without penalty.

I hereby freely consent to take part in this research study.

\_\_\_\_\_  
**SIGNATURE OF RESPONDENT**

\_\_\_\_\_  
**DESIGNATION**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF RESEARCHER**

## ANNEXURE F: DATA COLLECTION INSTRUMENT

QUESTIONNAIRE NUMBER

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

Dear Respondent

Please **read** the following instructions **carefully** before answering the questions.

1. **All** questions must be answered.
2. Use blue or black ink to record your response.
3. Indicate your choice by circling the number on the right hand side corresponding to your answer.
4. Unless otherwise stated, mark only **one answer** per question.
5. Do **NOT** write your name anywhere on this questionnaire.

### SECTION A: DEMOGRAPHIC INFORMATION

1. What is your gender?

|            | Answer |
|------------|--------|
| 1.1 Male   | 1      |
| 1.2 Female | 2      |

2. What is your age group?

|                 | Answer |
|-----------------|--------|
| 2.1 20–30 years | 1      |
| 2.2 31–40 years | 2      |
| 2.3 41–50 years | 3      |
| 2.4 51–60 years | 4      |
| 2.5 61–65 years | 5      |

3. What is your designation at the hospital?

|                                   | Answer |
|-----------------------------------|--------|
| 3.1 Enrolled Nurse Assistant      | 1      |
| 3.2 Enrolled Nurse                | 2      |
| 3.3 Community Service Officer     | 3      |
| 3.4 Registered Nurse – general    | 4      |
| 3.5 Registered Nurse – speciality | 5      |
| 3.6 Nurse Manager – all levels    | 6      |

4. What is the highest education qualification that you have completed?

|                      | Answer |
|----------------------|--------|
| 4.1 Certificate      | 1      |
| 4.2 National Diploma | 2      |
| 4.3 Bachelors Degree | 3      |
| 4.4 Honours Degree   | 4      |
| 4.5 Masters Degree   | 5      |
| 4.6 Doctoral Degree  | 6      |

5. How many years (excluding your basic training) have you been registered as a practitioner with the South African Nursing Council (SANC)?

|                        | Answer |
|------------------------|--------|
| 5.1 Less than 1 year   | 1      |
| 5.2 2–5 years          | 2      |
| 5.3 6–10 years         | 3      |
| 5.4 11–20 years        | 4      |
| 5.5 21–30 years        | 5      |
| 5.6 More than 30 years | 6      |

6. How many years have you been employed at this hospital?

|                        | Answer |
|------------------------|--------|
| 6.1 Less than 1 year   | 1      |
| 6.2 2–5 years          | 2      |
| 6.3 6–10 years         | 3      |
| 6.4 11–20 years        | 4      |
| 6.5 21–30 years        | 5      |
| 6.6 More than 30 years | 6      |

7. In which department are you currently working? Please mark **one** option only.

|   | Answer |
|---|--------|
| 7.1 Rotational basis (Nursing students) | 1      |
| 7.2 Medical                             | 2      |
| 7.3 Surgical                            | 3      |
| 7.4 Theatre & CSSD                      | 4      |
| 7.5 Paediatrics                         | 5      |
| 7.6 Maternal & neonatal                 | 6      |
| 7.7 Emergency & Trauma                  | 7      |
| 7.8 Outpatients                         | 8      |
| 7.9 Nursing administration              | 9      |
| 7.10 Clinics (Gateway & HAST)           | 10     |

**SECTION B: LEADERSHIP ROLE IN CONTINUING PROFESSIONAL DEVELOPMENT (CPD) \*\***

\*\*CPD includes all learning activities such as in-service training, workshops, formal studies (full time and part time), seminars, journaling, teaching and research which enables one to keep updated with nursing practice.

**For each item please indicate to what extent you agree or disagree with the statement.**

|   | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|---|-------------------|----------|----------------------------|-------|----------------|
| 8. Management staff consult with nurses regarding decisions relating to CPD.                | 1                 | 2        | 3                          | 4     | 5              |
| 9. Management staff support nursing personnel in CPD.                                       | 1                 | 2        | 3                          | 4     | 5              |
| 10. Management staff informs nurses about changes and new developments in nursing education | 1                 | 2        | 3                          | 4     | 5              |
| 11. Management staff are proactive in addressing my concerns regarding CPD                  | 1                 | 2        | 3                          | 4     | 5              |
| 12. Management staff take an interest in helping me identify training needs                 | 1                 | 2        | 3                          | 4     | 5              |

13. What priorities does your manager consistently pay attention to? Rate how important each of the following is for your manager?

|                             | Very important | Important | Somewhat important | Not important | Not sure |
|-----------------------------|----------------|-----------|--------------------|---------------|----------|
| 13.1 Supervision of staff   | 4              | 3         | 2                  | 1             | 99       |
| 13.2 Attending meetings     | 4              | 3         | 2                  | 1             | 99       |
| 13.3 Staff development      | 4              | 3         | 2                  | 1             | 99       |
| 13.4 Problem solving        | 4              | 3         | 2                  | 1             | 99       |
| 13.5 Improving patient care | 4              | 3         | 2                  | 1             | 99       |

**SECTION C: POLICY & STRATEGY FOR CPD**

|  | No              | Yes            | Unsure         |
|--|-----------------|----------------|----------------|
| 14. Are you aware of the hospital's policy on continuing education and training? | 1<br>Go to Q 19 | 2<br>Go to Q15 | 3<br>Go to Q19 |

If you answered yes to question 14, state to what extent you agree or disagree with questions 15–18 with regard to the hospital’s policy on continuing education and training.

|  | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|--|-------------------|----------|----------------------------|-------|----------------|
| 15. The policy meets my educational needs and expectations                           | 1                 | 2        | 3                          | 4     | 5              |
| 16. Nursing staff are involved in the formulation of policies relating to training   | 1                 | 2        | 3                          | 4     | 5              |
| 17. There is a procedure for ensuring that the policy is made known to nursing staff | 1                 | 2        | 3                          | 4     | 5              |
| 18. The policy is implemented fairly and consistently at all times.                  | 1                 | 2        | 3                          | 4     | 5              |

#### SECTION D: PEOPLE DEVELOPMENT

Indicate to what extent you agree or disagree with the following statements.

|  | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|--|-------------------|----------|----------------------------|-------|----------------|
| 19. The hospital supports the development of nursing staff   | 1                 | 2        | 3                          | 4     | 5              |
| 20. The hospital recognizes nursing staff when they perform well in their studies  | 1                 | 2        | 3                          | 4     | 5              |
| 21. The hospital involves nursing staff in decisions concerning CPD  | 1                 | 2        | 3                          | 4     | 5              |
| 22. In my work I am always challenged to grow by participating in training   | 1                 | 2        | 3                          | 4     | 5              |
| 23. The performance appraisal (EPMDS) process helps me identify my personal strengths and areas where I need improvement | 1                 | 2        | 3                          | 4     | 5              |

#### SECTION E: RESOURCES FOR CPD

24. When did you last attend a training course that was funded by the hospital?

|   | Answer |
|---|--------|
| 24.1. 0–12 months ago   | 1      |
| 24.2. 13–24 months ago  | 2      |
| 24.3. More than 2 years ago   | 3      |
| 24.4. I have never attended any training that has been funded by the hospital | 4      |

Indicate to what extent you agree or disagree with the following statements

|  | Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
|--|-------------------|----------|---------------------------|-------|----------------|
| 25. I would be willing to pay for training that is of interest to me                           | 1                 | 2        | 3                         | 4     | 5              |
| 26. I am satisfied with the funding provisions made by the hospital for attendance of training | 1                 | 2        | 3                         | 4     | 5              |
| 27. The hospital has personnel that are specifically allocated to the training department      | 1                 | 2        | 3                         | 4     | 5              |
| 28. I am satisfied with the services provided by the training department                       | 1                 | 2        | 3                         | 4     | 5              |
| 29. There is a designated learning resource centre in the hospital                             | 1                 | 2        | 3                         | 4     | 5              |
| 30. There is a well-resourced library available in the hospital                                | 1                 | 2        | 3                         | 4     | 5              |
| 31. Online facilities are available for use in the hospital, e.g. computers /internet access   | 1                 | 2        | 3                         | 4     | 5              |

32. Have you at any point applied for study leave?

|           |           |
|-----------|-----------|
| No        | Yes       |
| 1         | 2         |
| Go to Q34 | Go to Q33 |

33. Indicate the result of your application for study leave.

|  | Answer |
|--|--------|
| 33.1 My application for study leave was approved | 1      |
| 33.2 My application for study leave was declined | 2      |

## SECTION F: PROCESSES OF CPD

34. In the **last year** have you participated in any form of CPD (training) that was provided by the hospital?

|           |           |
|-----------|-----------|
| No        | Yes       |
| 1         | 2         |
| Go to Q36 | Go to Q35 |

35. Indicate which of the following forms of CPD provided by the hospital that you have participated in, in the **last year**.

|                            | No | Yes |
|----------------------------|----|-----|
| 35.1 Bridging programmes   | 1  | 2   |
| 35.2 Post basic programmes | 1  | 2   |
| 35.3 Workshops             | 1  | 2   |
| 35.4 Conferences/seminars  | 1  | 2   |
| 35.5 In-service training   | 1  | 2   |

36. What are some of the barriers to attending CPD activities in the hospital? Mark the **three main barriers** that you experience in attending CPD activities in the hospital.

|   | Answer |
|---|--------|
| 36.1 Lack of time due to workload                   | 1      |
| 36.2 Staff shortages make it difficult to attend    | 2      |
| 36.3 I was not selected to attend                   | 3      |
| 36.4 Uninteresting topics                           | 4      |
| 36.5 Lack of funding for courses                    | 5      |
| 36.6 Negative attitude towards CPD in the workplace | 6      |
| 36.7 Other (please state ).....                     | 7      |

37. Are you aware of the mandatory Continuing Professional Development system soon to be implemented by the SANC?

| No        | Yes       |
|-----------|-----------|
| 1         | 2         |
| Go to Q40 | Go to Q38 |

38. Have you attended an information sharing session on the mandatory CPD?

| No        | Yes       |
|-----------|-----------|
| 1         | 2         |
| Go to Q40 | Go to Q39 |

39. How well would you rate your understanding of how this new system will work? Mark **one option** only.

|   | Answer |
|---|--------|
| 39.1 I have a good understanding of the proposed CPD system | 1      |
| 39.2 I need more clarification on the proposed CPD system   | 2      |
| 39.3 I don't understand the proposed CPD system at all      | 3      |

40. In your opinion whose responsibility is it to identify educational activities for nurses? Mark **one option** only.

|   | Answer |
|---|--------|
| 40.1 Individual responsibility of the nurse | 1      |
| 40.2 The employing institution              | 2      |
| 40.3 The South African Nursing Council      | 3      |

41. Please indicate if you have attended any courses/training on the following topics in the **past year**.

|   | No | Yes |
|---|----|-----|
| 41.1 Ethics and legal aspects of nursing  | 1  | 2   |
| 41.2 Training that is specific to the current speciality/department where you are working, e.g. midwifery, paediatrics, medical, surgical | 1  | 2   |
| 41.3 Leadership   | 1  | 2   |
| 41.4 Teaching and research (includes teaching of students)  | 1  | 2   |

42. Have you participated in any CPD activities that are **not** provided for by the hospital? These are courses/training **that you did in your off duty time at your own cost**.

| No        | Yes       |
|-----------|-----------|
| 1         | 2         |
| Go to Q44 | Go to Q43 |

43. If you answered yes to question 42, indicate which activities did you participate in.

|                                   | No | Yes |
|-----------------------------------|----|-----|
| 43.1 Studies on private basis     | 1  | 2   |
| 43.2 Workshops                    | 1  | 2   |
| 43.3 Reading nursing journals     | 1  | 2   |
| 43.4 Involved in a research study | 1  | 2   |
| 43.5 Online courses               | 1  | 2   |
| 43.6 Other (please state)         |    |     |

44. If you answered no to question 42, what are some of the reasons for you not to engage in continuing education on your own? Please mark the **three main** reasons that apply to you.

|  | Answer |
|--|--------|
| 44.1 Family and home circumstances take up my time                     | 1      |
| 44.2 Lack of finance   | 2      |
| 44.3 No access to computers to do online courses                       | 3      |
| 44.4 Do not subscribe to journals or nursing update literature         | 4      |
| 44.5 Satisfied with training opportunities provided by the institution | 5      |
| 44.6 It is not a requirement by the SANC                               | 6      |
| 44.7 Lack of study leave approval by hospital                          | 7      |



**SECTION G: RESULTS OF CPD****Indicate to what extent you agree or disagree with the following statements**

|   | Strongly Disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|---|-------------------|----------|----------------------------|-------|----------------|
| 45.CPD has helped me to improve patient care  | 1                 | 2        | 3                          | 4     | 5              |
| 46.CPD has improved my nursing skills   | 1                 | 2        | 3                          | 4     | 5              |
| 47.CPD has increased my knowledge about nursing   | 1                 | 2        | 3                          | 4     | 5              |
| 48.CPD has improved my attitude towards patient care  | 1                 | 2        | 3                          | 4     | 5              |
| 49. CPD meets my personal needs, e.g. promotion /salary   | 1                 | 2        | 3                          | 4     | 5              |
| 50. I provide feedback to my colleagues after I have attended CPD activities                                      | 1                 | 2        | 3                          | 4     | 5              |
| 51. I receive support in ensuring that I apply what I have learned to practice                                    | 1                 | 2        | 3                          | 4     | 5              |
| 52. I am satisfied with the current status of CPD in the hospital   | 1                 | 2        | 3                          | 4     | 5              |
| 53. The mandatory CPD that is soon to be implemented by the SANC will have positive outcomes for nursing practice | 1                 | 2        | 3                          | 4     | 5              |

**THANK YOU FOR PARTICIPATING IN THIS STUDY**



# ANNEXURE H: DECLARATION OF COMPLIANCE FORM: REGISTERED NURSE/MIDWIFE



**South African Nursing Council**  
(Under the provisions of the Nursing Act, 2005)

e-mail: registrar@sanc.co.za  
website: www.sanc.co.za

Cecilia Makiwane Building,  
602 Pretorius Street, Arcadia,  
Pretoria, 0083

Tel: 012 420-1000  
Fax: 012 343-5400

Private Bag X132, Pretoria, 0001  
Republic of South Africa

## Annexure 5.1

### CPD Declaration Form – Year 2015 (Registered Nurse/Midwife)

| 1. PERSONAL DETAILS                                   |   |                              |
|---|---|------------------------------|
| Surname   |   |                              |
| Given Names (as per ID Document/Passport)             |   |                              |
| SANC Reference Number                                 |   |                              |
| Identity Number (South African ONLY)                  |   |                              |
| If NOT South African                                  | Passport Number   |                              |
|   | Country of Origin   |                              |
|   | Expiry Date   |                              |
| 2. EMPLOYMENT DETAILS                                 |   |                              |
| Health District (Circle option)                       | <b>GAUTENG:</b> City of JHB   City of Tshwane   Ekurhuleni   Sedibeng   West Rand<br><b>MPUMALANGA:</b> Ehlanzeni   Gert Sibande   Nkangala   |                              |
| Type of Establishment/Health Facility (Circle option) | Public Health   Private Health   SAMHS   Department of Correctional Services   Full time student   Academic (employed)   NGO   Private Practice   Corporate   Retired   Unemployed   Non-health related |                              |
| Name of Institution (if applicable)                   |   |                              |
| Area of Practice: Unit or Department (if applicable)  |   |                              |
| 3. CPD REQUIREMENTS                                   |   |                              |
| THEMES  | CPD POINTS REQUIRED   | CPD POINTS AQUIRED THIS YEAR |
| Ethical and Legal                                     | 4   |                              |
| Area/Field of Practice                                | 6   |                              |
| Leadership and Management                             | 3   |                              |
| Teaching and Research                                 | 2   |                              |
| <b>Total number of CPD Points</b>                     | <b>15</b>   |                              |

*(Tick the box that applies)*

|   |   |
|---|---|
| I declare that this is a true record of my CPD points acquired for the period <b>July 2015</b> to <b>June 2016</b> and that I have kept the required <b>Portfolio of Evidence/Logsheets</b> supporting this declaration. <input type="checkbox"/> | I hereby apply for exemption from CPD requirements due to the Exemption Criteria number ____ (See next page) <input type="checkbox"/> |
|---|---|

Signature: .....

Date: .....

Date Submitted to SANC: .....

# ANNEXURE I: DECLARATION OF COMPLIANCE FORM: ENROLLED NURSE



**South African Nursing Council**  
(Under the provisions of the Nursing Act, 2005)

e-mail: registrar@sanc.co.za  
website: www.sanc.co.za

Cecilia Makiwane Building,  
602 Pretorius Street, Arcadia,  
Pretoria, 0083

Tel: 012 420-1000  
Fax: 012 343-5400

Private Bag X132, Pretoria, 0001  
Republic of South Africa

## Annexure 5.2

### CPD Declaration Form – Year 2015 (Enrolled Nurse)

| 1. PERSONAL DETAILS                                   |   |                              |
|---|---|------------------------------|
| Surname   |   |                              |
| Given Names (as per ID Document/Passport)             |   |                              |
| SANC Reference Number                                 |   |                              |
| Identity Number (South African ONLY)                  |   |                              |
| If NOT South African                                  | Passport Number   |                              |
|   | Country of Origin   |                              |
|   | Expiry Date   |                              |
| 2. EMPLOYMENT DETAILS                                 |   |                              |
| Health District (Circle option)                       | <b>GAUTENG:</b> City of JHB   City of Tshwane   Ekurhuleni   Sedibeng   West Rand<br><b>MPUMALANGA:</b> Ehlanzeni   Gert Sibande   Nkangala   |                              |
| Type of Establishment/Health Facility (Circle option) | Public Health   Private Health   SAMHS   Department of Correctional Services   Full time student   Academic (employed)   NGO   Private Practice   Corporate   Retired   Unemployed   Non-health related |                              |
| Name of Institution (if applicable)                   |   |                              |
| Area of Practice: Unit or Department (if applicable)  |   |                              |
| 3. CPD REQUIREMENTS                                   |   |                              |
| THEMES  | CPD POINTS REQUIRED   | CPD POINTS AQUIRED THIS YEAR |
| Ethical and Legal                                     | 3   |                              |
| Area/Field of Practice                                | 9   |                              |
| Leadership and Management                             | 1   |                              |
| Teaching and Research                                 | 2   |                              |
| <b>Total number of CPD Points</b>                     | <b>15</b>   |                              |

*(Tick the box that applies)*

|  |   |
|--|---|
| I declare that this is a true record of my CPD points acquired for the period <b>July 2015</b> to <b>June 2016</b> and that I have kept the required <b>Portfolio of Evidence/Logsheet</b> supporting this declaration. <input type="checkbox"/> | I hereby apply for exemption from CPD requirements due to the Exemption Criteria number ____ (See next page) <input type="checkbox"/> |
|--|---|

Signature: .....

Date: .....

Date Submitted to SANC: .....

# ANNEXURE J: DECLARATION OF COMPLIANCE FORM: ENROLLED NURSE AUXILLIARY



**South African Nursing Council**  
(Under the provisions of the Nursing Act, 2005)

e-mail: registrar@sanc.co.za  
website: www.sanc.co.za

Cecilia Makiwane Building,  
602 Pretorius Street, Arcadia,  
Pretoria, 0083

Tel: 012 420-1000  
Fax: 012 343-5400

Private Bag X132, Pretoria, 0001  
Republic of South Africa

## Annexure 5.3

### CPD Declaration Form – Year 2015 (Enrolled Nurse Auxiliary)

| 1. PERSONAL DETAILS                                   |   |                              |
|---|---|------------------------------|
| Surname   |   |                              |
| Given Names (as per ID Document/Passport)             |   |                              |
| SANC Reference Number                                 |   |                              |
| Identity Number (South African ONLY)                  |   |                              |
| If NOT South African                                  | Passport Number   |                              |
|   | Country of Origin   |                              |
|   | Expiry Date   |                              |
| 2. EMPLOYMENT DETAILS                                 |   |                              |
| Health District (Circle option)                       | <b>GAUTENG:</b> City of JHB   City of Tshwane   Ekurhuleni   Sedibeng   West Rand<br><b>MPUMALANGA:</b> Ehlanzeni   Gert Sibande   Nkangala   |                              |
| Type of Establishment/Health Facility (Circle option) | Public Health   Private Health   SAMHS   Department of Correctional Services   Full time student   Academic (employed)   NGO   Private Practice   Corporate   Retired   Unemployed   Non-health related |                              |
| Name of Institution (if applicable)                   |   |                              |
| Area of Practice:Unit or Department(if applicable)    |   |                              |
| 3. CPD REQUIREMENTS                                   |   |                              |
| THEMES  | CPD POINTS REQUIRED   | CPD POINTS AQUIRED THIS YEAR |
| Ethical and Legal                                     | 3   |                              |
| Area/Field of Practice                                | 10  |                              |
| Leadership and Management                             | 1   |                              |
| Teaching and Research                                 | 1   |                              |
| <b>Total number of CPD Points</b>                     | <b>15</b>   |                              |

(Tick the box that applies)

|  |  |
|--|--|
| I declare that this is a true record of my CPD points acquired for the period <b>July 2015 to June 2016</b> and that I have kept the required <b>Portfolio of Evidence/??Logsheets</b> supporting this declaration. <input type="checkbox"/> | I hereby apply for exemption from CPD requirements due to the Exemption Criterion number ____ (See next page) <input type="checkbox"/> |
|--|--|

Signature: .....

Date: .....

Date Submitted to SANC: .....

## ANNEXURE K: PORTFOLIO OF EVIDENCE



### South African Nursing Council CPD Portfolio of Evidence Cover Sheet

#### *Personal Details:*

|                       |  |
|-----------------------|--|
| Name & Surname        |  |
| SANC Reference Number |  |
| ID /Passport Number   |  |
| Professional Category |  |

**Please ensure the following are kept in the file (Tick once in file)**

- SANC CPD Logsheet
  
- CPD activity evidence (registers, certificates, results)
  
- Declaration of compliance form
  
- Proof of SANC registration: Annual Practicing Certificate

# ANNEXURE L: EXEMPTION FORM



**South African Nursing Council**  
(Under the provisions of the Nursing Act, 2005)

Cecilia Makiwane Building,  
602 Pretorius Street, Arcadia,  
Pretoria, 0083

Tel: 012 420-1000  
Fax: 012 343-5400

e-mail: [registrar@sanc.co.za](mailto:registrar@sanc.co.za)  
website: [www.sanc.co.za](http://www.sanc.co.za)

Private Bag X132, Pretoria, 0001  
Republic of South Africa

## CPD Exemption Application Form for the period 1 July to 30 June

| 1. PERSONAL DETAILS  |  |
|--|--|
| Surname  | These details will be verified against the register / <b>eRegister</b>   |
| Given Names  | As per ID Document / Passport  |
| SANC Reference Number  |  |
| Identity Number (South Africa ONLY)  |  |
| If NOT South African   | Passport Number  |
|  | Country of Origin  |
|  | Expiry Date  |
| 2. EMPLOYMENT DETAILS  |  |
| Health District (code)   | Circle the Health District in which you are employed in the list overleaf and write the code here.   |
| Type of Establishment  | List of establishments – drop down (electronic) or list of codes (printed). If printed, practitioner to circle code and write here.            |
| Name of Institution (if applicable)  |  |
| Area of Practice (code) (if applicable)  | Circle your Area of Practice in the list overleaf and write the code here. If not in the list, write details under OTHER (overleaf).           |
| 3. APPLICATION FOR EXEMPTION/ACCRUAL OF REDUCED NUMBER OF CPD POINTS   |  |
| I hereby apply for exemption from CPD requirements for <b>the period</b> due to the fact that:<br><i>(please tick one box)</i> |  |
| <input type="checkbox"/>   | I was engaged in <b>formal education and training</b> (full time programme) during part or all of <b>the period</b> .                          |
| <input type="checkbox"/>   | I was engaged on <b>military assignment outside South Africa</b> during part or all of <b>the period</b> .                                     |
| <input type="checkbox"/>   | I was off work on <b>sick leave for more than six months</b> during <b>the period</b> .  |
| <input type="checkbox"/>   | I was off work on <b>maternity leave</b> during <b>the period</b> .  |
| <input type="checkbox"/>   | I am a <b>retired nurse</b> who is no longer practising and I did not practise during <b>the period</b> .                                      |
| <input type="checkbox"/>   | I am <b>not actively involved in nursing</b> (although I prefer to maintain my registration) and I did not practise during <b>the period</b> . |
| <input type="checkbox"/>   | I am eligible for reduced number of points   |
| Signature: ..... Date: .....   |  |

VISION: Excellence in professionalism and advocacy for health care users  
CPD for Nurses Exemption Application Form: Generic V4 2014-10-10

## ANNEXURE M: LETTER FROM THE EDITOR



### Editing Confirmation

33 Alan Paton Avenue  
Scottsville  
Pietermaritzburg  
3201  
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Email: [admin@kznlanguageinstitute.com](mailto:admin@kznlanguageinstitute.com)  
Website: [www.kznlanguageinstitute.com](http://www.kznlanguageinstitute.com)

Registration number: 131 804 NPO

16/11/2017

Report on document by: Deshnee Pillay

Document title: The assessment of the continuing professional development of nurses at a selected public hospital in KwaZulu-Natal

This serves to confirm that the above document was edited by a member of the KZN Language Institute's professional English language editing team. The document was returned to the author with tracked changes and suggestions for improvement. It was the author's responsibility to attend to these. The final corrected document was not proofread.

Handwritten signature of Ms G. Coertze.

Ms G. Coertze *MSocSc (Culture, Communication and Media Studies)*  
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Handwritten signature of Ms J. Kerchhoff.

Ms J. Kerchhoff *BEd (Hons), MA (Applied Language Studies), CELTA*  
Director  
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*KZN Language Institute – Transforming Words*