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**STRATEGIES TO ENHANCE ATTENDANCE OF A CONTINUOUS
PROFESSIONAL DEVELOPMENT PROGRAMME FOR CRITICAL CARE
NURSE PRACTITIONERS AT A PRIVATE HOSPITAL IN GAUTENG**

BY

MYRA ELIZABETH VILJOEN

Student Nr 25407733

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Department of Nursing Science
University of Pretoria**

Supervisor: Dr IM Coetzee

Co-supervisor: Dr T Heyns

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Declaration

Student number: 25407733

I declare that **STRATEGIES TO ENHANCE ATTENDANCE OF A CONTINUOUS PROFESSIONAL DEVELOPMENT PROGRAMME FOR CRITICAL CARE NURSE PRACTITIONERS AT A PRIVATE HOSPITAL IN GAUTENG** is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

Name

Date

*This dissertation is dedicated to my
husband Corrie and my sons, Corné
and Michael Viljoen.*

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"I can do all things through Christ which strengthened me."

Philippians 4:13

First and foremost, to my heavenly Father who gave me the strength through difficult and trying times. I give Him all the glory and honour.

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Abstract

The public's demand for competent and safe health care obligates the profession to meet the challenges of high quality care with current knowledge and skills. The maintenance of competence and the participation in continuous professional development (CPD) has firmly been established as a professional standard with the purpose of ensuring the safety of the public. The enhancement and maintenance of knowledge and skills can be obtained through participation in CPD programmes. Despite the importance of CPD, not many critical care nurse practitioners avail themselves of the opportunity to attend CPD programmes.

The overall aim of this research was to reach consensus regarding the reasons for the unsatisfactory attendance of a CPD programme developed for critical care units in a private hospital in Gauteng. A consensus methodology was used to involve the critical care nurse practitioners in planning and prioritising strategies for a future continuous professional development programme. Using the nominal group technique the critical care nurse practitioners reflected on their experience related to the current CPD programme and provided inputs and ranked priorities. Fourteen critical care nurse practitioners participated in the nominal group session.

Consensus was reached regarding five priorities that should be implemented as strategies to enhance attendance of future CPD programmes. In rank order these priorities were communication, continuous professional development, clinical training, time constraints and financial implications. A central theme "attitude" was included as attitude has a powerful effect on all of the above mentioned priorities. In conclusion the study focussed on identifying and discussing the reasons for unsatisfactory attendance of a CPD programme. Based on the reasons identified priorities were set and strategies were collaboratively developed to enhance future attendance of a CPD programme.

Key words

Continuous professional development programmes, consensus methods, critical care nurse practitioner.

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List of abbreviations

CCN	Critical care nurse
CCNP(s)	Critical care nurse practitioner(s)
CCU	Critical care unit
CPD	Continuous professional development
JPM	Job performance management
RN	Registered nurse
SANC	South African Nursing Council

1. ORIENTATION TO THE STUDY

"No man teaches another anything. All we do is to prepare the way."

- St. Augustine -

1.1 BACKGROUND AND RATIONALE

Continuous professional development (CPD) has been linked to quality healthcare delivery. In the midst of continual advances in technology and changes in medical and nursing practice there is a need for CPD whilst working within the critical care unit (Huggins, 2004:38). Continuous professional development is an important activity as it provides professionals with *"new theories and evidence of what does and does not work"* in their profession, (Nsemo et al., 2013:328). The ultimate outcome of CPD for the critical care nurse practitioner (CCNP) is to practice as a competent nurse practitioner with current knowledge and skills in existing and new areas of practice in order to deliver quality patient care (Brand, de Jager & Latengan, 2006:25).

Continuous professional development is defined as a strategy to promote lifelong learning to enhance competencies (Konkol, 2005:70). Similarly, Skees (2010:104) define CPD as lifelong learning or continuing education. The American Nurses Association (2000) defines the concept as *"learning activities designed to augment the knowledge, skills and attitudes of nurses and therefore enrich the nurses' contributions to quality healthcare"*. Furthermore, CPD is the responsibility of the individual CCNP to systematically develop, maintain and broaden his/her knowledge, skills and attitudes (competencies) and provide safe and quality care. Thus participation in CPD ensures continuing competence as a professional nurse practitioner, (Skees, 2010:104; Kitto et al., 2013:144, Nsemo et al., 2013:328).

Worldwide countries have adopted CPD programmes to maintain the competencies of professional nurse practitioners. Following are two examples of such programmes.

- In the United Kingdom (UK), due to the rapidly changing healthcare environment, health professionals are increasingly required to respond and react to the multifaceted healthcare needs of patients through CPD (Casey & Clark, 2009:35).

- In Iran, the Iranian Nursing Organization acts as the exclusive nursing regulatory body and has reformed the system of accountability for nurse practitioners. Nurse practitioners previously registered just once, after graduation, as professional nurse practitioners. Currently these professional nurse practitioners are now required to demonstrate continuing competence through a structured CPD programme if they are to maintain their registration (Khomeiran et al., 2006:66-67).

From a South African perspective, CPD programmes are viewed as systematic efforts to provide a profession with members who are fully trained and competent (Kaye-Petersen, 2003:94). While most developed countries have an established history of professional development, in South Africa the focus on the skills of the nation's workforce in general is relatively new (Mokhele & Jita, 2010:1762; National Nursing Summit, 2012:24). Future prospective CCNPs will in the future be increasingly required to have the knowledge, skills and attitude to base care on evidence, use critical thinking and demonstrate advanced leadership and decision making skills. For this reason CPD programmes are regarded as vital to augment and maintain nurse practitioners' knowledge, skills and attitudes with the ultimate aim of improving patient outcomes (Nsemo et al., 2013:328).

Various data bases, for example CINAHL, Medline and SabiNet were searched for literature regarding CPD for nurses in South Africa. However, limited studies were found in the available literature on CPD that focus on nursing in specifically the South African context. Literature found focused on professions which fall under the authority of the Health Professions Council of South Africa (HPCSA) such as medical doctors, pharmacists, psychologists, physiotherapists and radiographers amongst others.

In 1997 the South African National Department of Health put into effect what is known as the *White Paper for transformation of the Health System* which was published in the Government Gazette no. 17910. One of the focus areas was a CPD programme for nurses (Fouché, 2007:53). As yet, no formalised CPD programmes or CPD requirements have been legislated for nurse practitioners in South Africa (National Nursing Summit, 2012:7). The South African Nurses Council's (SANC) CPD programmes are currently regarded as the focus area of the SANC although these are still in the development phase (SANC, 2011).

According to the policy of a private hospital group in South Africa, every nurse practitioner has to obtain a minimum of 22 hours of in-service training per year. This requirement was set as part of the CPD initiative by the hospital group in an effort to enhance quality patient care (Hospital Group Policy, 2010:2). In one of the hospitals of the hospital group, a CPD programme was developed by the management staff (comprising the unit managers and the clinical facilitator) for the critical care units (CCUs). The content was based on the findings of risk assessment done through clinical audits and clinical ward rounds (The Hospital, 2010). The CPD programme consisted of various sessions facilitated and presented by numerous professionals including medical doctors, CCPNs, a dietician, clinical facilitator and so forth. It was presented over an eight-month period and every topic was presented three times to ensure that all the CCNPs were given the opportunity to attend (The Hospital, 2010). In Table 1.1 a detailed layout of the 2010 CPD programme, presenters/facilitators and attendance over the eight-month period is given.

Table 1.1: CPD Programme and attendance for 2010

SESSIONS	PRESENTER/ FACILITATORS	ATTENDED BY			AVERAGE ATTENDANCE
		CCN	RN	TOTAL	
1. Haemodynamic monitoring	Clinical facilitator	5	1	16%	30 %
2. Respiratory workshop (acid base balance, ABG, X-rays, endotracheal intubations)	Clinical facilitator	8	2	27%	
3. Respiratory conditions	Medical doctor: physician	9	6	41%	
4. Mechanical ventilation	Representative of ventilator company	4	3	19%	
5. Oscillation workshop	Representative of ventilator company	6	4	27%	
6. Electrolyte disturbance	Critical care nurse practitioner	11	4	41%	
7. Renal failure and dialysis	Professional nurse: dialysis specialist	11	4	41%	
8. ECG	Clinical facilitator	2	8	27%	
9. Intra-aortic balloon pump (IABP) – Workshop	Representative of IABP company	4	7	30%	
10. Neurological system (raised intra- cranial pressure; nursing patient with intracranial drain, back and neck surgery)	Medical doctor: neurosurgeon Critical care nurse	9	7	44%	
11. Nutrition	Dietician	6	10	44%	
12. Infection control	CCN specialised in infection prevention	2	2	11%	
13. Record keeping	Clinical facilitator	8	6	38%	

Source: The Hospital CPD statistics (2010)

As reflected in Table 1.1, the attendance of the CPD programme was a challenge. Hospital managers attempted to increase the attendance by providing the CCNPs between 6 to 8 hours official on-duty time to attend the CPD sessions (The Hospital, 2010). This strategy did not have the desired outcome and the average attendance remained below 30% as depicted in Table 1.1. Additionally, only 33% of the CCNPs were able to provide a portfolio of evidence regarding participation in CPD on an extended deadline.

It is the opinion of Skees (2010:104) that CPD serves as “*a bridge to excellence*” in nursing practice. However, this idea can only be appropriated if the CCNP is willing to make a commitment to learn and apply new knowledge. In the healthcare profession, the expectations and demands from individuals and society for the delivery of competent and safe healthcare compel all providers to meet the challenges of high quality patient care with up to date knowledge and skills (Khomeiran et al., 2006:67; Kitto et al., 2013:142). As the clinical facilitator in the particular hospital the researcher was concerned about the CCNPs’ obvious low attendance to the CPD sessions. Since, according to literature, CPD not only plays a crucial role in the professional growth and development of the individual healthcare practitioners but also has a positive impact on the quality of patient care rendered, the researcher viewed the CCNPs’ lack of interest in the CPD sessions even more distressing. This challenged and motivated her to conduct this study to explore the reasons why CCNPs do not attend CPD sessions.

1.2 PROBLEM STATEMENT

At the time this study was conducted there was a structured CPD programme in place in the CCUs of a private hospital in Gauteng. This CPD programme had been developed and was implemented collaboratively by the hospital management and the clinical training department. The components included in this programme were identified by the clinical facilitator through a process of clinical audits and clinical ward rounds and include the 13 themes mentioned in Table 1.1. Despite various efforts from the hospital management and training department, unsatisfactory attendance of the CPD programme resulted in the inability of the hospital management to reach the set CPD objectives as indicated in the hospital policy (The Hospital policy, 2010) as evidenced by the data shown Table 1.1.

An ineffective or underutilised CPD programme can jeopardise the quality of patient care. The lack of an effective, well attended CPD programme has negative implications for the CCNP as competencies are not updated which in turn can have a negative impact on the quality of nursing care (Yang et al., 2013:199; National Nursing Summit, 2012:24). In the view of Munro (2008:954) CPD requires a collaborative effort from all stakeholders if it is to be successful. The stakeholders for the current CPD programme involved the hospital management and clinical facilitators. The CCNPs who are central to the CPD programme was excluded in the planning of the CPD programme. The researcher envisaged that a possible solution to overcome the challenge of unsatisfactory attendance might be to use consensus methods and collaboration to explore the factors that contributed to unsatisfactory attendance of the CPD programme by giving CCNPs an opportunity to voice their concerns and experiences pertaining to the CPD programme. By including the CCNPs which is consistent with the view of Munro (2008:954) and providing them with an opportunity to be actively involved in planning of a CPD programme and prioritising strategies to overcome unsatisfactory attendance may enhance the attendance of a future CPD programme.

1.3 RESEARCH QUESTIONS

- Why do the CCNPs not attend the CPD programme developed for the critical care units in a private hospital in Gauteng?
- Which strategies can be employed to enhance the attendance of a CPD programme?

1.4 AIM AND OBJECTIVES OF THE STUDY

The overall aim of the study was to obtain consensus regarding the reasons for the unsatisfactory attendance of a CPD programme developed for critical care nurse practitioners in a private hospital in Gauteng.

- **Objective 1:** To identify, describe and obtain consensus regarding the reasons for unsatisfactory attendance of the CPD programme by the CCNPs; and
- **Objective 2:** To collaboratively develop strategies to enhance the unsatisfactory attendance of future CPD programmes.

1.5 RESEARCHER'S FRAME OF REFERENCE

The researcher's frame of reference is discussed under the following headings: role of the researcher, the setting, the paradigm, and the clarification of key concepts.

1.5.1 Role of the researcher

The researcher has been a registered professional nurse since January 2003. She holds a diploma in Critical Care Nursing from the University of Pretoria where she completed her studies in 2006. The researcher also completed a BCur (I et A) Clinical degree in 2008 with an additional qualification in Nursing Education. She worked as a CCNP in the critical care setting from January 2005 till October 2008 after which she was appointed as clinical facilitator in the specialised units (critical care, high care and trauma unit) of the hospital where this study was conducted.

The researcher had a role in gaining entry to the research study site and obtained consent to conduct this study (view Annexure A). She did not experience any difficulty in gaining access to the study site or to obtain permission to execute the study since she was known to the management team of the hospital. As suggested by Creswell (2006:184), the researcher provided detailed information to the gatekeepers such as why the specific site had been chosen for the study, what activities would be involved, whether the services would be disrupted or not, how the results would be disseminated and what the benefits of the study would be to ensure that permission would be granted.

As the study involved exploring the researcher's immediate work setting, it was her role to make sure that multiple strategies were employed to warrant the validity of the collected data (view Annexure C) to create "*reader confidence in the accuracy of the findings*" (Creswell, 2006:184). A further role was to "*comment about sensitive ethical issues*" that might arise (view Annexure A) in such a manner that no participants' names or place names were disclosed (Creswell, 2006:184).

1.5.2 Setting

The study setting refers to “*the physical location and conditions*” in which the collection of data for the study took place (Polit & Beck, 2008:766). The setting for this study was one hospital which is part of a private hospital group which consists of hospitals and healthcare services. At the time of the study the hospital group owned 63 hospitals and same-day surgical centres with a total of 7 569 acute care beds of which 657 were critical care beds. The healthcare services had a total of 8 749 chronic beds for tuberculosis (TB), psychiatric care as well as long-term care to chronically ill elderly and frail patients. These hospitals provide a range of healthcare services throughout South Africa and are situated in seven of the country's nine provinces (The Hospital Group, 2010).

The immediate setting for this study was one of the private hospitals in the hospital group situated in a well-established district in Gauteng. It was licensed for 364 beds with different specialty areas (view Table 1.2). The study was conducted at a time when the hospital was in the process of increasing the number of critical care beds. The bed distribution as per discipline at the time of study is set out in Table 1.2.

Table 1.2: Bed distribution

UNIT	NUMBER OF BEDS
General units	
Surgical	93
Medical	33
Neuro-orthopaedic	31
Orthopaedic	26
Cardio ward	12
Cardiovascular	18
Maternity	12
Paediatric	26

UNIT	NUMBER OF BEDS
Specialised units	
General high care unit	21
Cardio and cardiothoracic high care unit	6
<i>Cardio and cardiothoracic critical care unit</i>	12
<i>General critical care unit</i>	14
Neonatal unit	6
Rehabilitation	21
Trauma	11
TOTAL NUMBER OF BEDS	342

Source: The Hospital (2010)

As reflected in Table 1.2 there were 342 beds operational in the hospital of which 26 accounted for the critical care units. The focus of the study was on CPD in the **critical care units (CCUs)** thus the immediate setting was the CCUs in this private hospital.

The specific CCUs made use of a mixed skills approach. The nurse practitioners in the CCUs consisted of critical care nurses (CCNs), registered nurses (RNs) and enrolled nurses (ENs). The nurse practitioner composition and allocation per CCU is set out in Table 1.3.

Table 1.3: Nurse practitioner composition

UNIT	BEDS	RANK	NUMBER OF PERMANENT EMPLOYED STAFF
Cardio and cardiothoracic critical care unit	12	CCN	11
		RN	7
		EN	4

UNIT	BEDS	RANK	NUMBER OF PERMANENT EMPLOYED STAFF
General critical care unit	14	CCN	11
		RN	7
		EN	4

Source: The Hospital (2010)

The number of permanently employed staff as set out in Table 1.3 included day and night nurse practitioners functioning in these units. The focal point was on the CCNs (22 in total) and RNs (14 in total) working in the critical care unit who are collectively referred to as *CCNPs* in the study.

1.5.3 Paradigm

Polit and Beck (2008:761) define a paradigm as a method of viewing natural phenomena that integrate a range of philosophical suppositions and that directs one's methodology to inquiry; this view "*influences the way knowledge is studied and interpreted*" (Burns & Grove, 2009:713). The choice of the paradigm establishes the "*intent, motivation and expectations for the research*" (Mackenzie & Knipe, 2006).

Research in nursing is mainly, although not exclusively, conducted within two broad paradigms, namely the positivist paradigm and the naturalistic paradigm (Polit & Beck, 2008:14). The naturalistic paradigm is also referred to as the constructivist paradigm (Polit & Beck, 2008:15). According to various literature sources, what used to be known as the constructivist paradigm has lately been discussed and referred to as the interpretivist paradigm (Cohen & Crabtree, 2008:333; Van Wynsberghe & Khan, 2007:89-90; Mackenzie & Knipe, 2006).

The interpretivist researcher takes participants' subjective experiences genuinely as the fundamental nature of what is real for the participants (Terre Blanche, Durrheim & Painter, 2006:274) and attempts to enter the participants' world to discover the "*practical wisdom*,

possibilities and understandings found there” and which are considered the goal of interpretivist research (Polit & Beck, 2008:229). The interpretivist approach does not focus on isolating and controlling variables, but on enhancing and broadening the power of everyday language and the “*expression*” to augment understanding of the social world we live in (Terre Blanche et al., 2006:274). The commitment to understand human phenomena in context, as they are lived, is at the centre of interpretivist research. It is the development of methodologies for understanding human phenomena “*in context*” (Terre Blanche et al., 2006:276; Cohen & Manion, 1994:36) thereby suggesting that reality is socially formed (Mertens, 2005:12). As far as possible the interpretivist researchers thus rely on the “*participants’ views*” of the phenomenon being studied (Creswell, 2006:8); these researchers recognise that their own background and experiences have an impact on their interpretation of the research.

In interpretivist research there is a circular relationship in which the researcher attempts to understand the “*whole text in terms of its parts, and the parts in terms of the whole*” (Polit & Beck, 2008:229). The researcher continuously questions the meaning of the text, looking for “*frames that shape meaning*” (Henning, van Rensburg & Smit, 2004:20). A characteristic of interpretivist research is that bracketing does not necessarily occur, meaning that the researcher does not keep her or his preconceived beliefs and opinions on a tight rein (Polit & Beck, 2008:229).

The researcher’s aim in this study was to obtain a better understanding of the CCNPs’ unsatisfactory attendance of the CPD programme from the participants’ point of views. Thus, this research study was based on an interpretivist research paradigm with the emphasis on experience and interpretation. The researcher strived to gather information from the participants related to unsatisfactory attendance of the current CPD programme in order to develop strategies to enhance future attendance of the CPD programme.

1.5.4 Clarification of key concepts

According to Brink, van der Walt and van Rensburg (2006:25), concepts are “*linguistic labels*” that are assigned to objects or events. Polit and Beck (2008:57) regard concepts as abstractions, referring to concepts as a term that is used to abstractly describe and name an object or a phenomenon, thus providing it with a “*separate identity or meaning*” (Burns & Grove,

2009:128). The key concepts relevant in this study are conceptually defined in Sections 1.5.4.1 through to 1.5.4.3.

1.5.4.1 Continuous professional development (CPD)

Continuous professional development (CPD) has been defined synonymously as lifelong learning or continuing education (Skees, 2010:104; Kemp & Baker, 2013:2). The American Nurses Association (2000:6) defines the concept as “*learning activities designed to augment the knowledge, skills and attitudes of nurses and therefore enrich the nurses’ contributions to quality healthcare*”. For the purpose of this study the above mentioned definition is applicable and applied to the CCNPs.

1.5.4.2 Critical care nurse practitioner (CCNP)

Nolan and Murphy (2006:119) view the critical care nurse practitioner as a registered nurse who provides direct patient care to the most seriously ill or injured patients, and who has the ability to lead, teach and advocate for the patients they serve. The activities of the critical care nurse practitioner include supporting and maintaining the physiological stability of patients, responding with confidence and adapting to rapidly changing patient conditions, responding to the unique needs of patients and families, managing the interface between patients and technology, and monitoring and allocating critical care services.

In the context of this study a critical care nurse practitioner was a professional nurse registered with the South African Nursing Council (SANC) and working in the critical care unit. Working in the critical care unit does not require the acquisition of a diploma or degree in critical care nursing. Thus, in this study the term CCNP referred to an experienced CCNP, not formally trained in critical care nursing and/or a formally trained CCNP, registered with the SANC under Regulation 212, (SANC, 1997).

1.5.4.3 Critical care unit (CCU)

The critical care unit can be defined as a highly sophisticated, modern and technologically advanced area in a hospital where patients receive invasive as well as non-invasive nursing interventions under the best possible conditions (Urden, Stacy & Lough, 2013:2). Patients who

experience actual or potential life-threatening health problems and who need continuous, complex monitoring and supervision, complex assessment, invasive and non-invasive interventions as well as intensive and vigilant nursing care are admitted to these areas (South African Society of Anesthesiologists 1999:16; Urden et al., 2013:2).

1.6 SIGNIFICANCE OF THE STUDY

An important consideration to keep in mind when selecting a research problem is whether the problem is of significance to nursing. This implies that the research study results should have the potential to contribute meaningful to nursing practice (Polit & Beck, 2008:86).

This study was of significance because by identifying the reasons for the CCNPs' unsatisfactory attendance of the CPD programme, recommendations could be made to overcome these challenges which might help to increase future participation in CPD activities. Increased participation in the CPD programme might lead to the achievement of the set objectives of the specific hospital that relate to the attendance of the CPD programme. An improvement in the attendance of the CPD programme might ensure that the CCNPs' knowledge, skills and attitude remains current. Through the use of current knowledge the quality of nursing care practice might increase which might result in enhancing the quality of patient care rendered. Gould, Drey and Berridge (2007:603) indicate that CPD is essential for all health workers due to its *"importance in the delivery of safe and effective care and its supposed role in securing job satisfaction and reduced attrition"*. In addition to providing safe and effective care, CPD helps to increase the CCNPs' *"knowledge, contributes to professional growth, and promotes critical thinking,"* (Skees, 2010:105).

1.7 RESEARCH DESIGN AND METHODS

The choice of the research design must be the design most appropriate to the research question (Brink et al., 2006:118). In this study a design that was qualitative and descriptive in nature was utilised. An in-depth discussion of this design is presented in Section 3.2 in Chapter 3.

Polit and Beck (2008:765) describe the research method as the steps, procedures and strategies utilised for gathering and analysing data in a research study. In this study a consensus method was used to collect and analyse the data. Consensus methods are “*qualitative systematic means to select outcome measures, to reveal trigger tools for adverse event detection and to develop expert consensus in health care*”, states Tammela (2013:111). In the view of Botma, Greef, Mulaudzi and Wright, (2010:251) consensus method refers to methods in which the study results are based on general agreement of the participating group members in other words consensus. An in-depth discussion of consensus method is presented in Section 3.3 in Chapter 3.

Furthermore, the research methods in this study are also discussed in terms of population, sampling, data collection and analysis, and the maintenance of rigour throughout the study (Hofstee, 2010:115). In Table 1.4 a summary follows of the above mentioned methods as applied in this study.

Table 1.4: Summary of the research method

POPULATION	SAMPLING	SAMPLE AND SAMPLE SIZE	DATA COLLECTION	ESTABLISHING TRUSTWORTHINESS
CCNPs working in the critical care units of the private hospital in Gauteng (Section 3.4.1)	Non-probability – purposive (Section 3.4.2)	14 CCNPs (Section 3.4.3)	1) Nominal group technique (Section 3.4.4)	Strategies used: Credibility Dependability Confirmability Transferability Authenticity (Section 3.5)

As shown in Table 1.4 the methods used in this study included the population identification, sampling, sample, the data collection and the establishment of trustworthiness. An in-depth discussion of these methods is presented in Chapter 3.

1.8 ESTABLISHING TRUSTWORTHINESS

The term trustworthiness used in qualitative research refers to how much confidence the researcher has in his or her data. This confidence is obtained by assessing the data using various criteria such as credibility, dependability, transferability, confirmability, and authenticity (Polit & Beck, 2008:768). Trustworthiness is concerned with the quality of the data presented in qualitative research; the data obtained must accurately reflect the experiences of the participants. According to Lincoln and Guba (cited in Polit & Beck, 2008:196), trustworthiness covers aspects like the “*credibility, transferability, confirmability, dependability and authenticity*” of the study results.

Although the criteria for trustworthiness as applied in this study are discussed more comprehensively in Chapter 3, in Section 3.6, it is shortly mentioned here. **Credibility** means that the study results should be a true representation of the phenomenon under study. **Dependability** is about getting consistent and accurate results. **Confirmability** refers to the data being confirmed as a true reflection of the information that was presented by the study participants. **Transferability** means that the results of the study could be applicable to other different settings. **Authenticity** refers to a research report that shows the diversity that was portrayed by the study participants (Polit & Beck, 2008:539-540).

In Table 1.5 a summary of the strategies implemented to enhance trustworthiness in this study is presented.

Table 1.5: Strategies to enhance trustworthiness

CRITERIA	STRATEGIES	APPLICATION
Credibility	Prolonged engagement	<ul style="list-style-type: none"> The researcher strived to be engaged in fieldwork for a sufficiently long period of time to ensure data saturation and not to disengage simply because a convenient stopping point has been reached.
	Member checking	<ul style="list-style-type: none"> Feedback was provided to participants to confirm that the gathered data were correctly interpreted.
	Comprehensive and vivid recording of data	<ul style="list-style-type: none"> Comprehensive field notes were kept containing rich descriptions of what transpired in the field. Audiotaping was done to aid in the gathering and recording of the data. The logging of decisions made was maintained.
	Data saturation	<ul style="list-style-type: none"> The researcher planned to ensure data saturation through prolonged engagement in fieldwork. Once no new categories or themes emerged from the data as it was collected, two more rounds of round robin recordings were done to verify data saturation.

CRITERIA	STRATEGIES	APPLICATION
Dependability	Comprehensive record keeping and decision trails	<ul style="list-style-type: none"> • Comprehensive field notes were kept containing rich descriptions of what transpired in the field. • Audiotaping was used to aid in the gathering and recording of the data. • The logging of decisions made was maintained.
	Member checking	<ul style="list-style-type: none"> • Feedback was provided to participants to confirm the obtained data were correctly interpreted.
	Data and method triangulation	<ul style="list-style-type: none"> • Data triangulation was done in the form of person triangulation. Data were collected from different participants. • Method triangulation was done in the form of multiple data collection methods (interviews and nominal group technique).
Transferability	Thick description	<ul style="list-style-type: none"> • Rich, thorough, vivid descriptions were provided in the dissertation related to the research context, the participants and the experiences and processes observed during the inquiries. • The researcher strived to ensure that sufficient information was provided to allow the readers to make judgments related to contextual similarities.
	Comprehensive field notes	<ul style="list-style-type: none"> • Comprehensive field notes were kept containing rich descriptions of what transpired in the field.
	Saturation of data	<ul style="list-style-type: none"> • The researcher ensured data saturation through prolonged engagement in fieldwork. • Once no new categories or themes emerged during the data collection, two more rounds of round robin recordings were done to verify data saturation.

CRITERIA	STRATEGIES	APPLICATION
Confirmability	Careful documentation	<ul style="list-style-type: none"> Comprehensive field notes were kept containing rich descriptions of what transpired in the field. Audiotaping was used to aid in the gathering and recording of the data. The logging of decisions made was maintained.
	Independent coder checks	<ul style="list-style-type: none"> Through the use of a co-coder, themes and categories identified were verified to ensure that the researcher correctly interpreted the collected data.
Authenticity	Reflective journal	<ul style="list-style-type: none"> A reflective notes was used by the researcher to bracket preconceived ideas.
	Prolonged engagement	<ul style="list-style-type: none"> The researcher scheduled a long enough period of time and sufficient resources to engage in fieldwork. Prolonged engagement led to building trust and rapport with the participants which ensured that useful and accurate information was obtained.
	Thick vivid description of data and effective, evocative writing	<ul style="list-style-type: none"> Comprehensive field notes were kept containing rich descriptions of what transpired in the field. Audiotaping was used to aid in the gathering and recording of the data. The logging of decisions made was maintained.

(Source: Polit & Beck, 2008:542; Brink et al. 2006:118-119)

As reflected in Table 1.5, various strategies were used in this research study to enhance the trustworthiness of the study findings. As mentioned before, the in-depth discussion of trustworthiness is provided in Chapter 3.

1.9 ETHICAL CONSIDERATIONS

Ethical considerations are particularly prominent in nursing research (Polit & Beck, 2008:167). A researcher has the responsibility to conduct research in an ethical manner, failure to do so weakens the scientific process and may have negative consequences (Brink et al., 2006:30) as most often research involves human beings or animals. The violations of human rights during research studies in the earlier decades led to the development of various codes of ethics. The most widely known of these codes is the Belmont Report which not only provides a standard for many of the guidelines adopted by disciplinary organisations but and also serves as the basis for regulations affecting research (Polit & Beck, 2008:168-169). Conducting the current study, the researcher was thus especially careful to adhere to the ethical considerations contained in the Belmont Report (Polit & Beck, 2008:170-174).

Detailed discussions regarding ethical considerations also emerge in Brink et al. (2006:30-35) and Burns and Grove (2009:188-199). Three primary ethical principles have been identified which influence the conduct in nursing research: beneficence, respect for human dignity, and justice (Polit & Beck, 2008:170). These principles are discussed briefly in Sections 1.9.1 through to Section 1.9.3.

1.9.1 Beneficence

According to Polit and Beck (2008:170), beneficence is the most important principle in research as it imposes the responsibility of securing the well-being of participants upon the researcher. The researcher needs to ensure that the risk of harm is minimised and benefits are maximised for the participants. The principle of beneficence includes the right to freedom from harm and discomfort and the right to protection from exploitation (Polit & Beck, 2008:170) as discussed in Sections 1.9.1.1 and 1.9.1.2.

1.9.1.1 The right to freedom from harm and discomfort

Participants have various aspects of well-being which need to be protected, namely physical, emotional, social and financial well-being (Polit & Beck, 2008:170). No unnecessary risks for harm or discomfort should be imposed on participants in a research study and their participation

must be essential to achieving the research objectives (Polit & Beck, 2008:170). In this research study there were no risks of physical, psychological or social harm. Participants might have experienced slight discomfort in terms of time needed for the group session, but the researcher strived to minimise this discomfort by adhering to the scheduled time for the nominal group session. The researcher did not need to extend the set timeframe.

In addition the small risk for emotional harm (such as stress or fear) was minimised through the reassurance that the data collected would be treated confidentially and that nothing of the information shared by any participant would be used or held against him or her in any way. The risks for financial harm were minimised to the minimum as participants only had to pay for their own transport to the venue where the nominal group session was held. The researcher was able to negotiate with the management of the hospital that the nominal group session could be held during on-duty time. The researcher supplied the participants with refreshments.

1.9.1.2 The right to protection from exploitation

The right to protection from exploitation implies that the research study should not place the participants at a disadvantage or expose them to situations for which they have not been prepared (Polit & Beck, 2008:171). In this study the researcher assured the participants that their participation and the information they were willing to share would not be used against them in any way. The researcher made a point of adhering to all agreements made between her and the participants to not exploit the researcher-participant relationship; the researcher and the independent expert facilitator made sure that the nominal group session did not exceed the timeframe agreed upon beforehand.

1.9.2 Respect for human dignity

The second ethical principle articulated in the Belmont Report is respect for human dignity which is concerned with the right to self-determination and the right to full disclosure. This principle was adhered to in the current study.

1.9.2.1 The right to self-determination

The right to self-determination means that an individual has the right to decide whether or not she or he wants to participate in a study with no risk of penalty or prejudicial treatment (Polit & Beck, 2008:172). It also implies that the participant has the right to withdraw from the study at any time if the need arises, to refuse to give information she or he is not comfortable to give or to ask for clarification about the purpose of the study if it is unclear to her or him (Brink et al., 2006:32).

In the current study the researcher ensured verbally as well in writing that all the participants understood that their participation was voluntary; it was their own decision whether they wanted to participate or decline participation thus there was no coercion involved. The participants were further guaranteed that, if they wished to withdraw at any time from the study, they could do so without stating a reason and without prejudice.

1.9.2.2 The right to full disclosure

For the participants to give consent to participate in the study, they had the right to full disclosure. Full disclosure mean that the researcher had to fully described the nature of the study, the participant's right to refuse participation, the researcher's responsibilities, and also the risks and benefits involved in the conduction of the study (Polit & Beck, 2008:172).

Full disclosure was given to all prospective participants in this study without any covert data collection, concealment or deception techniques involved. Full disclosure of all relevant information was done in the information leaflet which also served as the consent form. The researcher was also available to clarify any uncertainties related to the research study.

1.9.3 Justice

The third principle in the Belmont Report, namely that of justice, was maintained throughout the current study. This principle relates to the fact that participants have the right to fair treatment and the right to privacy (Polit & Beck, 2008:173).

1.9.3.1 *The right to fair treatment*

In accordance with the justice principle, the researcher is obliged not to exploit participants simply for the advancement of knowledge; participants should be selected based on the eligibility criteria and not due to “*vulnerability or compromised position*” since justice involves “*fairness and equity*” (Polit & Beck, 2008:173). Also, the benefits and burdens of the research study must be equally distributed. The principle of justice not only focuses on a fair selection of participants but also involves the fair treatment of people who decline to participate in the study or who choose to withdraw from the study (Polit & Beck, 2008:173).

The researcher strived to obtain a fairly selected group of participants for the current study through purposive sampling. She also ensured that she treated all participants, including those who declined and who decided to withdraw during the course of the study, equally and without prejudice.

1.9.3.2 *The right to privacy*

The principle of privacy relate to an individual’s right to control the time, extent, and general circumstances under which personal information will be shared with or withheld from others. This information involves an individual’s “*attitudes, beliefs, behaviors, opinions, and records*” (Burns & Grove, 2009:195).

The researcher made certain that strict confidentiality was maintained throughout the study. No information was used in any manner that revealed the participants’ identities. The research study was not more intrusive than required to achieve the study’s objectives and the participants’ privacy was respected and protected at all times during the study as well as thereafter.

1.10 DISSEMINATION OF RESULTS

A research study is not completed until the results have been shared (Polit & Beck, 2008:691). The results of the current study will be shared with the participants. It will be published as an article in a scientific journal and will be presented at national conferences.

1.11 LAYOUT OF THE STUDY

The study will be disseminated in five chapters. The layout of the study is illustrated in Figure 1.1.

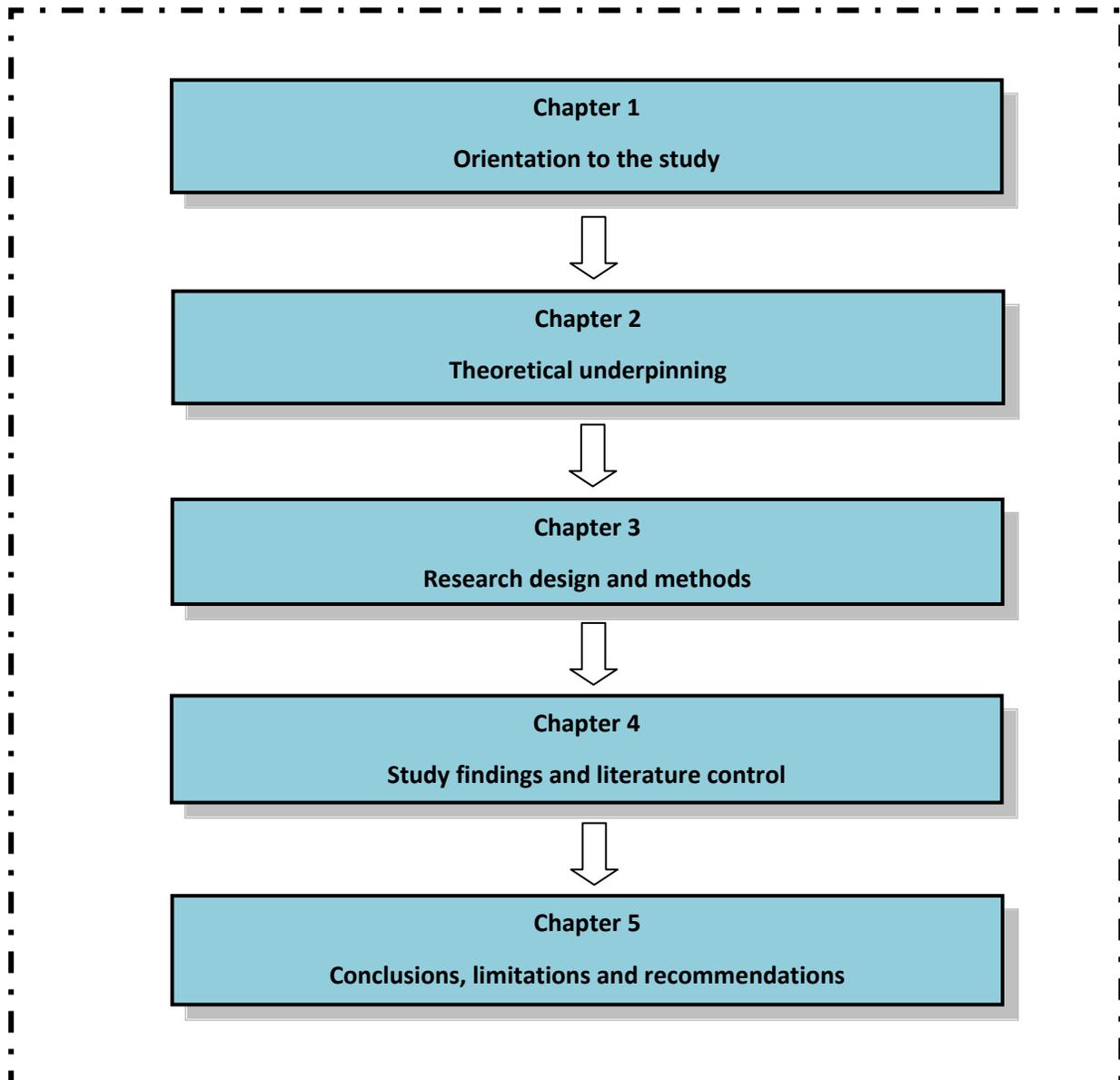


Figure 1.1: Overview of the chapter layout

1.12 CONCLUSION

The overall aim of the study was to obtain consensus regarding the reasons for the unsatisfactory attendance of a CPD programme developed for critical care nurse practitioners in a private hospital in Gauteng. Attendance of the CPD programme was a challenge despite the professional and personal advantages as promoted by Mokhele & Jita, (2010:1765). For the CPD programme to be successful it must be meaningful to and respond to the needs of the CCNPs (Mokhele & Jita, 2010:1765). By identifying, describing and obtaining consensus with regard to the reasons for the unsatisfactory attendance of the CPD programme by the CCNPs, strategies could be developed to enhance the future attendance of the CPD programme.

In Chapter 1 an overview of the research study was provided. In Chapter 2 an in-depth discussion follows with regard to CPD and adult learning.

3. RESEARCH DESIGN AND METHODS

“There are no mistakes, no coincidences, all events are blessings given to us to learn from.”

- Elisabeth Kubler-Ross -

3.1 INTRODUCTION

In Chapter 2 an in-depth discussion was provided on CPD and adult learning. Chapter 3 discusses the use of a nominal group technique as a consensus methodology in-depth. A consensus method was utilised in this study as this type of research is becoming more and more used to bring about change. Focusing on the CCNP to provide inputs in future CPD programmes was regarded as vital for success in the implementation and enhancement of attendance of the CPD programme. In addition, an in-depth description of the research design as well as trustworthiness is also provided.

3.2 RESEARCH DESIGN

A research design is the “*overall plan for addressing the research question*” and is dependent on the intentions of the researcher and the aims of the research; the research design also includes the “*specifications to enhance the study’s integrity*” (Polit & Beck, 2008:764) to ensure that the factors that could influence the validity of the study is controlled (Burns & Grove, 2009:696). According to Green and Thorogood (2005:34), a qualitative research design refers to “*the what, how and why of data production*”. As stated in Section 1.7, a qualitative descriptive research design was chosen to describe the reasons for the unsatisfactory attendance of the CPD programme by the CCNPs and to develop strategies to enhance future attendance of a CPD programme. The research design used is discussed in-depth in Sections 3.2.1 and 3.2.2.

3.2.1 Qualitative design

A qualitative design is used when the researcher wants to “*explore the meaning, or describe and promote understanding of human experiences*” (Brink et al., 2006:113). The foundation of qualitative research lies in the interpretive approach to social reality and the description of human beings (Holloway & Wheeler, 2010:3; Leedy & Ormrod, 2005:94). As indicated by Leedy

and Ormrod (2005:94), the qualitative research approach is also “*referred to as the interpretive, constructivist or postpositivist approach.*” Offredy and Vickers (2010:22) observe there is a social component to everything individuals do and experience which is reflected in their “*attitudes to, experiences of, confrontations with and perceptions of society*” and their place in it. Qualitative research is a type of inquiry that focusses on the way individuals make sense of their experiences and the world in which they live (Holloway & Wheeler, 2010:3; Leech & Onwuegbuzie, 2007:557; Leedy & Ormrod, 2005:94).

The term ‘qualitative research design’ is an “*umbrella term for a wide variety of approaches to and methods for the study of natural social life*” (Saldaña, 2011:3) and mainly focusses on qualitative aspects such as meaning, experience and understanding (Brink et al., 2006:10). In addition, Holloway and Wheeler (2010:3) view qualitative designs as a way to acquire insights by discovering meanings through the exploration of the behaviour, feelings and experiences of individuals and that which lies at the centre of their lives. Leech and Onwuegbuzie (2007:557-558) state qualitative research is used to achieve a “*more naturalistic, contextual and holistic understanding of human beings in society*”. These authors add qualitative research is extremely valuable for gaining insights into unusual or problematic experiences and that the meanings attached to these experiences can lead to a better understanding of the phenomenon. Thus, qualitative research is valuable in assisting to gather descriptions of other people’s ideas, thoughts, feelings, attitudes and values.

Qualitative researchers frequently commence with general research questions rather than a specific theory. From these questions a wide amount of verbal data is collected from a small number of participants. By organising the data into a design that gives the data coherence as well as using verbal descriptions to describe the studied phenomenon, the researcher arrives at findings which will assist with enhancing a better understanding of the topic under study (phenomenon). A qualitative study will most probably end with tentative answers or hypotheses about what was observed (Leedy & Ormrod, 2005:94).

As indicated by Green and Thorogood (2005:5), qualitative research differs from quantitative research in that qualitative data use language data (written or verbal) whereas quantitative research uses numerical data. The general aim of the questions asked by qualitative researchers is to seek answers to questions about the “*what, how or why*” of a phenomenon

instead of focussing on “how many or how much” (Green & Thorogood, 2005:5). Qualitative researchers search for a better understanding of complex situations and their research is usually exploratory in nature; they use their observations to build theory from the ground up (Leedy & Ormrod, 2005:95).

According to Leech and Onwuegbuzie (2007:560), qualitative research has many positive characteristics. Most importantly, qualitative research provides natural occurring information that allows researchers to increase their understanding of the phenomenon. Secondly, qualitative research data tend to be collected in close proximity to the specific situation, for instance, through direct observation or interview with the influence of the confined context being taken into consideration and not being discarded. Thirdly, qualitative research frequently includes some intrinsic richness and holism with the intense possibility of enlightening complexity that generates thick, rich descriptions to facilitate contextualisation. Fourthly, qualitative research data are mostly collected over a lengthy period of time, thereby permitting for the longitudinal analyses of the data. Finally, qualitative data often focus on individuals’ lived experiences and thus allow researchers to study the phenomenon and attempt to make sense of it with respect to the meanings people bring to it. This point of view of Leech and Onwuegbuzie (2007:560) is supported by Green and Thorogood (2005:19,22) as well as by Leedy and Ormrod (2005:95).

A qualitative design is an adaptable and evolving research process. As the study progresses ongoing decisions are made, reflection is done on what has already been learned about the phenomenon and therefore a qualitative design is also referred to as an ‘emergent design’ (Polit & Beck, 2008:219; Burns & Grove, 2009:51; Leedy & Ormrod, 2005:95). A qualitative design is thus not a single approach to research but embraces a number of approaches which have their roots in the interpretive methodologies. An emergent design is not indicative of “*sloppiness or laziness*” (Polit & Beck, 2008:219) on the part of the researcher but instead it is a reflection of the researcher’s desire to have an enquiry which is based on the realities and viewpoints of the participants (Polit & Beck, 2008:219; Burns & Grove, 2009:51; Offredy & Vickers, 2010:22). Qualitative researchers do not have preconceived ideas and focus on the participants’ interpretation of the specific event and circumstances and not on the researcher’s interpretations. Although a qualitative design does not require a rigid design, it is a systematic and precise process that requires “*high skill in conceptualization, imaginative reasoning, and elegant expression*” (Burns & Grove, 2009:51).

Due to the fact that a qualitative design adopts a “*person-centred and holistic perspective*” (Holloway & Wheeler, 2010:11), this design is useful when the researcher wants to “*explore the meaning, or describe and promote understanding of human experiences*” (Brink et al., 2006:113). This is an important aspect for health care professionals who “*focus on caring, communication and interaction*” (Holloway & Wheeler, 2010:11). The questions asked by a qualitative researcher generate data which enhance the understanding of the phenomenon under study (Green & Thorogood, 2005:6). The phenomenon under study in the current study was: ‘Why do CCNPs not attend the CPD programme developed for the critical care units in a private hospital?’ Polit and Beck (2008:219) identify six characteristics of qualitative designs which were applied in this study and are discussed in Section 3.2.1.1.

3.2.1.1 Characteristics of qualitative research

The characteristics of a qualitative research design identified by Polit and Beck (2008:219) are underscored by authors such as Offredy and Vickers (2010:24-27) and Holloway and Wheeler (2010:3). The application of these characteristics as applied in this study is delineated in Table 3.1.

Table 3.1 Application of qualitative research characteristics in this study

CHARACTERISTIC	APPLICATION
<ul style="list-style-type: none"> • Flexible and elastic <p>This approach is not tightly fixed which leads to a fluid and dynamic approach; thus the research questions and the data collection process might be changed or refined for the better due to what is being learned during the progress of the research study.</p>	<p>A flexible approach was used in order to accommodate changes during the nominal group technique which enhanced a wider variety of views on the phenomenon under study, ensuring a more comprehensive and a more complete data collection process.</p>
<ul style="list-style-type: none"> • Views the phenomenon holistically in order to understand it in its entirety. 	<p>All the data collected during data collection were included in the data analysis. This led to the production of more comprehensive, innovative and creative descriptions of the phenomenon.</p>

CHARACTERISTIC	APPLICATION
<ul style="list-style-type: none"> Qualitative research is conducted in the natural setting. 	<p>The data collection was done in the natural setting to gain insight and improve the researcher's understanding of the phenomenon under study. By exploring the depth, richness, and complexity of the phenomenon resulted in a better understanding of the phenomenon.</p>
<ul style="list-style-type: none"> Requires the researcher to be intensely involved, often "<i>remaining in the field for lengthy periods of time</i>" (Polit & Beck, 2008:219). 	<p>The researcher was directly involved with the participants and had an emic perspective on the phenomenon. The researcher spent a vast amount of time in the field and strived to gain complete understanding.</p>
<ul style="list-style-type: none"> Combine various data collection methods (triangulation). 	<p>Due to the emergent nature of qualitative research, the researcher was able to modify the data collection to obtain the best possible data to answer the research question, for example, a nominal group technique and individual ideas.</p>
<ul style="list-style-type: none"> Requires the researcher to become the "<i>research instrument</i>" (Polit & Beck, 2008:219). 	<p>The researcher was part of the study and responsible for various aspects of inquiry, including the data collection and analysis. The researcher's participation enhanced the richness of the data. The researcher had known the participants for a long time and "<i>so the researcher's views are also important to understanding</i>" the phenomenon (Offredy & Vickers, 2010:26).</p>
<ul style="list-style-type: none"> Requires ongoing analysis of the data collected in order to "<i>formulate subsequent strategies</i>" and to determine when data saturation has occurred (Polit & Beck, 2008:219). 	<p>Data analysis was done throughout the nominal group technique to determine whether the data collection strategy needed to be modified to improve the data collection should the need arise.</p>

Source: adapted from Polit et al. (2008:219)

As depicted in Table 3.1, a qualitative research design was appropriate to this study to provide answers to the research question. In Section 3.2.1.2 additional elements of a qualitative design are discussed.

3.2.1.2 Additional elements of a qualitative design

The following additional elements of qualitative designs have been identified (Gilles & Jackson, 2002:186; Holloway & Wheeler, 2010:3; Offredy & Vickers, 2010:27) to further validate the use of a qualitative design in a research study.

- **The primacy of data**

The research data enjoy priority above the theoretical framework which should not be predetermined but should emerge from the research data. Researchers normally approach individuals with the aim of gaining insight about their concerns; they approach the participants to collect rich and in-depth data which can then become the basis for theorising. A qualitative design is committed to identify an approach to ensure an understanding supportive of the phenomenon studied; understanding and generalisation are mainly based on the collected data. Qualitative designs are not static but developmental and dynamic in character; the focus is on the process as well as on the outcome (Holloway & Wheeler, 2010:4).

- **Identification of perspectives**

Qualitative designs are used when there is a need to fully explore a phenomenon about which little is known. The decision with regard to which research design to use is guided by the type of information required to answer the research question and the new information obtained in the field. Qualitative designs do not depend on a preset design (Holloway & Wheeler, 2010:4).

- **The existence of multiple realities**

There is more than one reality or truth and it is the researcher's responsibility to identify these realities and the ways in which the participants' views are constructed around what they believe to be the truth (Holloway & Wheeler, 2010:6).

- **Commitment to the participants**

The researcher is committed to the participants' viewpoints and acknowledges the participants in the research process. The researcher must be sensitive to the context of the research and immerse her- or himself in the setting and situation. In this study the researcher is a co-participant and strived to understand the participants' viewpoints as advised by Holloway and Wheeler, (2010:8).

- **Emic perspective**

Qualitative designs are linked to the subjective nature of social reality and provide insights from the perspective of participants, enabling the researcher to view events as the participants do. The researcher therefore explores "*the insiders' view*" (Holloway & Wheeler, 2010:6). In this study the researcher was directly involved in the provision of CPD in the CCUs.

- **Rich description**

Rich descriptions involve detailed portrayals of the participants' experiences, uncovering feelings and the meanings of their actions (Holloway & Wheeler, 2010:7). The participants were provided with a worksheet to make written comments with regard to what their views were on why CCNPs did not attend the CPD programme (view Annexure C).

- **Reflexivity**

Reflexivity refers to critical reflection on what has been thought and done in a qualitative research study. It locates the researcher in the study and is a conscious attempt by the researcher to acknowledge her or his own involvement in the study (Holloway & Wheeler, 2010:8).

3.2.2 Descriptive design

The term 'description' refers to the intensive examination of a phenomenon and its deeper meaning resulting in a more detailed description of the phenomenon under study (Rubin & Babbie, 2001:125). Descriptive designs are defined as research that has as its primary objective the "*accurate portrayal of the characteristics of persons, situations, or groups, and/or the*

frequency with which the certain phenomena occur" (Polit & Beck, 2008:752). Thus, descriptive qualitative research designs are used to gain accurate information about characteristics of persons, situations, or groups within a specific field of study. The purpose is to provide a picture of situations as they occur naturally through exploring and describing the phenomenon (Burns & Grove, 2009:45).

A descriptive design describes the variables (Brink et al., 2006:102; Polit & Beck, 2008:274) and uses the research data to answer the research question. In many aspects of nursing a phenomenon must be clearly delineated before prediction or causality can be examined – but descriptive designs do not determine the cause-effect relationship (Brink et al., 2006:102). Descriptive designs *"may be used to develop theory, identify problems with current practice, justify current practice, make judgments, or determine what others in similar situation are doing"* (Burns & Grove, 2009:237). Qualitative descriptive researchers attempt to present comprehensive summaries of the phenomenon in everyday language. Qualitative descriptive research tends to be diverse and is based on the general premises of naturalistic inquiry (Polit & Beck, 2010:273).

In this study the researcher used a typical descriptive design as the intention was to merely search for accurate information regarding the characteristics of a particular situation namely, why CCNPs do not attend the CPD programme. A descriptive design is especially useful when there is little known about the phenomenon (LoBiondo-Wood & Haber, 2006:240; Brink et al., 2006:102; Burns & Grove, 2009:45).

3.3 RESEARCH METHODS

The term 'research method' refers to the principles and ideas on which the researcher base his or her procedures and strategies; it is therefore the process or plan which is used by the researcher to structure the study and gather and analyse the information relevant to the research question (Polit & Beck, 2008:15,765; Holloway & Wheeler, 2010:21). This research study was conducted utilising a consensus method. Consensus method is based on methods whose results involve consensus, or general agreement of the group. It is the opinion of Tammela (2013:111) that consensus methods provide systemic qualitative alternatives to evaluate and control inconsistencies in scientific information. In addition, consensus methods

are used to measure and develop consensus with the methodological goal to establish the extent to which a group of individuals agree about a particular issue (Tammela, 2013:111; Hutchings et al., 2013:492). Consensus methods consist of the Nominal Group technique, Delphi technique methods (Botma et al., 2010:251), consensus development conference (Hutchings et al., 2013:492; Tammela, 2013:111), statized group, social judgement analysis and structured discussion (Tammela, 2013:111). Consensus methods aim to establish the extent to which a group of individuals agree about a particular issue. Additionally consensus methods also aim to conquer the problems associated with group decision-making processes, where dominant views may lead and crowd out other perspectives (Hutchings et al., 2013:492; Tammela, 2013:114).

This research study utilised the nominal group technique. The nominal group technique (NGT) is a more structured form of gathering data from groups because exchange and interaction between group members is more controlled than in focus groups (Powell & Single, 1996:503). In the opinion of Wilkes, Cummings and McKay (2013:2) the NGT is a method which “*promotes creative and meaningful interpersonal disclosures from the participants by gathering equally weighted responses that can offer valid representations of the group views*”. The researcher specifically selected the NGT as opposed to the focus group technique because nominal groups are preferred when a more impersonal and less threatening form of group dynamics is needed. The NGT is less prone to bias arising from vocal individuals influencing group members’ views, which tend to occur in open discussions (Gerrish & Lacey, 2006:353; Potter, Gordon & Hamer, 2004:127). Additionally, during the nominal group session the researcher is also able to ascertain that data saturation has occurred. Participants will discuss previously identified categories and themes which might lead to the emergence of more categories/themes indicating that data saturation has not been reached.

The collaborative nature of the NGT heighten the likelihood that the group will work together on problem identification, generating research questions and to develop solutions to change and enhance nursing practice, (Wilkes et al., 2013:2). In addition, this collaborative nature of the NGT increases the participants’ ownership of the ensuing research and thus increases the likelihood of changing clinical practice (Harvey & Holmes, 2013:188). Furthermore, if the process is followed there are significant higher levels of group satisfaction as the procedure ensures that all participants have an equal chance of producing new ideas as the possibility of

domination by other group members are minimised (De Ruyter, 1996:48; Dunham, 1998). According to Jones and Hunter (1995:312), a nominal group usually consists of 9 to 12 participants, although some researchers have effectively utilised NGT with larger groups (Potter et al., 2004:126; Tammela, 2013:112). The application of the NGT as in this study will be discussed in Section 3.4.4.

In addition to the NGT, the research method in this study is also discussed in terms of population, sampling, sample, data collection and data analysis in Section 3.3.1 through to Section 3.3.4.

3.3.1 Population

The term 'population' refers to the entire group of persons that is of interest to the researcher (Brink et al., 2006:123; Burns & Grove, 2011:290). The target population is the entire group of individuals who forms the focus of the study. For the purpose of this study CCNPs working in the CCUs of the specific hospital group in Gauteng was the target population. However, the accessible population refers to a portion of the target population which is accessible to the researcher for participation (Burns & Grove, 2011:290; Gerrish & Lacey, 2010:143). The accessible population for the current study was the CCNPs working in the specific setting as explained in Section 1.5.2.

3.3.1.1 Eligibility criteria

As it is not easy to collect data from each and every person in a population, the researcher needs to obtain a sample of the specified population. The participants have to meet the eligibility criteria to be included in the data collection process. The eligible criteria refer to the characteristics which participants should possess to be included in the accessible population (Burns & Grove, 2011:291). The eligibility criteria for the sample of this study consisted of CCNPs who were:

- employed in a permanent position at the hospital where the study was conducted
- working in one of the specified hospital's CCUs.

In Section 3.3.2 the researcher focusses on the sampling process which, according to Burns and Grove (2009:361), is determined by the purpose of the study.

3.3.2 Sampling

Sampling refers to the process of selecting a group of individuals from the accessible population with whom to conduct a research study with and this group then represent the entire target population (Burns & Grove, 2009:43; Polit & Beck, 2010:307; Gerrish & Lacey, 2010:22). This implies that only a portion of the population are selected representing the entire population “so that inferences” can be made with regard to the specific population (Polit & Beck, 2008:339). Sampling lowers the costs of research projects and also minimises the time required to collect the data (Gerrish & Lacey, 2010:22). Sampling designs are classified into two categories, namely probability and non-probability sampling (Polit & Beck, 2008:340). In this study a non-probability sampling approach was used as discussed in Section 3.3.2.1.

3.3.2.1 Non-probability sampling

Non-probability sampling is used in this study as it allows for theoretical sampling; the goal is not primarily to generalise but to discover truths regarding a phenomenon (Gerrish & Lacey, 2010:144). With non-probability sampling participants are not selected randomly. In this study it implied that not all of the CCNPs had an equal chance for inclusion to participate in the study. Non-probability sampling allows for the “*study of populations when they are not amenable to probability sampling, or when the researcher is unable to locate the entire population*” (Brink et al., 2006:131). This type of sampling “*requires the researcher to judge and select*” (Brink et al., 2006:132) participants who know the most about the phenomenon and who are able to express and explain “*nuances*” to him or her (Gerrish & Lacey, 2010:144).

A disadvantage of non-probability sampling is that it is not possible to guarantee a representative sample because not every element of the population has an equal chance of being selected to participate in the research study. This may result in systematical under or over presentation of some segments of the population/phenomenon. An advantage of non-probability sampling is that it is convenient and economical (Polit & Beck, 2010:309).

There are various approaches in non-probability sampling which includes purposive sampling, convenience sampling, quota sampling and snowball sampling (network sampling) (Brink et al., 2006:132; Polit & Beck, 2008:341; Burns & Grove, 2009:353). A purposive sampling method was used in this study. When using purposive sampling the researcher, using his or her

knowledge and insights about the population (Polit & Beck, 2008:343; Gerrish & Lacey, 2010:149) to consciously select certain participants (Burns & Grove, 2009:355). The definitive goal of purposive sampling is to select information-rich cases from which the researcher can obtain in-depth information needed for the study.

A disadvantage of purposive sampling is that it is difficult to evaluate the accuracy or relevance of the researcher's judgment. According to Burns and Grove (2011:313), purposive sampling is the best way to gain insights and obtain an in-depth understanding of a complex experience or event. This sampling method further allows the researcher to capture major variations in a sample, for example, participants may vary in ethnicity, age, economic circumstances and come from different settings.

The reason for choosing purposive sampling was to select participants who were concerned with the research topic and who would be able make a valuable contribution to address the research question. Purposive sampling is used to gain insight into a new area of study or to obtain in-depth understanding of a complex experience or event (Burns & Grove, 2009:355). In Section 3.3.3 the sample of the study is described.

3.3.3 Sample and sample size

A 'sample' refers to a "*subset of a population, selected to participate*" in a research study (Polit & Beck, 2008:765). A sample in a research study is therefore the participants used in the study from whom the desired information is collected. The researcher worked with a sample in the current study instead of with the entire population because it was more economical as well as practical (Polit & Beck, 2010:307).

The sample size is determined by the depth of information that is needed to expand insight into the phenomenon. The number of participants is adequate once data saturation has been achieved (Burns & Grove, 2009:361; Polit & Beck, 2010:321; Burns & Grove, 2011:317). Data saturation did occur in this study as the participants started to repeat the same information already listed on the flip charts during the 4th round of the round robin recording (step 2 of the data collection phase).

The sample used in this study was the CCNPs working in the CCUs of the specific private hospital. Twenty invitations were handed out to CCNPs in the specific hospital. The invitations were divided among CCNPs working in the three CCUs. Fifteen participants accepted the invitation to participate in the study of which fourteen attended the nominal group technique for data collection. The characteristics of the participants are set out in Table 3.2.

Table 3.2 Participant characteristics

HIGHEST QUALIFICATION	NUMBER OF PARTICIPANTS	UNIT*		
		M/CCU	S/CCU	C/CCU
Registered nurses: <i>Critical care trained</i>	4	3	0	1
Registered nurses: <i>Critical care experienced</i>	10	2	5	3

*M/CCU = medical critical care unit; S/CCU = surgical critical care unit; C/CCU = cardiac critical care unit

As depicted in Table 3.2 the total number of voluntary participants in the study was 14. Four participants were registered nurses with a qualification in critical care nursing, the remaining 10 participants were registered nurses experienced in critical care nursing. Participants represented the three CCUs in the specific hospital. In Section 3.3.4 the data collection process is described in detail.

3.3.4 Data collection

Data collection refers to the actual gathering of information related to the phenomenon under study (Polit & Beck, 2008:751). The data collection strategies used in this study included the nominal group technique, observation of participants during the group session, audio tape recordings, documents (individual worksheets, flip charts and field notes) which aided in the gathering of rich data (information). In the following sections a discussion of the nominal group technique is presented as applied in this study.

3.3.4.1 The preparation for the nominal group technique

Initial contact was made with the participants as the researcher personally handed out the invitations to participate in the NGT to 20 purposefully selected participants. A short introduction

regarding the aim of the study was given verbally to every prospective participant to encourage participation. Adding an RSVP date on the invitations with the researcher's contact details gave the invited CCNPs the opportunity to first consider whether they wanted to participate in study. Some of the participants accepted the invitation personally while others' acceptance to participate was done telephonically. The researcher took down the contact details of those who voluntarily agreed to participate and contacted them to schedule a day and time for the NGT that was suitable to all. Three days before the scheduled NGT the researcher sent out follow-up short message service (sms) to the participants reminding them of the date and time and advising them of where the venue would be.

Since the researcher had no prior experience in conducting an NGT she recruited an independent expert facilitator to facilitate the NGT. The researcher sent the proposal electronically to the independent expert facilitator two weeks in advance of the scheduled group session and telephonically clarified the research questions to be asked one day before the NGT was facilitated.

On the morning of the NGT the researcher prepared the venue, in the training room of the private hospital's training centre, as requested by the independent expert facilitator. The participants would be seated in two groups. Two sets of tables were arranged to divide the participants into two groups: one with 7 and the other with 8 participants. The equipment setup included two audio-recorders, one on each table, which would be used to ensure that minimum data loss would occur. The researcher made sure that the audio-recorders were both in working order and that she had spare batteries in case of a power loss. Two flip chart boards were placed in the front of the room for the listing of themes and categories. Black pens and worksheets were placed on the tables for each of the participants to use during the first step of the NGT.

The researcher made sure that there was sufficient light and adequate ventilation. Water jugs and glasses were set on the tables as well as small bowls containing a variety of sweets. As the participants arrived at the venue refreshments in the form of rusks, coffee and tea were provided in the reception area of the training centre. The preparation was done as suggested by Powell and Single (1996:501). Once all of the participants had arrived, they were invited into the prepared venue. In Section 3.3.4.2 the conduction of the NGT is discussed in depth.

3.3.4.2 Conduction of the nominal group technique

On entering the prepared venue the participants spontaneously divided themselves into two groups. The fourteen participants were welcomed by the researcher and thanked for their willingness to participate as well as for their time. The background, aims and objectives of the study were then briefly described and the participants' roles and group objectives were clarified. The information leaflet (view Annexure B) was then distributed to the participants and the researcher verbally discussed the information with them.

Aspects such as voluntary participation as well as confidentiality were highlighted. The participants were reminded that the nominal group discussion would be audio recorded. She asked whether any of the participants had an objection but none was raised. The participants were then asked for their permission to take a photograph of the group session to be added as an annexure in the researcher's dissertation. Permission was granted by all participants. Then the participants were given the opportunity to read through the information leaflet on their own and to ask questions to clarify any uncertainties, request more information or address any problems they might have. The information leaflet containing the problem statement served as the consent form and was signed by each participant voluntarily before the official commencement of the NGT session. The researcher introduced the independent expert facilitator to the participants who explained to them the format of the nominal group session.

Due to the fact that the researcher was directly involved in the provision of CPD to the participants of the CCUs, the researcher excused herself from the nominal group session to ensure that the participants did not feel intimidated or threatened by her presence. The nominal group session officially began with the first of six steps that is followed during data collection session in the nominal group process (De Ruyter, 1996:45; Hutchings, et al., 2013:493). Figure 3.1 provides a schematic diagram representing the six steps of the nominal group process.

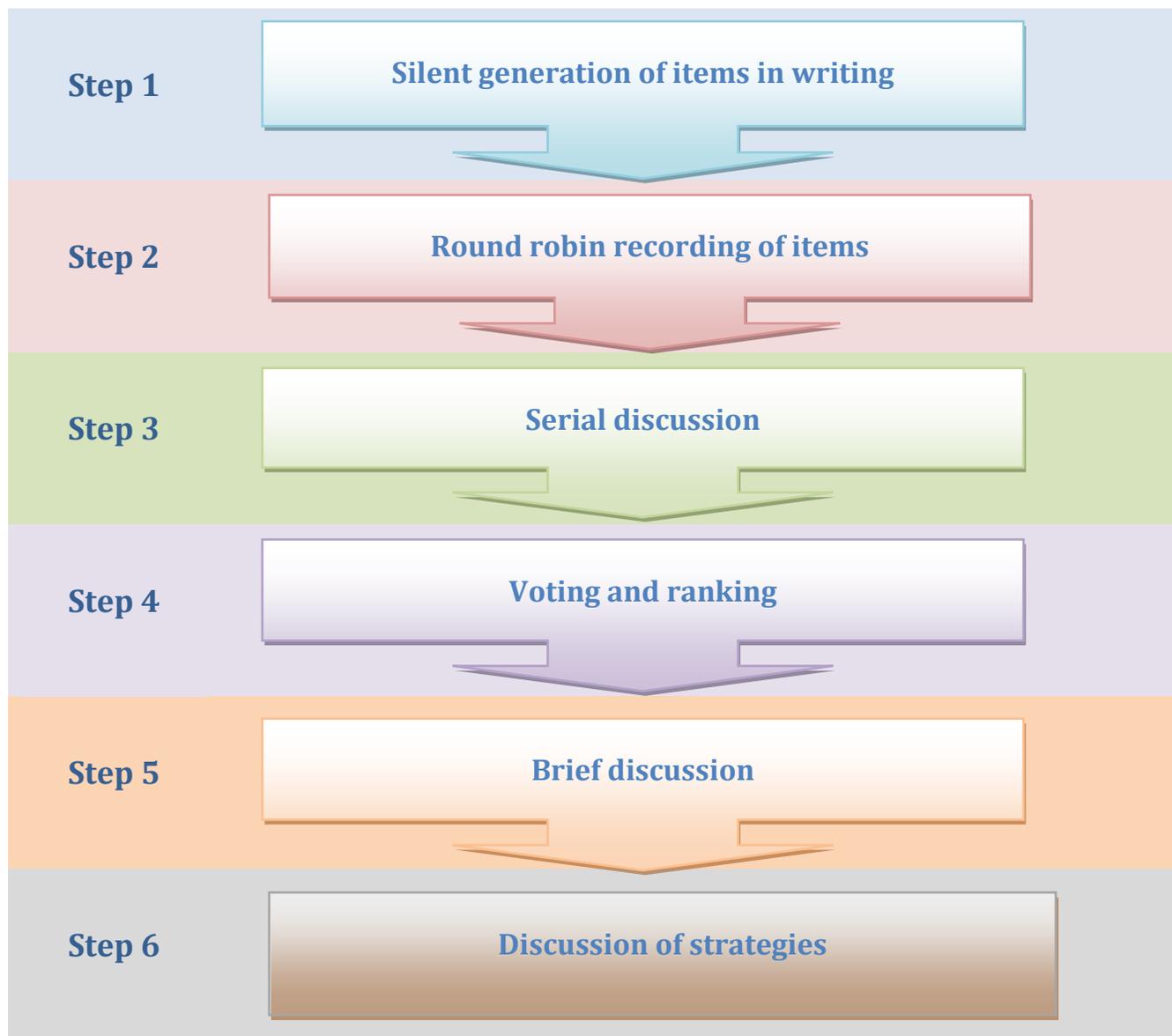


Figure 3.1 Schematic presentation of the nominal group technique

Each of the six steps in the NGT applied in this study as depicted in Figure 3.1 is individually discussed in Sections 3.3.4.3 to 3.3.4.8.

3.3.4.3 Step 1: Silent generation of items in writing

During Step 1 of the NGT the research question was read to the participants by the facilitator: “*Why do CCNPs not attend the continuous professional development programme for the critical care units?*” The participants were informed that this was not a discussion but they had to keep

quiet and silently write down a list of items in response to the research question. They were reminded not to write their names on the worksheets as it needed to be handed in at the end of the session and anonymity had to be strictly maintained. The facilitator gave them ample time to think, reflect and generate their ideas on the question and to list it as items on the given worksheet (Potter et al., 2004:128; Hutchings, 2013:493). Once the participants indicated that they were done, the facilitator moved to the next step of the NGT which is known as the round robin recording of items.

3.3.4.4 Step 2: Round robin recording of items

In the second step the items of the participants (in no specific order and anonymously) were recorded on a flip chart visible to the entire group. 'Round robin recording' means the expert facilitator started with the one group of participants seated at the same table and then continuing to the next group seated at the second table asking for one item at a time from each participant to list on the flip chart. Participants were allowed to 'pass' if they had no new items but were allowed to re-enter again later if they wished to do so. During this step items were only listed on the flip chart and not discussed or debated. Once participants started to repeat previously mentioned ideas, it was clear data saturation had been obtained (Potter et al., 2004:128; Hutchings, 2013:493). The independent expert facilitator continued for two more rounds to ensure that no new items emerged and then proceeded to Step 3 of the process which was the discussion of the listed items.

3.3.4.5 Step 3: Clarification of items and serial discussion

During this step the audio-recorder was switched on. Every item on the list was briefly discussed by the facilitator for the purpose of clarification, in other words to ensure that the facilitator had understood the participants correctly. The participants then joined in the discussion to give their viewpoints or share items on the listed data. Both the facilitator and the participants then looked at the listed data and together decided which data showed similar meanings and grouped it together. The data were grouped and re-grouped until specific items and categories that belonged together were identified to the satisfaction of the facilitator and the two groups of participants (Potter et al., 2004:128). The final items and categories were listed on the second flip chart and once the participants were satisfied with the items, the facilitator

continued forward to the next step in which the participants were required to vote. This step is known as 'voting and ranking' and is discussed in Section 3.3.4.6.

3.3.4.6 Step 4: Voting and ranking

The purpose of this step was to aggregate the judgment of the participants to determine the relative importance of the various items on the list. Each participant was requested to identify from the flip chart a list of five items which they considered the most important. On their worksheets they had to arrange it from 'most important' to 'the least important'. The worksheets were collected and shuffled. While the participants were given 30 minutes to relax and enjoy a light meal the facilitator counted the votes and recorded each vote on the flip chart next to relevant item (Potter et al., 2004:128; Hutchings, 2013:493).

3.3.4.7 Step 5: Brief discussion

After the groups had viewed the ratings of their votes, a brief discussion followed that focussed on the items that were rated the highest during the preliminary voting process. During this short discussion they concentrated on clarification of these items. Once the facilitator was satisfied that the participants had reached consensus with regard to the items and their ratings, the process moved forward to the last step.

3.3.4.8 Step 6: Discuss strategies

This step of the NGT was spontaneously and unintentionally combined with Step 3 by the participants. In Step 3, which was the discussion of the data listed on the flip charts, the participants also mentioned possible solutions to specific challenges. Subsequently, in Step 6 the participants were asked if there were any additional suggestions they wanted to add for possible strategies that could be implemented to address the unsatisfactory attendance of the CPD programme by CCNPs. Additional suggestions was recorded and added to the possible strategies to improve the attendance of the CPD programme.

3.4 RIGOUR IN QUALITATIVE RESEARCH

The term 'rigour' has its origin in science; scientific rigour is respected because it is associated with the significance of research outcomes (Holloway & Wheeler, 2010:298, Burns & Grove, 2009:720). According to Gerrish and Lacey (2010:24), rigour refers to the "*strength of the research design*" in ensuring that all possible procedures have been followed carefully, that all possible perplexing factors have been eliminated and that the reader can have confidence in the conclusions; meaning that the conclusions are dependable. The two main concepts concerning rigour are validity and reliability. Validity focusses on the extent to which the researcher is able to measure what is claimed to be measured without bias or distortion. Reliability is concerned with the consistency of measurement within a study.

Burns and Grove (2009:720) view rigour as the researcher's endeavour for excellence in research through the "*use of discipline, scrupulous adherence to detail, and strict accuracy*". According to these authors, the term 'rigour' is used differently in quantitative and qualitative research (Burns & Grove, 2009:54). Quantitative researchers use it due to its connotations with measurement and objectivity whereas qualitative researchers view rigour in terms of openness, relevance, epistemological and methodological congruence, conscientious adherence to a philosophical perspective, meticulousness in collecting data, thoroughness, the researcher's self-understandings and competence (Burns & Grove, 2011:75; Holloway & Wheeler, 2010:298). The different views attributed to the term 'rigour' in research study designs contributed to the debate as to whether it is appropriate to be used when addressing quality concerns during the conduction of qualitative research (Polit & Beck, 2010:490; Gerrish & Lacey, 2010:25; Graneheim & Lundman, 2004:109). Earlier, Morse et al. (2002:4) conducted a research study from the stance that reliability and validity are appropriate to qualitative research. Their findings also led them to conclude that "*the literature on validity has become muddled to the point of making it unrecognisable*". Additionally, Rolfe (2006:304) found that the concern of rigour in qualitative research has weighed down nursing "*for at least a quarter of a century*".

In the view of Polit and Beck (2008:536) concepts of "*rigor and validity are empirical analytical terms*" and do not fit into an interpretive approach which "*values insight and creativity*." Standards of trustworthiness are used in qualitative research and are equal to that of validity and reliability in quantitative research (Polit & Beck, 2008:537). Hence, qualitative researchers

prefer the term ‘trustworthiness’ (Gerrish & Lacey, 2010:25; Polit & Beck, 2008:71). According to Graneheim and Lundman (2004:109), research findings ought to be as trustworthy as possible and every research study should be evaluated with regard to the methods used to generate the findings. Trustworthiness refers to the degree of confidence qualitative researchers have in their data assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2008:768; Graneheim & Lundman, 2004:109). In the opinion of Polit and Beck’s (2008:536) the strategies to enhance trustworthiness of a qualitative study flows throughout the research. Trustworthiness in qualitative research is an all-embracing issue that begins when the questions are formulated and continuous through till the preparation of the report. The criteria of trustworthiness are discussed in terms of credibility, dependability, transferability, confirmability and authenticity (Polit & Beck, 2008:768).

3.4.1 Credibility

The term ‘credibility’ refers to the “*confidence in the truth of the data and interpretation of them*” (Polit & Beck, 2008:539). In the view of Lincoln and Guba (cited in Polit & Beck, 2008:593) credibility is the overriding goal of qualitative research. Credibility implies that the participants of the research study are able to recognise the meanings that they themselves gave regarding the research phenomenon and the truth of the findings in their own social context (Holloway & Wheeler, 2010:303). Qualitative researchers have a responsibility to establish credibility in the truth of the research findings. Credibility involves two aspects: firstly, to perform the research study in such a manner that the believability of the findings is enhanced and, secondly, to disclose the steps taken to enhance credibility to external readers (Polit & Beck, 2008:539).

3.4.2 Dependability

Dependability refers to consistent and accurate research findings (Holloway & Wheeler, 2010:303). Concurring, Polit and Beck (2008:539) note dependability is the “*stability (reliability) of data over time and conditions*”. These statements imply that should the study be repeated with different participants in a different setting the same or similar results will be obtained. According to Polit and Beck (2008:539), it is not possible to achieve credibility in the absence of dependability.

3.4.3 Confirmability

Confirmability refers to the objectivity of the research, meaning that there is conformity between two or more independent researchers about the data's accuracy, relevance or meaning (Polit & Beck, 2008:539). Confirmability focusses on establishing that the data are representative of the information provided by the participants as well as ensuring that the interpretations of the data are what the participants meant and not figments of the researcher's imagination (Holloway & Wheeler, 2010:303). In this study the researcher attempted to ensure that the findings reflected the *"participants' voice and conditions of the inquiry, not the biases, motivations, or perspectives of the researcher"* (Polit & Beck, 2008:539). This was done through the use of an independent expert facilitator who also acted as an independent coder for the analysis of the data.

3.4.4 Transferability

Transferability refers to whether the research findings can be transferred to or applied to other settings or groups; in other words, transferability implies generalisability (Polit & Beck, 2008:539; Holloway & Wheeler, 2010:303). Transferability is viewed as the responsibility of the researcher who has to produce *"sufficient descriptive data in the research report"* so that consumers of research can evaluate the applicability of data to other contexts themselves (Lincoln & Guba cited in Polit & Beck, 2008:539).

3.4.5 Authenticity

Authenticity refers to the degree to which the researcher reports the research findings so that it is a truthful representation of the participants' views, experiences and ideas (Holloway & Wheeler, 2010:304; Polit & Beck, 2008:540). Authenticity emerges in the research report if it *"conveys the feeling tone of the participants' lives as they are lived"* states Polit and Beck (2008:540). When a research report attains authenticity, readers are able to clearly understand the lives being portrayed *"in the round, with some sense of mood, feeling, experience, language, and context of those lives"* (Polit and Beck (2008:540).

In Section 3.5 a discussion follows of the strategies used to enhance trustworthiness in this study.

3.5 STRATEGIES TO ENHANCE TRUSTWORTHINESS

Various strategies were employed in this study to enhance rigour as suggested by Polit and Beck (2008:539). These strategies and their application in this study are discussed in the following sections.

3.5.1 Prolonged engagement

Prolonged engagement refers to the investment of sufficient time collecting data to have an in-depth understanding of the view of the participants and to ensure saturation of all categories (Polit & Beck, 2008:542). Prolonged engagement aids to strengthen the credibility of a study. In this study prolonged engagement was utilised in the form of scheduling a sufficiently long period of time for data collection (4 hours) and to achieve data saturation.

3.5.2 Member checking

Member checking refers to the researcher asking the participants whether they feel the interpretation of the data are a true and fair representation of their views (Holloway & Wheeler, 2010:305). Member checking is regarded as an important technique for establishing credibility as well as dependability (Polit & Beck, 2008:545). Member checking was utilised as a strategy to enhance credibility in this study as follows:

- feedback was given to the participants to confirm that the data collected were correctly interpreted by the facilitator
- the participants were encouraged to provide critical feedback about factual errors or interpretive deficiencies
- member checking was done through a face-to-face discussion with the participants directly after the themes and categories had been identified. Member checking in the NGT not only validated that the researcher understood and correctly interpreted the data but also aided in reaching group consensus on the priorities of the identified themes and categories (Polit & Beck, 2008:545).

3.5.3 Data triangulation

Data triangulation is a method in which the researcher uses multiple data sources for the purpose of validating conclusions (Holloway & Wheeler, 2010:308; Polit & Beck, 2008:751). The use of data triangulation strengthens the credibility and dependability of a research study. Data triangulation in this study was done through the use of multiple sources, including literature, field notes and participants who provided diverse information with regard to challenges and reasons for unsatisfactory attendance of the CPD programme.

3.5.4 Person triangulation

Person triangulation signifies that more than one expert researcher is involved in the research study (Holloway & Wheeler, 2010:308; Polit & Beck, 2008:761). The utilisation of person triangulation strengthens the credibility of a research study. Person triangulation was done in this study through the participation of members of all the CCUs in the hospital instead of using members of only one critical care unit.

3.5.5 Investigator triangulation

Investigator triangulation implies the involvement of two or more researchers to do data collection, coding and analytic decisions (Polit & Beck, 2008:546). The application of investigator triangulation strengthens the credibility of a research study. In this study investigator triangulation was done through the use of an independent expert facilitator and supervisors from the university.

3.5.6 Comprehensive record keeping and decision trails

Comprehensive records and decision trails were maintained during the progress of the current study. The comprehensive records included thick descriptions, field notes, log of decisions made, verbatim audio transcriptions and worksheets (view Annexure C). Thick description is an account of the complex process in a specific context and a rich and holistic portrayal of the phenomenon under study. It helps to establish the truth value of the research and is linked to the decision/audit trails (Holloway & Wheeler, 2010:310). The application of thorough record keeping and thick description in the study is described below.

- Comprehensive field notes were kept containing rich descriptions of what surfaced in the field during the nominal group session as suggested by Polit and Beck (2008:539).
- Audio recording was used to aid in the gathering and recording of data as well as to ensure minimum loss of information.
- Participants' worksheets were collected at the end of the nominal group session for additional information and for aiding in the data analysis process.
- Data were throughout the study process regularly scrutinised by the supervisors at the University of Pretoria to enhance its confirmability.
- Rich, thorough, vivid descriptions related to the study context, the participants, the experiences and processes observed during the inquiries were provided.
- Influential descriptions enhanced authenticity in that they had an evocative quality and the capacity for emotional impact (Polit & Beck, 2008:550).
- Clear and textured descriptions with the sensible inclusion of verbatim quotes from the participants were used to enhance authenticity.
- The researcher strived to ensure that sufficient information was provided to allow the readers to make judgments related to contextual similarities.

In this study comprehensive records and decision trails influenced all 5 criteria related to trustworthiness (credibility, dependability, confirmability, transferability, authenticity).

3.5.7 Reflective notes/journal

Reflective notes or journals refer to materials that document the researcher's personal experiences, reflections, and progress in the field (Polit & Beck, 2008:406). The maintenance of a reflective journal strengthens the credibility and authenticity of a research study. In this study:

- the researcher kept reflective notes relating to her intentions and dispositions throughout the progression of the study
- maintaining the reflective notes did not only strengthen credibility but also authenticity in the study.

3.5.8 Data saturation

Data saturation refers to the collection of data to the point where a sense of closure is attained because new data yield redundant information (Polit & Beck, 2008:765). In this study the researcher ensured that data saturation occurred before participants disengaged from the nominal group session.

- Two hours after the onset of the nominal group session no new information surfaced.
- Data saturation was reached when no new items emerged during the step 2 of the NGT. The participants were given the opportunity after the data had been listed to add more items but no new information emerged.

The researcher strengthened the credibility and transferability of the study by ensuring that data saturation had been achieved.

3.5.9 Co-coder

The assistance of an independent expert facilitator was acquired to help with the data collection and coding of the collected data to enhance the confirmability of the study findings. The data were analysed by the facilitator (co-coder) of the nominal group session, but the researcher also checked and coded all the data (flip charts and participants' worksheets) and listened to the audio recordings as well as worked through the verbatim transcribed data.

3.5.10 Audio recording, verbatim transcription and field notes

Authenticity is strengthened by ensuring minimal data loss occurs. It also provides the researcher a resource to refer back to when uncertainty regarding some of the data emerges.

Field notes are carefully and thoughtfully prepared rich descriptions of what transpired in the field during data collection (Polit & Beck, 2008:543). These notes are broader, more analytic, and more interpretive than the simple listing of events. Field notes contain a narrative account of what happened in the field and are most often written after an observational session in the field has been completed. To properly write field notes are time consuming as they are often lengthy. These notes must include descriptions of what transpired in the field as well as enough

contextual information about the time, place and the actors to portray the situation fully (Polit & Beck, 2008:405). Although the field notes might not necessarily be used, it is better to have too much information than insufficient information. In this study the field notes during the NGT were recorded by the independent expert facilitator.

3.6 CONCLUSION

In Chapter 3 the researcher provided an in-depth description of the research design and methods used in this study. The strategies to establish trustworthiness as applied in this study were also discussed. Chapter 4 is concerned with the research findings and the literature control for this study.

2. THEORETICAL UNDERPINNING

“When planning for a year, plant corn. When planning for a decade, plant trees. When planning for life, train and educate people.”

- Chinese Proverb -

2.1 INTRODUCTION

An overview of the study was provided in Chapter 1. In Chapter 2 an in-depth discussion is presented on continuous professional development (CPD) and adult learning as it formed the basis of this study.

2.2 CONTINUOUS PROFESSIONAL DEVELOPMENT

In the healthcare sector continuous professional development (CPD) is an established, vital strategic instrument aimed at improving healthcare services by ensuring that healthcare professionals have up to date skills and knowledge. Continuous professional development promotes healthcare providers' personal as well as professional competence thereby ensuring that the demands placed on healthcare service delivery by all people can, and are, met (Brand et al., 2006:25; Brown, Belfield & Field, 2002:652; Beausaert et al., 2013:146). According to Petaloti (2009:46), the increasing need for CPD is closely connected to the globalisation and the rapid changes in science and technology; this can mean that organisational growth is not linked to growth in staff levels anymore, but to the level of skills the staff possesses.

In literature there are various definitions of CPD but only the most relevant definitions were considered for this study. Continuous professional development is synonymously defined as a process of lifelong learning or continuing education (Skees, 2010:104; Mohanna et al., 2011:35; Yang et al., 2013:202). For healthcare professionals CPD means to advance their knowledge and skills to satisfy the needs of the patients, the healthcare services as well as augment their own professional development (Brand et al., 2006:25; Mohanna et al., 2011:35). The Department of Health (cited in Brown et al., 2002:652) defines CPD as *“a way of maintaining standards of care; improving the health of the nation; and recruiting, motivating, and retaining*

high quality staff.” Brown et al. (2002:653) state CPD is the “*post-registration acquisition of skills or knowledge.*” Kaye-Petersen (2003:94) combines the aforementioned views of the DOH and Brown et al. by stating that CPD is lifelong learning which takes place in a professional career after the acquisition of a qualification or registration of a qualification. In addition, Mohanna et al. (2011:35) suggest that the principles of CPD apply to both clinical and non-clinical personnel. Continuous professional development forms the basis of professional continuous education. Mohanna et al. (2011:35) add that there is a growing awareness of the need to enhance the quality of healthcare through the process of revalidation. Healthcare professionals must therefore constantly evaluate and improve their services as there is a growing expectation by the public that healthcare professionals are accountable for demonstrating competence (Lahti et al., 2013:1).

The importance of CPD is highlighted by Joyce and Cowman (2007:63) who claim that a greater than ever accountability is placed on the healthcare professional by society as well as the healthcare profession. The public’s demand for competence and safe practice “*obliges the profession to meet the challenges of high quality care*” with up to date knowledge and skills (Skees, 2010:105). In addition, Collins (2009:613) points out that participation in CPD activities are recognised by various organisations such as governing bodies, accreditation organisations, certification boards, employers and also the general public “*as one the most important competencies*” that professionals must possess. Competence depends on updated knowledge and skills in one’s field of practice (Kitto et al., 2013:144; Pool, Poell & Ten Cate, 2013:35).

In the UK the maintenance of competence and the participation in CPD has firmly been established as a professional standard with the purpose of ensuring the safety of the public (Munro, 2008:954). The assumption that nurses' roles are extended through CPD and that CPD is a key factor in nursing retention underlines the health policy in the UK (Munro 2008:608). In the opinion of Munro (2008:958), CPD is related to personal and professional development and is relevant to the work context of the experienced nurse, but it is dependent on individual motivation, a positive attitude towards work, the identification of the benefits of learning, as well as personal family and financial circumstances. Jones and Fear’s (1994:49) stance is that CPD should be owned and managed by the individual professional while reflecting on appropriate business needs; CPD cannot be separated from a “*business-driven perspective*”. This view is supported by Munro (2008:958) who points out that the nature and type of CPD required are

determined by the individual professional on the one hand and by the employer on the other hand. The author adds, however, that CPD should never be an integral part of professional activity within the context of work as it can then result in conflict or mismatch between personal and organisational goals.

Continuous professional development is thus also dependent on the collaboration of the employer with regard to ongoing development, career advancement, dedicated time and financial support. Plans for CPD need to be incorporated into strategic action plans that include all stakeholders. Continuous professional development activities assume different forms for updating knowledge, for example, workshops, conferences, grand rounds, hospital wide CPD programmes, professional organisation-based CPD programmes, online educational programmes, journal articles, journal clubs and unit-based presentations and programmes (Skees, 2010:111; Kemp & Baker, 2013:2).

Joyce and Cowman (2007:632) points out that CPD is dependent on the CCNP's openness to new ideas, decisions, skills or attitudes. In support of this statement, Mokhele and Jita (2010:1765) advocate: "*Change occurs most rapidly when people want to change*" and when they see the benefit in doing so. Therefore, it can be surmised that if professionals (in the context of the current study the CCPNs) understand the need for CPD and they recognise the benefits thereof they will most probably participate more actively. In Section 2.3 the purpose and benefits of CPD are elaborated on.

2.3 PURPOSE AND BENEFITS OF CONTINUOUS PROFESSIONAL DEVELOPMENT

Continuous professional development has developed to help professionals embrace lifelong learning because the knowledge and skills with which a professional begins his or her career has a "*short shelf-life*" (Professional Associations Research Network cited in Sturrock & Lennie, 2009:12). It is therefore essential for the CCNP to actively participate in CPD activities to guarantee and maintain a high quality of patient care and patient safety (Petaloti, 2009:46; Clapton, 2013:411). According to Joyce and Cowman (2007:632), the ultimate outcome of CPD should be to ensure improved healthcare. Pool et al. (2013:40) state that in their view the purpose of CPD is the "*retention of core skills, improvement of career opportunities and*

extension of nursing roles". This view is supported by Jones and Fear (1994:50) who view the purpose of CPD as an attempt to encourage efficient performance at work while Petaloti (2009:48) sees CPD as essential to ensure professional development; it is necessary for strengthening and autonomy in decision making as well as for the process of personal development in that it expands "*capacity and recognition of maximum capacity in the workplace*". Continuous professional development thus provides a framework to ensure that professionals maintain their capacity to practice safely, effectively and legally within their scope of practice. It empowers them to meet the increasing demand for quality, competence and accountability from the various governing bodies, employers and the public (Sturrock & Lennie, 2009:12; Lahti et al., 2013:2).

Dauer (2003:s49) suggests that today's workplace can be characterised as "*requiring continuous on-the-job growth and development*" which is especially true in highly regulated environments such as medical and health organisations. By implementing a CPD programme, an organisation guarantees that it stays competitive and attractive to retain highly trained CCNPs that, in turn, is also a means of ensuring quality. The main principle behind CPD is not to merely view it as an opportunity for learning, but to take control of the opportunity to enrich critical care nursing practice through professional development (Skees, 2010:115). Also, Munro (2008:956) reflects that CPD is important in the ever-changing nursing and other healthcare environments because "*professional standards maintain the hallmark of professions through a regulatory framework to ensure that standards are met and that practice is maintained and developed*".

Mentioning that in "*this information age, it is the survival of the fittest*", Ogbaini-Emovon (2009:45) believes that CPD is the key to optimise a professional's career opportunities for the present as well as the future. The benefits of CPD are listed by Ogbaini-Emovon (2009:45) as improved patient care and reduced cost of patient treatment, intellectual challenge which leads to personal development and professional growth resulting in greater competence, the capacity to embrace new responsibilities and, finally, compliance with employer's as well as professional bodies' requirements. Continuous professional development help CCNPs to "*acquire, maintain and improve their abilities and skills*" in their field of specialisation (Petaloti, 2009:46). Further benefits indentified by Skees (2010:105) include positive patient outcomes; increased

knowledge contributing to professional growth and promoting the CCNP's critical thinking skill. Additionally, more benefits of CPD are listed by Mohanna et al. (2011:35) as indicated next.

- Pursuing personal and professional growth by widening, developing and changing the learners' roles and responsibilities.
- Keeping up to date, and accommodating clinical, organisational and social changes that affect professional roles in general.
- Acquiring and refining the knowledge and skills that are needed for new or current roles, responsibilities, and career advancement.
- Placing individual development and learning needs into a team, organisational and multi-professional context.

According to Theofunidis and Fountouki (cited in Petaloti, 2009:48), it is vital for CCNPs to learn constantly. These authors note that, regardless of the fact that their initial and basic education is a prerequisite for professional competency CCNPs' professional conscience is increased through participation in CPD programmes. Through the maintenance of practicing with updated knowledge the nursing profession is guaranteed to be based on best evidence which will make a difference in patient outcomes. The CCNPs abilities to be self-directed and their desire to set the foundation for excellence in practice are reflected in their participation in CPD activities (Skees, 2010:105).

In summary, the "*acquisition and integration of new knowledge and skills through CPD*" positively influences healthcare on various levels. A commitment to participate in CPD benefits the CCNP, the organisation where she or he is employed and ultimately patient care (Skees, 2010:114). Considering all the benefits of participation in CPD activities, the following question was raised: should CPD be mandated or voluntary? In Section 2.4 a discussion of mandatory versus voluntary CPD attendance is presented.

2.4 MANDATORY VERSUS VOLUNTARY CONTINUOUS PROFESSIONAL DEVELOPMENT

In literature it was found that there seems to be an ongoing dispute as to whether CPD should be voluntary or mandatory. Jones and Fear (1994:52) argue that should CPD only be a

voluntary activity, CPD would become minimal. These authors posit that it is always those who need CPD most who are least likely to participate in CPD activities when it is a voluntary activity. On the other hand, once CPD is viewed as a mandatory activity it could be viewed as a chore being forced on the CCNP by the profession and this could result in resistance (Jones & Fear 1994:52). It is Joyce and Cowman's (2007:627) opinion that voluntary CPD would result in situations where there is a system of CPD in nursing which is "*ad hoc and irregular*". However, if CPD is mandatory, the enforcement of CPD could also affect the individual's attitude towards it and devalue the individual's learning (Friedman & Philips, 2004:367). Henwood and Taket's (2008:209) stance is that if CPD is mandated it will impose pressure on the employee as well as the employer. They argue that mandated CPD conflicts with what is considered professionalism where the focus is on self-governance (Henwood & Taket, 2008:209).

Another aspect considered in literature that relate to the mandatory versus voluntary CPD argument is whether or not CPD leads to nursing competence. According to Skees (2010:107), if CPD does fulfil this crucial component of professional nursing it will support the governing bodies even more to mandate CPD since it is their role to protect the public. There is also controversy in the literature with regard to the amount of learning achieved through CPD activities (Skees, 2010:107; Lahti et al., 2013:2; Pool et al., 2013:38). Henwood and Taket (2008:210) argue that attending of a CPD activity does not guarantee that transfer of knowledge has occurred and therefore it may not result in a change in practice. For Muller (2004:291) the problem lies therein that, even if a CPD activity is outstanding and the attendance is significant, it also does not necessarily mean that learning has taken place. Petaloti (2009:45), however, suggests that CPD is not the "*simple absorption*" of knowledge but the development of critical thinking; it is thus an ongoing process enabling the CCNP to cope in an environment where rapid changes occur constantly. Skees (2010:108) adds that work experience alone is not sufficient to grasp the vast amount of new knowledge required for current practice in the 21st century due to the "*information explosion in this era of health care*".

Yet, as advocated by Skees (2010:107), remaining updated through participation in CPD programmes are considered a professional and ethical responsibility and physical clinical nursing alone cannot replace the imperative for learning; whether mandated or not the CCNPs cannot afford to be without CPD. Skees (2010:107) claims that the CCNPs have a "*responsibility in caring for their patients whose lives are literally in their hands*", especially in the

CCU. Therefore, although CPD alone do not necessarily prove that a nurse is competent, it can make a difference in patient survival. Skees (2010:107) also warns that CCNPs should be conscious that professional boards of nursing regulations specify the number of hours needed for CPD as well as the fact that there are penalties involved when failing to meet the requirements. The author further warns that pleading non-awareness is not seen as a credible excuse.

According to Gould et al. (2007:603), little has been written regarding the challenges experienced by CCNPs participating in CPD despite the "*requirement to engage in life long study and professional updating*". In spite of all the advantages of CPD there are various reasons cited in the literature why nurses do not participate more frequently in CPD. These reasons are discussed as barriers to CPD in Section 2.5 which follows. These barriers need to be addressed from a personal as well as organisational perspective. Stakeholders need to collaborate in examining the reasons behind nonparticipation in CPD and then develop realistic solutions to overcome these barriers (Skees, 2010:107). Barriers are not an acceptable excuse for nonparticipation.

2.5 BARRIERS TO CONTINUOUS PROFESSIONAL DEVELOPMENT

Despite the fact that Florence Nightingale already noted in 1860 the need for continuous education, in the 21st century CPD programmes are still "*carried out occasionally and without gravity*" (Petaloti, 2009:46). This may be related to several factors. Hopstock (2008:429), for example, states: "*The mismatch between confidence and skill and the poor skill retention are basic problems ... and have been well-known for decades.*" Although various studies mention barriers to CPD, limited studies were found that focus primarily on the barriers to CPD in nursing specifically. The barriers to CPD as identified by Mohanna et al. (2011:36) are summarised in Table 2.1.

Table 2.1: Barriers to continuous professional development

BARRIERS
<ul style="list-style-type: none"> • Isolation of healthcare professionals – even many who appear to work in a team. • ‘Tribalism’ as different disciplines protects their traditional roles and responsibilities. • Lack of incentives to participate in learner-centred interactive education as opposed to more passive modes of educational delivery. • Various employed/attached/self-employed terms and conditions between staff employed in the same workplace, including differing rights to time and funds for continuing education. • Lack of communication between healthcare organisations and individuals. • Domination of the medical model over those of other disciplines. • Strict educational budgets of different professionals obstructing the true multidisciplinary education. • Lack of personal educational need assessments which means that education may not be targeted appropriately for individual/organisational needs. • Practitioners being overwhelmed with service work and therefore having little time for CPD. • Conflict between individuals’ educational needs and organisational needs. • Lack of shared ownership of both education and development. • The perception that all education should be paid by someone else. • Conservatism – unwillingness to develop or accept new models of working and extended roles. • Selection of CPD activities according to preference rather than need. • Mental ill health – depression, stress, burnout of learner/teacher, fear of, and resistance to change.

Source: Mohanna et al. (2011:36)

Considering the barriers mentioned in Table 2.1 it is clear that for CPD to be successful, it must be personally meaningful to the individual professionals. The challenge is therefore to find ways to understand what the individual professionals want and what they will find personally meaningful, and only then to design CPD programmes that respond to these needs as well as considering the organisational needs (Mokhele & Jita, 2010:1765). Despite the fact that a large

number of research studies have reported poorly retained skills, less work has been done to find out why. Some studies highlight the awareness of the psychological factors and attitudes in CPD. For instance, Hopstock (2008:425) holds that a familiar “*predictor of learning outcomes is the level of learning motivation*”.

Mohanna et al. (2011:36) identify criteria for successful CPD by indicating that the “*most successful CPD involves learning*” which -

- has a clear reason for the specific CPD to be undertaken
- is led by the learner’s own identified needs
- is based on what is already known by the learner
- appropriately makes use of a variety of teaching / learning modalities
- encourages active participation by the learners
- uses the learners’ experience as resources
- includes relevant and timely feedback
- allows for the reinforcement of learning to take place through follow-ups (for example, reflection).

Thus, CPD should be made relevant to the healthcare service needs while remembering to build on the criteria for individual successful learning. For the facilitator to be successful in the facilitation of CPD activities, she or he has the responsibility to design a CPD programme which will ensure that participants achieve specific objectives (Mohanna et al., 2011:36). According to Fink and Osborne (1992:60), the facilitator should be familiar with certain key principles that guide learning to ensure designing an effective CPD programme. Therefore, the facilitator needs to consider what would be the best way to facilitate the CPD activity. To make such a decision the facilitator needs to have a definite understanding of concepts such as learning, principles of learning, learning domains, learning styles and the following various aspects related to the adult learner: characteristics of adult learners, adult learning theories as well as teaching theories (Nsemo et al., 2013:332; Beischel, 2013:227).

2.6 LEARNING

Collins (2009:614) is of the opinion that learning occurs throughout life and should not be viewed as “*preparation for life*” but rather as “*part of life*” itself. The definition of the “*Commission of a Nation of Lifelong Learners*” is used by Collins (2009:615) and is as follows:

... a continuous supportive process which stimulates and empowers individuals ... to acquire all the knowledge, values, skills and understanding they will require throughout their lifetimes... and to apply them with confidence, creativity, and enjoyment in all roles, circumstances, and environments.

Collins further breaks this definition into smaller parts explaining it as follows:

... (a) continuous (never stopping); (b) supportive (it is never done alone); (c) stimulating and empowering (it is self-directed and active, not passive); (d) incorporating knowledge, values, skills and understanding (it's more than what we know); (e) spanning a lifetime (it happens from our first breath to our last); (f) applied (it's not just for knowledge's sake); (g) incorporating confidence, creativity, and enjoyment (it's a positive, fulfilling experience); and (h) inclusive of all roles, circumstances, and environments (it applies not only to our chosen profession, but to our entire life).

In the opinion of Muller (2004:291) “*learning is an internal activity*” which results in behavioural changes. This opinion of Muller is supported by Knowles, et al. (2005:10) definition of learning as a process which results in a change in behavior, knowledge, skills and attitude with the emphasis on the learner in whom change takes place. Knowles et al. (2005:10) further separate the terms ‘learning’ and ‘education’ from each other. In Knowles et al.’s opinion education is the activity designed to effect change in knowledge, skill and attitudes with the emphasis on the educator who presents the stimuli and reinforcement for learning and change. Collins (2009:614) maintains that individuals can no longer view “*the end of compulsory education with relief or value freedom from educational obligation more highly than the continuation of intended learning*”. For learning to be successful certain principles need to be considered. Principles of learning are addressed in Section 2.6.1.

2.6.1 Principles of Learning

As indicated earlier by Muller (2004:291) education provided may be outstanding but without any learning taking place. In order for learning to be successful the learner needs to internalise the given information by analysing the learning content and making it his or her own to ensure that the information will be valuable to the learner (Poell & van der Krogt, 2013:1). In the views of Fink and Osborne (1992:61) and Muller (2004:292) the following principles of learning help to enhance the learning process.

- The degree of motivation displayed by the learner correlates directly with the way that the learner incorporates new facts, concepts, skills, values and so on. The learner should display readiness to learn by showing interest, motivation and a sense of responsibility.
- The active participative learner tends to display a higher quality of learning than the passive, uninvolved experienced learner. Active participation includes doing the necessary preparation and displaying a “*critical-analytical attitude*” by asking questions, participating in discussions and case studies, demonstrating newly acquired skills, positive behavioural change and so forth.
- The use of a problem-solving approach tends to enhance motivation as well as active involvement and thereby facilitates learning.
- Repetition and reinforcement result in an improved recollection of information; especially if the reinforcement comes as a result of usage of the new information.
- Reward and positive feedback are related principles and help to promote useful learning; especially if the reward is internalised which means that the learner has to ask him- or herself: “*How does this help me?*”
- The use of multisensory signals, referring to the use of more than one sense (for example, hearing and seeing) during the learning process is helpful to most learners.
- The establishment of a positive learning climate in the unit plays an important role. The environment needs to be conducive for learning to aid in the learning process.

Furthermore, for learning to be successful the facilitator needs to be familiar with the various learning domains. In Section 2.6.2 the different learning domains are outlined.

2.6.2 Learning domains

Taylor and Hamdy (2013:e1562) agree with Lesner, Sandridge and Newman (2011:29) who claim that clinical activities/learning mostly require three learning domains – cognitive, psychomotor and affective. Bloom's Taxonomy of learning breaks these domains up into progressively more complex stages where each stage must be mastered before progressing to the next. An overview of the three learning domains is set out in Table 2.2.

Table 2.2: Learning domains

COGNITIVE DOMAIN		
Taxonomy level	Definition	Examples of taxonomy verbs
Level 1: Knowledge	The learner is able to recall and demonstrate information that has been memorised.	<ul style="list-style-type: none"> • Define • List • Record • Repeat
Level 2: Comprehension	The learner grasps meaning and is able to translate from one form to another.	<ul style="list-style-type: none"> • Compute • Describe • Explain • Restate • Review
Level 3: Application	The learner can use information in a new situation.	<ul style="list-style-type: none"> • Demonstrate • Interpret • Solve • Use
Level 4: Analysis	The learner is able to examine concepts, break them down into component parts and see patterns in them.	<ul style="list-style-type: none"> • Analyse • Categorise • Compare • Contrast • Differentiate
Level 5: Synthesis	The learner is able to put information together in unique ways to solve problems.	<ul style="list-style-type: none"> • Arrange • Create • Formulate • Prescribe
Level 6: Evaluation	The learner is able to make quantitative or qualitative judgments based on reasoned argument.	<ul style="list-style-type: none"> • Assess • Evaluate • Rate • Revise

PSYCHOMOTOR DOMAIN		
Taxonomy level	Definition	Examples of taxonomy verbs
Level 1: Perception	The learner is able to use sensory cues related to motor acts.	<ul style="list-style-type: none"> • Distinguish • Hear • See • Touch
Level 2: Set	The learner is ready to react to mental, physical, and/or emotional sets.	<ul style="list-style-type: none"> • Adjust • Locate • Place • Prepare
Level 3: Guided response	The learner is able to imitate the performance of another person and through trial and error repeat until the performance is correct.	<ul style="list-style-type: none"> • Copy • Duplicate • Imitate • Repeat
Level 4: Mechanism	The learned response becomes habitual and the degree of proficiency increases.	<ul style="list-style-type: none"> • Adjust • Build • Manipulate • Mix
Level 5: Complex overt response	The learner is proficient and performs without hesitation and with coordination.	<ul style="list-style-type: none"> • Calibrate • Demonstrate • Maintain • Operate
Level 6: Adaptation	The learner is able to modify movement patterns to fit new situations.	<ul style="list-style-type: none"> • Adapt • Change • Develop • Supply
Level 7: Origination	The learner is able to create new motor acts or ways of manipulating objects in response to particular situations or problems.	<ul style="list-style-type: none"> • Construct • Create • Design • Produce

AFFECTIVE DOMAIN		
Taxonomy level	Definition	Examples of taxonomy verbs
Level 1: Receive	The learner is aware and willing to direct attention.	<ul style="list-style-type: none"> • Accept • Attend • Realise • Recognise
Level 2: Respond	The learner complies with suggestions, is willing to respond, and responds with satisfaction.	<ul style="list-style-type: none"> • Behave • Cooperate • Obey • Observe
Level 3: Value	The learner accepts a value as a belief, and pursues the value.	<ul style="list-style-type: none"> • Accept • Believe • Prefer • Seek
Level 4: Organise	The learner conceptualises a value and organises a value system into an ordered relationship.	<ul style="list-style-type: none"> • Codify • Display • Favour • Systematise
Level 5: Internalise	The learner acts consistently in accordance with values that are integrated into a total philosophy or worldview.	<ul style="list-style-type: none"> • Internalise • Verify

Source: Lesner, Sandrige and Newman (2011: 29-32)

As depicted in Table 2.2 there are three main learning domains: cognitive, psychomotor and affective. Each of these domains consists of various levels which progress from simple to complex. Since every individual is a unique human being, every person uses a different learning style and some use a combination of learning styles to master the intended information/education. In Section 2.7 a discussion of various learning styles follows.

2.7 LEARNING STYLES

Learning styles refer to the view that different people learn information in different ways (Pashler, et al., 2009:106). Adults learn in different ways and are able to adjust the way in which they learn to fit the circumstances and subject content (Mohanna et al., 2011:49; Taylor & Hamdy, 2013:e1561). Adult learners develop a preference for learning that is formed during and

based on childhood learning patterns. In the opinion of Vollers (2008:28), learning is a skill. Beischel (2013:228) states that an individual's learning style has the potential to affect learn. Additionally, Lesner et al. (2011:29) point out that no universal learning style works for everybody and that every adult learner style tends to be influenced by various factors such as personality, intelligence, culture, and sensory and cognitive preferences. Beischel (2013:228) states that an individual's learning style has the potential to positively or negatively affect learning.

Various models have been described with regard to learning; however, it cannot be concluded that one is better than the other (Vollers, 2008:28). All models are useful when considering the concept of learning styles (Mohanna et al., 2011:49). In the opinion of Vollers (2008:40) the better the facilitator's understanding of learning styles is, the better the facilitator can direct his or her effort to improve the learning process. In addition, Pashler et al. (2009:108) and Baykan and Nacar (2007:160) concede that learning will be ineffective or less efficient if learners receive instruction that does not consider their learning styles. Russell (2006:350-352) states the most frequently used method to differentiate between learning styles is through describing visual, auditory and kinesthetic learners as discussed in Sections 2.7.1 through to 2.7.3.

2.7.1 Visual learners

Visual learners learn best through seeing what they learn and therefore pictures and images are very helpful to these learners for promoting a better understanding of ideas and information. Visual learners typically read the given information and follow directions as they work and in general appreciate it when diagrams or images are included. Visual learners most often desire timelines, mind maps, or some other similar guideline to remember the sequence of events; these learners usually organise their learning materials carefully (Felder & Soloman, 2000:3; Russell, 2006:351-352; Graf, Kinshuk & Liu, 2008:484; Arora, Leseane & Raisinghani, 2013:80).

2.7.2 Auditory learners

Auditory learners are learners that learn best by hearing the information. These learners have a preference for a facilitator or person to talk them through the specific information rather than reading through the information. They remember verbal information well through verbal repetition and by saying or repeating information out loud (Baykan & Nacar, 2007:158).

Auditory learners usually prefer to discuss the information which they do not immediately understand and in general find it difficult to work quietly for long periods of time. Auditory learners are frequently easily distracted by noise as well as silence; this is the group of persons who generally enjoy group discussions (Felder & Soloman, 2000:3; Russell, 2006:351-352; Graf et al., 2008:484).

2.7.3 Kinesthetic learners

Kinesthetic learners learn best by being physically involved in whatever is being learned or taught. These learners normally enjoy the opportunity to physically handle the learning materials and tend to take notes to keep busy although they often do not use these notes. Kinesthetic learners commonly tend to remember how to do things after doing the specific activity once and have good motor coordination. Typically, these learners are the ones who do not appreciate or like lectures or discussion classes (Russell, 2006:351-352; Baykan & Nacar, 2007:158).

The model of learning styles proposed by Mohanna et al. (2011:49) discusses the four learning styles identified by Honey and Mumford. Learners may use a combination of two styles, or possess characteristics of all four styles in similar proportions, or may only have the characteristic of one learning style. Honey and Mumford's (cited in Mohanna et al., 2011:49) four learning styles are described as activist, reflector, theorist and pragmatist learners as discussed in Sections 2.7.4 through to 2.7.7.

2.7.4 Activist learners

Activist learners enjoy participating in new experiences; they are open-minded and willing to try "*anything once, thriving on the challenge of new experience*". These learners tend to get bored quickly and want to move on to the next challenge. Activist learners are expressive learners and enjoy being the centre of attention. They learn best when new experiences are introduced; short activities suit them; they enjoy situations where they can be centre stage; they thrive when allowed to generate new ideas and "*have a go at things/brainstorm ideas*" (Mohanna et al., 2011:49). Graf et al. (2008:483) agree and add that active learners prefer to process the information actively by doing something with the material, for example, by discussing or testing the information received. Felder and Soloman (2000:2) and Arora et al. (2013:80) claim that active learners tend to like group work; according to Felder and Silverman (1988:678) this

statement is true as they propose active learners do not learn much in situations requiring of them to be passive.

2.7.5 Reflective learners

Reflective learners tend to stand back, think thoroughly about a situation and collect a vast amount of information before reaching a conclusion. Generally, reflective learners are cautious and “*take a back seat in meetings and discussions*”; they maintain a low profile and tend to appear tolerant and in control (Mohanna et al., 2011:49). When reflective learners act, it is by using the big picture of their own and others’ views. In fact, reflective learners learn best when they are authorised to watch and think about activities, have time to think before acting, are allowed to carry out research first and to review evidence by producing carefully constructed reports and research decisions in their own time (Mohanna et al., 2011:49). It is the stance of Graf et al. (2008:483) that reflective learners prefer to work alone, a view supported by Felder and Soloman (2000:2) as well as Arora et al. (2013:81). In the opinion of Felder and Silverman (1988:678) reflective learners do not benefit from situations that do not provide an opportunity to think about the information being presented.

2.7.6 Theorist learners

Theorist learners generally adjust and integrate observations into logical maps and models. These learners have a propensity to be perfectionists, unbiased, analytic, and objective. Furthermore, they tend to reject information that is subjective, unjustifiable in nature or that involves tangential thinking. Theorists learn best when activities include plans, maps and models to describe what is going on; when afforded time to explore the methodology; when given an unambiguous purpose with a structured situation as well as when given complex situations to understand. Theorist learners learn best when intellectually challenged (Mohanna et al., 2011:49).

2.7.7 Pragmatist learners

Pragmatic learners tend to try out new ideas, theories and techniques in order to determine for themselves whether or not it works in practice. These learners act rapidly and confidently on ideas that attract them, and are impatient with tedious repetition and open-ended discussions.

Pragmatist learners have a preference for problem-solving and attempt to make practical decisions; they learn best when there is a clear link between the information and their job (Mohanna et al., 2011:49). Other learning styles are summarised in Table 2.3.

Table 2.3 Learning styles

CONVERGENT	VERSUS	DIVERGENT
Learners tend to find a single solution to a problem that is presented to them.		Learners tend to generate new ideas, expand existing ideas and explore widely.
SERIALISTS	VERSUS	HOLISTS
Learner learns best by taking one step at a time.		Learner learns best by first obtaining the big picture and then filling in the gaps.
DEEP PROCESSORS	VERSUS	SURFACE PROCESSORS
The learner tends to focus on the main points of information in order to understand it.		The learner tends to read through the material, remembering as much as possible.

Source: Mohanna et al., 2011:50.

As seen in Table 2.3 there are more than just the seven learning styles which are discussed in Section 2.7. In Section 2.8 the focus will be on the adult learner since CPD activities for CCNP focus on adult learners.

2.8 ADULT LEARNER

According to the Children's Act no. 38 of 2005 (South Africa, 2005:24), the legal age for a person to be considered an adult in South Africa is 18 years. In definition an adult is a person who has attained the age of maturity as specified by law (*Dictionary.com*, 2013). However, Gravett (2008:7) proposes that the idea of being 'adult' is not necessarily directly connected to the numeral age but to what happens as a person matures physical and emotionally while growing older in years. The concept of being viewed as adult is socially constructed and the status of an adult is frequently dependent on the degree to which the individual fulfils her or his

social role and accepts responsibility for her or his own life. Various authors endorse the suggestion that the term 'adult learning' implies that the adults' way of learning differs from the way children learn (Beavers, 2009:26; Curry, 2008:18; Gaiser, 2010:2; Russell, 2006:349; Goldman, 2009:927). However, Havelock et al., (1995:13) do not agree with this view, by stating there are many similarities between children and adult learning which include:

Individuals, which would include both adults and children, learn best when –

- they are motivated to learn
- what they need to learn is clear
- different methods of learning are combined (for example, when seeing, listening, talking and doing are combined).

Furthermore, Havelock et al. (1995:13) point out that for both an adult and a child to learn, they need to –

- understand new information to make sense of it
- alter her or his established way of seeing the world in order to make better sense of available information about it.

Havelock's view is supported by Taylor and Hamdy (2013:e1561) who state that the "*differentiation*" between adult and child learning seems to be artificial as many of the principles of adult learning can be equally applied to child learning.

Goldman's (2009:927) ascertains that effective adult learners are independent, self-motivated, and self-directed individuals. In this study the researcher accepted this stance of Goldman to base this study on. Consequently, to develop an effective CPD programme for CCNPs consideration of the characteristics of adult learners and adult learning principles are vital because the facilitator has the responsibility to design a programme that will guarantee that the CCNPs achieve specific objectives. For the facilitator to design such appropriate CPD activities he or she should therefore have a "*firm understanding of certain key principles*" which guide learning (Fink & Osborne, 1992:60; Knowles et al., 2005:174). In addition, Goldman (2009:927), Gravett (2008:8) and Knowles et al. (2005:148) are in agreement that certain critical elements and principles apply to the promotion of optimal and effective adult learning; Knowles et al.

(2005:40) and Gravett (2008:8) in fact refer to it as the characteristics of adult learners. Goldman (2009), Gravett (2008) and Knowles et al. (2005) state adult learners should –

- be actively involved in composing individual goals and meanings
- activate and build on prior knowledge
- own their learning which are done by having intrinsic motivation
- take increasing responsibility for being their own teachers.

The characteristics of adult learners are discussed in more detail in Section 2.8.1.

2.8.1 Characteristics of the adult learner

In Bennett's (1992:31) view every individual who participates in a CPD activity has a unique outlook that is shaped by past experience, individual interest and specific situations or settings. Considering this [Bennett's] view, Walker's (1999:16) statement that the complexities of learner characteristics create challenges in designing studies is valid. Nevertheless, evidence to support the necessity for effective educational interventions is of enormous importance for implementing change in the healthcare system. Havelock et al. (1995:13) posit that facilitators therefore need to be excited and positive yet remain lucid about their objectives. In the opinion of Lesner et al. (2011:32), "*preceptors and learners pursue knowledge together*" to ensure successful teaching of adult learners. This view [Lesner et al.] is supported by Knowles et al. (2005:39) who state that an adult learners' experience counts for as much as the facilitator's knowledge and that it is not always possible to determine who is learning the most, the learner or the facilitator.

The contribution of Lesner et al. (2011) and Knowles (2005) are of particular interest to the researcher as it implies that both the facilitator as well as the learner is then simultaneously engaged in ongoing learning. Ultimately though, as emphasised by Lesner et al. (2011:32) and supported by Muller (2004:293), the responsibility for learning remains with the student. Bearing in mind that all critical care nursing students are adults, it is important to recognise that it cannot be simply be assumed that they are all able to function as adult learners yet.

Despite the fact that every CCNP has individualised characteristics, histories and social linkages that influence their aptitude for learning, they all have certain similarities as adult

learners. Bennett (1992:31) lists ten statements that characterise the “*process of learning for adults*” (adult learners) and these are discussed in Sections 2.8.1.1 through to Section 2.8.1.10.

2.8.1.1 Adults of all ages have the ability to learn

According to Bennett (1992:32), research studies show that, when compared with age, a human being’s ability to learn has a high degree of stability when one is in between one’s twenties and fifties. Additionally, the more active adult learner is indicated to have more stability in learning over time. In support of Bennett’s (1992) view, Pashler et al. (2009:117) state all humans, except those who are afflicted with certain types of organic damage, are born with an astonishing capacity to learn, “*both in the amount that can be learned and in the variety and range of what can be learned*”.

2.8.1.2 Adults are self-directed in their learning

As a general rule, adult learners decide what to learn, when to learn, and how to apply the new knowledge. Although professional groups or organisations may recommend certain activities or content to be learned, most often it is the adult learners themselves who initiate and direct their learning (Bennett, 1992:33). Reaffirming the previous statement, Beavers (2009:27) indicate that adult learners resist learning that is in conflict with the direction they believe their learning should go. Gravett (2008:9) as well as Knowles et al. (2005:40) also agree with Bennett (1992) and Beavers (2009) that adult learners have a self-concept of being responsible for their actions and want to be self-directed in their learning. These authors view are supported by Jones (2013:37) who state that “*learners want to perceive themselves as being in control of their own learning*”. Beavers (2009:27) moreover opine that learning that occurs from personal enquiry is most effective and lasting.

2.8.1.3 Experience is a source of learning

Adult learners utilise their experiences to provide them structure on what to think about certain concepts and how to interpret new concepts: “*Experience provides the path for going from what you know to what you don’t know*” states Bennett (1992:33). Once again, this viewpoint is supported by both Gravett (2008:9) and Knowles et al. (2005:40). These authors indicate that adult learners enter the learning activity or situation with a large amount of experience which

varies from individual to individual. These experiences can aid as a rich source of learning resources. Knowles et al. (2005:40) further explain that experience is the “*richest resource for adults’ learning*” and that the “*core methodology of adult education is the analysis of experience*”. However, Gravett (2008:9) seems to disagree on this point as she indicates that experience can also be an obstacle to learning due to “*well-established attitudes, convictions and thinking patterns*” which is especially applicable if the new information contradicts the adult learners’ beliefs and experiences.

2.8.1.4 Participants look for practical learning

Adult learners usually use their current knowledge to address immediate problems (Bennett, 1992:33). Knowles et al. (2008:40) agree by noticing that adult learners’ learning is “*life-centered*”. Therefore, adult learners will only participate if they are of the opinion that the new information will help them to solve life situations as claimed by Curry (2008:18), Gaiser (2010:4) and Jones (2013:38).

2.8.1.5 Adults learn by choice; learning is voluntary

Voluntary learning is stimulated by the motivation to learn accompanied by great enthusiasm. Motivation to learn is suppressed when an adult is forced to acquire new knowledge which tends to lead to resistance to change (Bennett, 1992:34). According to Gravett (2008:11), if adult learners participate in CPD activities “*out of a sense of need*” and to follow their “*personally relevant goals*”, they are more willing to apply what they have learned. On the other hand, participation may not be voluntary when, for example in work-related training, the learners doubt the relevance; they may regard it as a waste of time (Gravett, 2008:11). Roulston’s (2010:345) stance on voluntary adult learning is also that adults do engage in educational activities by choice; they cannot be forced to learn.

2.8.1.6 Learning is more effective when adults are actively involved

For adult learners to effectively think about new information and to decide where the contents fit into practice, requires active involvement in the testing of new ideas. The same sort of idea testing can occur through passive learning, but without the benefit of thinking and justifying the reason for the outcomes in combination with feedback and support offered by the facilitator

and/or other learners (Bennett, 1992:35). The adult learning process is facilitated when the learner actively participates in the learning process states Russell (2006:350). According to Chikotas (2009:393) and Russell (2006:352), research shows that information learned through active participation is retained longer and leads to the development of self-directed learning which enables individuals to adapt to changes in the practice environment.

2.8.1.7 Feedback is a critical part of learning

Henderson and Eaton (2013:199) indicate that the provision of feedback is essential for enhancing learning in practice. Learning starts with a purpose and objectives for learning; it then moves to translating the purpose into specific content and ends with feedback. Feedback is the "*checkpoint to match the purpose of learning with what is actually learned*" (Bennett, 1992:35). Curry (2008:20) and Nsemo et al. (2013:329) confirm that adult learners have a need for feedback and evaluation because adult learners want to know which standards they are to aim for. Additionally, Clynes and Raftery (2008:406) states that feedback also aids in personal and professional growth.

2.8.1.8 Uses for learning change with different stages in a career

Adult learners differ in their approach to learning at different stages in their careers and lives (Bennett, 1992:35). A child is in school because he has to whereas an adult plan her or his own learning experience due to a need to know (Musinski, 1999:23; Curry, 2008:19). When confronted with a totally new situation or subject the adult learner may require a teacher-centered model until they grasped sufficient knowledge to change over to a learner-centred model (Curry, 2008:18).

2.8.1.9 People learn differently

Adult learners learn in ways differing from each other and in different situations. Since addressing and solving a problem can occur through various ways, learning also occurs through a variety of ways (Bennett, 1992:36; Taylor & Hamdy, 2013:e1561). Research has shown that there is no single learning style better than another due to the fact that people are different in the way they process information. It is thus essential for the facilitator to incorporate activities that will fit different the learning styles of the learners (Bennet, 1992:36; Lesner et al., 2011:29).

The view of these authors is supported by Russell (2006:352) who states that even though each learner requires a unique learning style, adults learn best when teaching strategies combine learning styles such as auditory, kinesthetic and visual as mentioned under Section 2.7.

2.8.1.10 Learners are more likely to make changes as a result of learning if they have a clear image of what will be achieved

For learning to bring change in behaviour, practice and ideas the adult learners usually need to have a clear idea of what change will be achieved before they will consider voluntary participation (Bennett, 1992:31). In support of Bennett's view, Russell (2006:352) states that when an adult learner does not understand the need for change in knowledge or behavior, a barrier exists. Once again, the viewpoint of Bennett (1992) and Russell (2006) is supported by Knowles et al. (2005:183) who reflect on the importance of making use of a collaborative planning process to ensure that adult learners engage in CPD; adult learners need to know the 'why' before they participate in learning activities.

Adult learning theories have evolved over several decades states Walker (1999:18). In the stance of Knowles et al. (2005:73) adult learning theories are only useful to adult learners when they are applied to the facilitation of learning. Learning theories are concerned with the ways in which an adult learns. The various existing theories with regard to adult learning are discussed in Section 2.9.

2.9 ADULT LEARNING THEORIES

Mason (2006:122) refers to the debate regarding the difference (or not) between adult and child learning as longstanding. In the opinion of Curry (2008:17), who favours the idea that a difference does indeed exist, the major difference between child and adult learning is "*life experience and a sense of control*". Children start their school career on a "*clean slate*" because they do not have much knowledge about anything yet since they have only been minimally exposed to life experiences (Curry, 2008:18). Additionally, children have no control over their education, they are sent to elementary, primary and secondary educational institutions without having any say about it. Once again, this view is supported by Havelock et al. (1995:15) who

reflect on children accepting the direction about what they should learn from their teacher whereas adult learners are expected to take responsibility for what, how and when they learn.

Knowles' principles of adult learning are cited in the majority of literature related to the topic of adult learning. The theory driving 'adult learning' is that learning is an internal process where the learner takes control of the learning process and the instructor only facilitates the content. According to Lesner et al. (2011:32), adults "*like autonomy and problem-solving*" as identified by Knowles. Thus, in order to teach adults successfully the facilitators and learners "*pursue knowledge together*" (Lesner et al., 2011:32). The differences in pedagogy (term used when referring to child education) and andragogy (term used for adult education initially used by Knowles) are highlighted in Table 2.4.

Table 2.4 Comparison of pedagogy to andragogy

	PEDAGOGY	ANDRAGOGY
Definition	Education of children	Education of adult
Role of personal experience	To be built upon	Serves as a resource (negative and positive) for learning
Learning preparedness	Assumed by making children go to school	Personal experience stimulates learning
Learning orientation	Depends upon the subject and what is being taught that day	Depends totally upon the adults' goals and interests
Motivation to learn	Grades and praises/ reprimand from teachers	Totally internal; requires personal reflection

Source: Gaiser, 2010:2

It is evident from the information shown in Table 2.4 that there are definite differences between adult and child learning. Cangelosi (2008:125) states adult learners are self-directed and problem-orientated instead of content-orientated. The author adds that motivation to learn is pragmatic and supports the view of Knowles that adults learn best when they are asked to use their experience in their learning and to apply new knowledge; children, on the other hand, may

not have had exposure to certain situations and can therefore not use experience as a resource of information.

Mezirow's theory of transformational learning is also considered an adult learning theory. The supposition behind Mezirow's theory is that adult learners view the world through a personal lens which consists of values, beliefs, and assumptions that have been shaped throughout life (Cangelosi, 2008:125). Thus, the way they process and internalise new information is influenced by their values, beliefs and assumptions.

Another influential adult learning theory is the experiential learning of Kolb which describes adult learning as a cyclical process where the learner moves from experience to reflection to conceptualisation and, finally, to action (Mason, 2006:122). This cyclical process has been identified as the basis for training and learning events including CPD (Mason, 2006:122). Conversely, Brookfield (1998:128-129) warns that caution needs to be used when considering the acceptance of experiential learning as a defining characteristic of adult learning due to the habitual ways from which we draw meaning from our experiences – our experiences may become evidence for the “*self-fulfilling*” perceptions that stand in the way of critical insight. In the context of this study, Brookfield's (1998) warning could have been applicable. The implication thereof is that using experience as a resource of information may also have a negative impact because CCNPs at times practiced in the way they were taught by senior CCNPs who might not always have been up-to-date with best evidence nursing practice information.

According to Knowles et al. (2005:18) “*many of the ‘scientific’ theories of learning have been derived from the study of learning by adults and children*”. Learning theories can be categorised into two groups, namely behaviorist/connectionist theories and cognitive/gestalt theories (Knowles et al., 2005:14). Mohanna et al. (2011:46) categorise learning theories into behaviourist, cognitive and motivational theories. Behaviourist theories indicate that learners learn best by doing, thus through active participation. Cognitive theories indicate that these learners learn best if they understand the content, thus the information is meaningful and fits in with what the learners already know. Motivational theories indicate that learners are naturally curious and are able to learn from all kind of situations. Taylor and Hamdy (2013:e1562) categorise learning theories into instrumental learning theories, humanistic theories, transformative learning theory, social theories of learning, motivational models and reflective

models, all with subcategories. Learning theories should be used in combination and not only one learning theory to take priority above another as learning theories are each incomplete without others states Taylor and Hamdy (2013:e1563). For the purpose of this study more attention is given to Knowles' andragogical model.

2.9.1 Knowles' andragogical model

The term **andragogy** was introduced by Knowles to highlight the differences between adult and child learning (Lesner et al., 2011:32). Knowles initially presented four core learning principles which were later expanded to the six (Norrie & Dalby, 2007:320) core learning principles discussed next.

- **Learners need to know:** if learners are aware of why a topic is important they will be more strongly motivated to learn. When adult learners attend a course without knowing why, what and how there is a decrease level of interest and motivation. By evaluating their own learning needs adults identify the gaps in their knowledge basis which they may need to fill in order to perform efficiently at work. This adult learning principle confirms that individualisation of information is important because adults learn when they realise that the information is relevant to them. Such relevance cannot be attained if individuals are not aware of the importance of learning the skill (Hopstock, 2008:428).
- **The learner's self concept:** adult learners take responsibility for their own learning. Placing the learners in dependant situations will promote resistance and conflict. According to Hopstock (2008:428), adult learners want to be self-directed and feel autonomy in some way. They do not appreciate it when their time is controlled by what others want them to learn. It may lead to feelings of resistance and passivity. By being part of decision-making has a positive correlation to motivation.
- **The role of the learner's experience:** the learners themselves become an important resource for learning. Their experience is an important motivator.
- **Readiness to learn:** adults are ready to learn about topics that become of use to them as they develop personally, for example, empathy and counselling becomes relevant after learners themselves have been in situations that required empathy and counselling skills. This view of Knowles is supported by Govranos and Newton

(2013:2) who state that “*adults engage in learning when they have a reason to engage*”.

- **Orientation to learning:** Knowles describes the learners as being “*life-centred*” (Knowles, 1998:67). Adult learners seek the learning of skills necessary in real life situations and are problem-centred in their learning (Hopstock, 2008:429). This implies that students learn more effectively when presented with real life situations, for example, using the impetus of exposure to new clinical practice.
- **Motivation:** internal motivation to keep growing and developing should be fostered by following the principles of adult learning (Norrie & Dalby, 2007:320). In the stance of Russell (2006:349) life experiences or situations stimulates motivation as adults learn best when they are convinced of the usefulness for knowing the information. In the view of Jones (2013:33) a learner’s motivation to engage in a learning activity depends on the learner’s attitudes, before entering training. In addition, Jones is of the opinion that the learner’s motivation to continue depends on this internal motivation.

Humphreys and Quinn (1994:18) report that Knowles focussed on a new approach to learning, namely adult learning (andragogy) and it was in contrast to child learning (pedagogy). Pedagogy refers to the “*art and science of teaching children*” and andragogy refers to the “*art and science of teaching adults*” (Humphreys & Quinn, 1994:18). These two models are viewed in equivalent, and not in opposition. Pedagogy is appropriate when the learner is exposed to new information or a new learning situation. According to Norrie and Dalby (2007:320), pedagogy is a “*passive strategy*” because learners have “*little personal prior experience and are motivated primarily by external pressures*” whereas andragogy is more concerned on active learning. Havelock et al. (1995:13-16) and Humphreys and Quinn (1994:18-19) highlight five areas where these two models (andragogy and pedagogy) function on different assumptions. These five areas are briefly presented next.

2.9.1.1 *The concept of the learner*

Havelock et al. (1995:13) indicate that the objective of teaching a child is to prepare him or her for adulthood whereas the objective of adult learning is to acquire responsibilities and to function independently; should “*doing and learning come into conflict*”, it is the “*doing*” that wins.

Musinski's (1999:23) stance is that "*a child is in school because he has to be*" while adults return to learning voluntarily. Humphreys and Quinn (1994:18) indicate that pedagogy emphasises the dependence and the role of the teacher and andragogy focusses on self-direction and responsibility (Curry, 2008:18).

2.9.1.2 Self-esteem and motivation to learn

Havelock et al. (1995:14) claim that becoming an adult does not only imply that the person is there to perform a function, but it also means that one needs to be treated with respect. Children are dependent on external motivation by, for example, the teacher and parents; in andragogy internal motivation is what will lead to success (Humphreys & Quinn, 1994:19; Curry, 2008:19; Taylor & Hamdy, 2013:e1568).

2.9.1.3 Previous experience

Humphreys and Quinn (1994:19) indicate that pedagogy makes minimal use of child experience whereas andragogy realises the "*richness and diversity*" which adult experience bring to the learning situation. In addition, Havelock et al. (1995:14) also consider the fact that adults have wider experiences which influence the way they think. Furthermore, Curry (2008:19) states the identity of the adult learner tends to be wrapped up in his or her experience, making it sometimes difficult to engage the adult learner in new learning. This is especially noticeable if the new concepts are in conflict with the old ones they have held for some time.

2.9.1.4 The learners orientation to learning

Children learn in classrooms that have been designed solely for this purpose; adults most often learn in the working environment that was designed for action (Havelock et al., 1995:15). Pedagogy is a subject-orientated approach whereas andragogy is a life-centred, problem-solving approach (Humphreys & Quinn, 1994:19; Curry, 2008:19). This view of Humphreys and Quinn (1994) and Curry (2008) is supported by Gaiser (2010:4) that the adult learner acquire knowledge when the learning is judged to be meaningful instead of the mere acquisitions of information and facts.

2.9.1.5 *The learner's agenda / The learner's readiness to learn*

Children receive direction about what to learn in contrast to adults who are expected to take responsibility for what, how and when they learn. Adults normally only learn what they view as relevant and useful, and at a time that are appropriate for them (Havelock et al., 1995:15; Humphreys & Quinn, 1994:19; Curry, 2008:19).

2.10 CONCLUSION

According to Skees (2010:108), learning is made easier when the work is enjoyable and challenging. Under such circumstances, critical care nurse practitioners are afforded the opportunity to gain knowledge and skills that add value and meaning to their work – what develops then is a cyclical pattern. This cyclical pattern adds to theory and practice integration which in turn results in satisfaction and passion. Satisfaction and passion will then result in a “*greater desire*” (Skees, 2010:108) to learn, and when the new updated knowledge is applied in the critical care unit, excellence in patient care can be the result. A passion for continuous development brings life into the entire learning process, as there is no limit to what and how much a CCNP chooses to learn throughout her or his career. Vella (2000:8) views transformation not as the grasping of an external set of information, knowledge or skills, but more as a “*change into one's new self, informed by the new knowledge and skills*”.

The work environment in the critical care unit “*involves a complex web of interrelated internal and external forces that will affect how the CCNP performs*” (Skees, 2010:108). The organisation's commitment to a “*healthy work environment and excellence in practice*” is only possible by recommending that a bridge be built to achieve it; the bridge, in this case, being encouraging participation in CPD activities.

In Chapter 2 an in-depth discussion of the related literature is provided. The focus in Chapter 3 will be on the research design and methods applied in this study.

4. STUDY FINDINGS AND LITERATURE CONTROL

"What we find changes who we become"

- Peter Morville -

4.1 INTRODUCTION

In Chapter 3 the research method was discussed in depth. In Chapter 4 the researcher provides a thorough discussion of the study findings and how they relate to literature.

4.2 SUMMARY OF THE RESEARCH FINDINGS

Through the use of the nominal group technique (NGT) as described in Chapter 3, five items each with categories and subcategories were identified by the participants in the nominal group. Fourteen critical care nurse practitioners (CCNPs) attended the nominal group session and consensus was reached on five items as well as the rank order according to priority (View Annexure C). The five items were named communication, continuous professional development (CPD), clinical training, time constraints and financial implications.

4.2.1 Ranking process of items

The NGT used various steps for the collection of data as discussed in Chapter 3, Section 3.3.4.2. In the first three steps the participants silently generated items (Step 1), listed the items (Step 2) and then discussed the items for clarification purposes (Step 3). The ranking of the items according to priority occurred during Step 4 when a preliminary voting session was held. The preliminary voting was done on the basis of ranking the items. The participants were requested to rank all five items where five (5) was indicative of the highest priority, progressing downwards with one (1) as an indicator of the lowest priority. Table 4.1 summarise the results of the rank in priorities as delineated by the 14 participants.

Table 4.1. Summary of rank in priorities

RANK	ITEMS	TOTAL VOTING SCORES
1	Communication	56
2	Continuous professional development (CPD)	50
3	Training	42
4	Time constraints	41
5	Financial implications	25

Reading and re-reading through the individual worksheets from the participants, verbatim transcribed data, flip charts as well as through the field notes made during the NGT the researcher identified a central theme, namely **Attitude**. Although attitude was discussed by the participants during Steps 2 and 3 of the NGT, the participants ignored attitude as an item during the ranking process. Following discussions with the independent facilitator and university supervisors, attitude was added as a central theme. Various literature supports the fact that individuals' attitude has an influence on their participation in CPD programmes. The negative attitude of the CCNPs towards the CPD programmes may result in the floundering of even the best planned CPD programmes. The data collected during the NGT are included as evidence (view Annexures C2, C3, C4, and C5).

A summary of the priorities, categories and subcategories are presented in Table 4.2.

Table 4.2 Summary of the priorities, categories and subcategories

RANKED PRIORITIES	CATEGORY	SUBCATEGORY
1. Communication (Section 4.3)	<ul style="list-style-type: none"> Logistic information (Section 4.3.1) 	
	<ul style="list-style-type: none"> Collaboration (Section 4.3.2) 	
2. Continuous professional development (CPD) (<i>“out of the unit”</i>) (Section 4.4)	<ul style="list-style-type: none"> Awareness (Section 4.4.1) 	<ul style="list-style-type: none"> Importance of CPD (Section 4.4.1.1) Job performance management system (Section 4.4.1.2)
	<ul style="list-style-type: none"> Planning (Section 4.4.2) 	<ul style="list-style-type: none"> Needs assessment (Section 4.4.2.1) Collaboration with regard to the choices of topics (Section 4.4.2.2) Acknowledgement of different knowledge levels (Section 4.4.2.3)
	<ul style="list-style-type: none"> Implementation (Section 4.4.3) 	<ul style="list-style-type: none"> Facilitator (Section 4.4.3.1) Teaching strategies (Section 4.4.3.2) Adult learner (Section 4.4.3.3)
	<ul style="list-style-type: none"> Evaluation (Section 4.4.4) 	<ul style="list-style-type: none"> Evaluation of CPD sessions (Section 4.4.4.1) Evaluation of knowledge transfer (Section 4.4.4.2)
3. Clinical training (<i>“clinical in the unit”</i>) (Section 4.5)	<ul style="list-style-type: none"> Planning (Section 4.5.1) 	<ul style="list-style-type: none"> Need assessment (Section 4.5.1.1) Relevance of the topic (Section 4.5.1.2) Collaboration with regard to training topic (Section 4.5.1.3)
	<ul style="list-style-type: none"> Implementation (Section 4.5.2) 	<ul style="list-style-type: none"> Clinical facilitator (Section 4.5.2.1) Teaching strategy (Section 4.5.2.2)

RANKED PRIORITIES	CATEGORY	SUBCATEGORY
4. Time constraints (Section 4.6)	<ul style="list-style-type: none"> Scheduled time for CPD (Section 4.6.1) 	
	<ul style="list-style-type: none"> Personal time (Section 4.6.2) 	
5. Financial implications (Section 4.7)	<ul style="list-style-type: none"> Personal financial implications (Section 4.7.1) 	<ul style="list-style-type: none"> Overtime (Section 4.7.1.1) Job performance management system (Section 4.7.1.2)
	<ul style="list-style-type: none"> Organisational financial implications (Section 4.7.2) 	
CENTRAL THEME:		
<ul style="list-style-type: none"> Attitude (Section 4.8) 		

Each of the 5 priorities as well as the central theme is discussed in depth in Sections 4.3 to 4.9. The discussions focus on the priorities, categories and subcategories on which consensus were reached following the nominal group process. In addition, supportive literature for each priority, category and sub-category is provided.

4.3 PRIORITY 1: COMMUNICATION

From the study findings, it was evident that CCNPs were of the opinion that the main reason for unsatisfactory attendance of the CPD programme was related to lack of effective communication. The following quotes (quotation is from participants) pertaining to communication support the findings that communication is an area of concern.

Supportive quotations:

- "... information needs to be communicated ..."*
- "... poor communication ..."*
- "... it is all about communication ..."*

- *“... it also creates conflict between the workers [CCNPs] and the shift leaders that has to arrange the off duties ...”*

Discussion: According to Gibbs (2011:155), one of the challenges regarding the improvement of CPD provision and attendance is effective communication. Effective communication facilitates better understanding of a person or situation, enables individuals *“to resolve differences, build trust and respect, and create environments where creative ideas, problem solving,”* as well as caring can grow (Robinson, Segal & Segal, 2013). This view is supported by Brinkert (2010:146) who states that effective communication is crucial because it often *“creates conflict, reflects conflict and is the way in which conflict is productively or destructively managed”*. Additionally, effective communication is associated with improved job satisfaction (McCaffrey et al., 2011:121). To communicate effectively means communication is *“timely, accurate, complete, unambiguous, and understood by the recipient”* which reduce errors and result in improved outcomes (Victorian Quality Council, 2010:3).

Tay, Ang and Hegney (2012:2648) state effective communication is a two-way process. These authors support the view of Robinson et al. (2013) by ascertaining that it is essential to ensure that the correct message is sent and that it is correctly received and interpreted. As easy and simple as communication appears to be, the message is often misunderstood by the recipient and this may result in conflict and frustration in professional relationships. Through the use of effective communication skills, the individual can excel in connecting with co-workers and other individuals (Robinson et al., 2013). In the study done by Gibbs (2011:155) the research findings highlight that two-way communication is commonly a problem because the needs of the CCNPs are not constantly recognised from management’s perspective and also CCNPs do not constantly communicate their needs effectively to the clinical facilitators.

According to Smith (2006:300), ineffective communication is one of the reasons for failure of well-developed CPD programmes. To achieve success and lasting change as a result of the attendance of a CPD programme, it is essential to ensure efficient communication (Smith, 2006:304; McCaffrey et al., 2011:121). Personnel are more susceptible to participation when they are provided with clear information regarding the reasons for the needed change. In

contrast, resistance to change is to be expected when “*clear and honest communication is absent*” (Smith, 2006:304). According to Brekelmans, Poel and van Wijk (2013:4), participation in CPD programmes is stimulated by effective communication whereas poor communication is shown to have the opposite effect. Jost and Rich (2010:35) hold that skilled communication focusses on developing skills around how to listen actively and communicate effectively. The participants in the current study referred to the lack of communication with regard to logistic information and collaboration.

The two categories that emerged from Priority 1: communication included logistic information and collaboration and these are discussed in Sections 4.3.1 and 4.3.2.

4.3.1 Category 1: Logistic information

From the collected data participants indicated that they require certain information early in the year in order to plan their activities. This information includes information pertaining to the topics and/or content of the CPD programme planned for the coming year and should include the dates, times, duration, venues and contents for these courses. The following quotes pertaining to communication recognise the findings related to the importance of general communication with regard to the logistics around the CPD programme.

Supportive quotations:

- “... *get the memorandum too late that there has to be training ...*”
- “... *getting the dates too late ...*”
- “... *courses are not communicated ...*”
- “... *attending the course, then it is not what you expected ...*”

Discussion: Smith (2006:304) indicates that efficient communication is essential to achieve successful and ongoing change brought about by attending a CPD programme. The study done by Lee (2011:393) indicates that consistent communication is highly appreciated when the nature, timing and dissemination of CPD opportunities as well as the expectations following the

CPD programme are pointedly communicated. In this case, communication will be positive and contribute to the effective provision of and attendance to the CPD programme.

A barrier identified by Lee (2011) related to communication is that follow-up, evaluation and ongoing support with regard to CPD programmes were minimal. The author therefore advocates that communication of the expectations of the CPD programme should include a clear discussion of the intended outcomes following the programme – *“what is expected of the participants, what is the time frame, what resources are there to help, and how the CPD enhances”* the healthcare service provided by the organisation (Lee, 2011:393). In the stance of Brekelmans et al. (2013:4) effective communication stimulates participation in a CPD programme. In addition, effective communication is classified by McCaffrey et al. (2011:122) as an important aspect to successful collaboration.

4.3.2 Category 2: Collaboration

The participants voiced that the current communication between the CCNPs and management was a one-way system. The participants shared that they wanted to be involved in the decision making process with regard to the CPD programme and indicated that there should be collaboration between the CCNPs and management on this aspect. The participants speculated that if there was collaboration between management and the CCNPs they would probably participate more easily in the CPD programme, even when they experienced it as uninteresting and irrelevant.

The following quotes pertaining to communication support the findings related to collaboration with regard to the CPD programme.

Supportive quotations:

- *“... it [CPD process] is a one way thing ...”*
- *“... everything is just pushed down upon the staff ...”*
- *“... employers [CCPNs] do not have a say in what their [CCNPs] needs are ...”*
- *“... are scheduled ... without being discussed first whether you’ll [the CCNP] be able to attend ...”*

- “... it [CPD] is not prearranged with staff and discussed beforehand the needs to improve or needs to train ...”
- “... the company is taking over and do not give us ownership ...”
- “... we [CCNPs] are treated as children ...”

Discussion: According to Smith (2006:305), it is important to attend to the human factor – thus the people – in the organisation as they hold “*the key to success or failure*”. For a CPD programme to result in changes in practice it is essential to ensure that personnel stay informed, is connected with and treated professionally as they form the basis which leads to success or failure of the organisation. McCormack, Manley and Titchen (2013:2) support the view of Smith by stating that a top-down approach without bottom-up inputs result in ineffective changes processes and poor outcomes. Furthermore, Smith (2006) believes that “*poorly handled*” personnel “*may be the biggest hurdle*” in achieving success. This view is supported by Gould et al. (2007:607) who point out that the feeling of being “*pressurised by managers*” to engage in a CPD programme with the mere objective to meet the requirements of the organisation will contribute to poor attendance of the CPD programme. The factor of collaboration provokes the idea that CCNPs are completely pivotal to nursing care (Jost & Rich, 2010:36).

Collaboration involves supporting sustained teamwork by developing a culture that values personal integrity, sharing power and respect, integrating individual differences, resolving competing interests, and safeguarding the essential contribution that each individual makes to achieve the desired outcomes (McCaffrey et al., 2011:122). Richardson and Storr (2010:13) describe collaboration as a process influenced by respectful interactions among personnel which include information sharing and coordination of activities to achieve organisational goals. McCaffrey et al. (2011:121) as well as Marzlin (2011:49) agree and describe collaboration as a process of joint decision making which involves joint ownership of the decisions and responsibility for the outcomes. Furthermore, Jost and Rich (2010:36) view collaboration as a practice philosophy which demonstrates trust, team orientation, respect, collegial communication and behaviour as well as respect for diversity.

It is the view of Vaziran et al. (2005:71) that collaboration is the interaction between stakeholders which, as explained by Newton, Wood and Nasmith (2012:95), “enables the knowledge and skills of both professionals to synergistically influence the patient care being provided”. In fact, Jost and Rich (2010:36) posit that the absence of collaboration would signify that care delivery is incomplete or less excellent. Lee (2010:393) predicts that joint collaboration during the exploration of the dissemination of CPD opportunities would increase understanding and result in extended opportunities for CPD participants.

4.4. PRIORITY 2: CONTINUOUS PROFESSIONAL DEVELOPMENT

From the data collected it was clear that the participants viewed CPD and training (clinical training, on-the-spot teaching) as two different aspects and for this reason it is discussed as two different themes. When they discussed CPD the participants only referred to activities that normally take place outside their CCUs. Continuous professional development was identified by the participants as the second theme with categories and subcategories. The following quotes pertaining to CPD verify the findings that CPD was viewed mainly as formal (off hospital premise) courses by the CCNPs.

Supportive quotations:

- “... lack of knowledge about CPD ...”
- “... confusion as to which programmes have CPD points ...”
- “... want to attend conferences, congresses ...”

Discussion: Schostak et al. (2010:588) reason that maintaining current knowledge, expanding existing knowledge and confirming practice vary from the attendance of conferences, workshops, external meetings, in-house meetings and the sharing of real life case studies to interactions with colleagues. By engaging in a CPD programme the practitioner may learn something new, or may re-learn something which he or she has lost sight of, or it may involve looking at something from a totally new or different angle. In the view of Barnes et al. (2013:13) effective CPD is that which enables the participants to gain new knowledge and or new skills.

Based on the data collected the following four categories emerged under Priority 2: continuous professional development: awareness; planning; implementation and evaluation. A detailed discussion of each category including its subcategory is presented from Sections 4.4.1 to Section 4.4.5.

4.4.1 Category 1: Awareness

All the participants were in agreement that the CCNPs' awareness of CPD needed to be increased well as the effect of CPD on their job performance management scores (JPMs). The following verbatim quotes support the findings related to the need for an increased awareness of CPD.

Supportive quotations:

- *"... they [CCNPs] do not think it is necessary to attend CPD ..."*
- *"... not well marketed into our minds ..."*
- *"... personnel don't see the importance of it [CPD] ..."*

Discussion: According to Draper and Clark (2007:515), it is essential that the value of a CPD programme to direct patient care is conveyed to employees. Sturrock and Lennie (2009:13) highlight the fact that the lack of understanding the importance of a CPD programme can be a barrier to successful implementation of such a programme. Brekelmans et al. (2013:3) agree and state awareness of and understanding a CPD programme does influence the attendance of a CPD programme. Brekelmans et al. (2013:11) advise that furthering the awareness of CPD is essential; this important statement is supported by Gibbs (2011:156) who points out that professionals require guidance to heighten their awareness and understanding of CPD as it will enable them to develop into lifelong independent learners.

From Category 1 two subcategories emerged: The importance of CPD programmes and Job performance management (JPM) system. These two subcategories are discussed in Section 4.4.1.1 and Section 4.4.1.2.

4.4.1.1 Subcategory 1: The importance of CPD programmes

The participants confirmed that the CPD programme was not perceived as important because they were not aware of the significance of CPD as such. They admitted they did not know what CPD was and therefore did not understand the reasons behind CPD. It was further indicated by the participants that they expected the Human Resource Department to inform the CCNPs with regard to the requirements of the SANC regarding CPD. The following quotes support the findings related to the awareness of the importance of the CPD programme.

Supportive quotations:

- *“... the introduction of CPD for nurses was not communicated ...”*
- *“... not communicated on the importance of CPD ...”*
- *“... don’t understand the reasons for CPD and how its [CPD points] accumulated ...”*
- *“... do not understand why they [CCNPs] must attend ...”*
- *“... don’t see the need to go, we [CCNPs] know what to do ...”*
- *“... personnel don’t see the importance of it [CPD], they [CCNPs] are not educated enough on why they need CPD points ...”*

Discussion: In today’s social environment society is likely to seek professional legal assistance if they feel that their rights have been neglected or denied. It is the view of Roscoe (2002:3) that no professional completes her or his initial training equipped to practice competently for the rest of her or his career. Therefore, it is important for CCNPs to ensure that they take responsibility for their own CPD in order to maintain currency of practice as a devotion to provide best evidence practice and to deliver safe and effective healthcare (James & Francis, 2011:132; Gould et al., 2007:605; Poell & van der Krogt, 2013:1). In the stance of Bennetts, Elliston and Maconachie’s (2012:541) CPD is a professional obligation for all health workers.

Continuous professional development is an important activity which has the potential to promote the CCNPs’ adoption of the most effective practices (Légaré et al., 2010). Not only is CPD an important learning opportunity but it plays a vital role in nursing retention and in securing job

satisfaction. Henderson and Eaton (2013:197) state CPD is moreover needed to ensure that healthcare practice is current.

In the view of Murphy, Cross and McGuire (2006:367) CPD is not “*a luxury, but a necessity*” because the speed of change is continually increasing and in order to cope with the level of change professionals must continue to learn. The commitment to learning enhances a professional’s ability to keep up to date with the frequent changes in the healthcare setting. Brekelmans et al. (2013:3) share this view by stating the requirement to stay “*up to date*” professionally has become of critical importance to guarantee high quality of healthcare. Johnson et al. (2010:618) contribute to nurses’ ongoing learning and development by highlighting that the investment in professional learning and development of personnel has a positive impact on patient care, the individual nurse, as well as the healthcare organisations. Participating in a CPD programme improves staff recruitment, retention and also supports practitioner knowledge and skills. This view is [Johnson et al.] supported by Lahti et al. (2013:6). It furthermore ensures the maintenance of quality standards of patient care which keeps organisations competitive in the market (Marzlin, 2011:47; Kitto et al., 2013:150; Barnes et al., 2013:13).

According to Gallagher (2007:467), the importance of CPD has been highlighted since the “*beginning of the profession, as recounted in Florence Nightingale’s (1859, 1893) annotations, encouraging nurses to continue to learn*”. Gibbs (2011:154) indicates that CPD is an assortment of learning activities through which professionals can maintain and develop continuously to ensure that they uphold their capacity to practice legally, safely and effectively within an advancing scope of practice. McHugh and Lake (2010:279) make a profound statement on the importance of nurses’ participation in CPD programmes; these authors maintain that “*without background knowledge, nurse’s risk using poor judgment ... theory and principles enable nurses to ask the right questions ... to provide safe care and make good clinical decisions*”. In support Marzlin (2011:45) adds that “*knowledge is the foundation for clinical judgement, clinical reasoning and critical thinking*”.

To Lee (2011:390) it is clear that CPD enables the individual professionals to adapt, adjust and update their skills to deliver high quality patient care. This can be done by addressing the need for healthcare professionals to update their expertise in the context of changing nursing and

healthcare practices through initiatives such as lifelong learning. Continuous professional development is “*a process of lifelong learning*” with the intention to meet the needs of patients and to enable the CCNPs “*to expand and fulfil their potential*” (Lee, 2011:390).

James and Francis (2011:133) found that mandatory CPD proved to increase “*general knowledge, increase awareness of issues concerning the profession, and improve practice*”. The interest in the identified CPD topics is relevant to practice and is the most common reason for the particular programmes to be selected. It is advised that a practical way in which the nursing profession can accomplish best practice and to be sure that all nurses are competent is by implementing mandatory CPD for registration purpose (James & Francis, 2011:133). In the study conducted by Brekelmans et al. (2013:9) the findings indicate that “*most nurses do not undertake CPD activities by themselves*”; this is indicative that the need for CPD is still not adequately recognised by nurses.

In literature there are differing opinions on the issue of mandatory CPD. For Eustace (2001) (cited in James & Francis, 2011:133) the issue is that mandatory CPD “*undermines the inherent responsibility of the nursing profession*” thereby implying that embark on CPD the nurse must be forced to do so. Waddell (2001) (cited in James & Francis, 2011:133) challenges the view that CPD should be a mandatory activity as the concept ‘mandatory’ “*violates the social contract held between the nursing profession and the public with regard to the process of self-regulation*”. James and Francis (2011:133) provide evidence that the attendance of a CPD programme alone does not guarantee that learning took place. These authors note that to assess participation in a CPD programme as adequate to maintain competence, is difficult.

4.4.1.2 Subcategory 2: Job performance management system

The participants concurred that the CPD programme should be linked to the specific hospital’s job performance management (JPM) system and that the CCNPs should be made aware of what the implications of such a linkage would entail. They felt that all the CCNPs would then have to participate in the CPD programme as they claimed it was not always those who needed training the most who participated in the CPD programmes. The following quotes pertaining to awareness of CPD verify the findings related to the JPM system.

Supportive quotations:

- “... do not get reprimanded for not going [attending CPD programme] ...”
- “... company takes our responsibility ... should take our own CPD points responsibility ... make it part of JPM ...”
- “... planning for year in correlation with courses ... JPM two way process ... have dates before then [JPM meeting] and discuss with staff ...”

Discussion: Jaradeh and Hamdeh (2010:314) state CPD has become a necessity to maintain effective, safe and quality nursing. Marzlin (2011:41) points out that a CPD programme must result in change in practice, skills and/or attitudes in order to be effective. Marzlin (2011) also establishes that integration of knowledge takes place when it is combined with performance and confirms that the primary aim of a CPD programme should be to link the newly acquired knowledge to clinical practice (Marzlin 2011:47).

In the opinion of Muijs and Lindsay (2008:196) CPD is a shared responsibility between the individual and the employer as it serves the interest of both parties. However, James and Francis (2011:132) indicate that the main responsibility stays with the individual professional by pointing out that as a professional individual the CCPN is an accountable person and should be committed to participate in a CPD programme to ensure delivery of competent and quality healthcare. This point of view endorses the **Nursing Act (33 of 2005)** of South Africa in which it is stipulated that a professional nurse is a person who is qualified and competent to practice comprehensive nursing independently to the level prescribed and who is capable of assuming responsibility and accountability for her or his actions. According to Jooste and Jasper (2010:706), continuous competence is an integral part of professional responsibility and for this reason CCNPs are accountable for maintaining their competence in nursing care. Brekelmans et al. (2013:3) reaffirms this view by pointing out that professional development should be a belief for which each nurse takes personal responsibility.

4.4.2 Category 2: Planning

The planning of a CPD programme has a major influence on the attendance of the CPD programme as indicated by the participants. The following quotes pertaining to CPD support the findings related to the planning of a CPD programme.

Supportive quotations:

- “... *poor planning ahead* [on management level] ...”
- “... [management and CCNPs need to] *try to plan early in year* ...”
- “... *it also comes back to planning* ...”

Discussion: According to Gibbs (2011:156), the key to successful CPD is to “*know what is to be achieved*”; only when the objective is clear, it is possible to plan an appropriate strategy. Continuous professional development by definition is a continuous process and is not an instant solution to “*the problem of developing a sustainable skill base*”. Continuous professional development should rather be considered to be a long-term devotion to continuous improvement through the development of a “*capable and effective workforce*”. Jaradeh and Hamdeh (2010:320) highlight that for CPD to be effective it should be based on proper planning.

Based on the data collected, three subcategories emerged from the category, planning of a CPD programme. These subcategories included need for assessment, collaboration with regard to the topic choices and acknowledgement of the different levels of knowledge. A detailed discussion of each category including its subcategory is presented in Sections 4.4.2.1 to Section 4.4.2.3.

4.4.2.1 Subcategory 1: Need assessment

The participants strongly agreed that it is important that a thorough need assessment should be done before the planning of a CPD programme. Their viewpoint was that there was no need assessment done before the planning and thus the needs of the CCNPs were not considered. The following quotes pertaining to CPD support the findings related to the importance of a need assessment.

Supportive quotations:

- “... individual’s needs differs from person to person ...”
- “... employees’ needs for improvement are not met ...”
- “... no thorough evaluation is done to determine the need for improvement of specific ranks and categories ...”

Discussion: Schostak et al. (2010:590) claim that for a CPD programme to be effective it must address the needs of the individual practitioners, the population and the organisation they serve. Findings from the study done by Munro (2008:959) indicate that it seems as if learning is not valued and that the needs of the individual experienced practitioners are not being addressed. In their study Berridge, Kelly and Gould (2007:64) raised the following significant question: “Whose *needs prevail?*” In the view of Poell and Van der Krogt (2013:1) CCNPs may have other interests coming to learning [CPD] than their managers and educators do. Berridge et al. (2007) claim that there exist tension between personal objectives/development and the needs of the organisation and posit that compromise on the part of the individual (the CCNP) tends to lead to frustration.

Jaradeh and Hamdeh (2010:314) state participation in a CPD programme depends on work situations as well as on changes of personal needs and the individual’s ability to consider CPD which is driven by behaviours that are rewarded either extrinsically or intrinsically. The findings from the study conducted by Jaradeh and Hamdeh (2010:318) indicate that when the type, nature and content of the CPD programmes are not in accordance with the individuals’ (CCNPs’) needs, the individuals are reluctant to participate in these programmes. Reaffirming the aforementioned findings, Beavers (2009:27) concede that adults tend to resist learning that is in conflict with the direction they believe their learning should go. In addition, Poell and Van der Krogt (2013:5) states that practitioners acts strategically when it comes to their professional development as their individual professional developmental goals may or may not align with the organisational goals.

Marzlin (2011:49) states for participating practitioners to be engaged, committed and able to maximise their contribution to improve patient outcomes, it is pivotal that their needs are met. In

support of Marzlin view, Pool et al. (2013:42) state that CPD has to take the participants needs and aspirations into consideration. Brekelmans et al. (2013:14) opine that CCNPs are responsible for their identifying their own professional development needs. According to Berridge et al. (2007:68), a proper need assessment is essential to ensure that effective and appropriate training is available to meet the needs of the CCNPs. These authors further advise that a need assessment should be flexible, well-executed and have clear links to the CPD directive.

4.4.2.2 Subcategory 2: Collaboration with regard to topic choices

From the collected data it was evident that the participants found the CPD programme to be boring and not interesting. The participants claimed that a collaborative approach might change these perceptions since collaboration may increase the sense of ownership and increase the value of topics to the participants. The following quotes pertaining to CPD support the findings related to collaboration with regard to topic choices.

Supportive quotations:

- “... if you [CCNP] make the decision to go on specific courses then you will attend ...”
- “... not applicable to speciality ...”
- “... same training that is been repeated ...”
- “... [CCPN] do not understand the topic ...”

Discussion: According to Jost and Rich (2010:36), collaboration includes terms such as ‘shared governance’ and ‘partnership’ which conveys a sense of being connected to the other members of the health team; in other words, all are equally engaged and accountable for the decision making as well as for the outcomes.

Marzlin (2011:41) points out that nurses often engage in CPD programmes in “*a randomly selected manner with little structure or defined expectations for resultant change in clinical practice*”. Marzlin (2011:49) therefore reasons that it is imperative to meet the needs of the participating professionals for them to be engaged and committed as well as for them to be able to maximise their contribution to improve patient outcomes through the use of up-to-date

knowledge and skills. As mentioned before, Muijs and Lindsay (2008:196) write CPD is a shared responsibility between the individual and the employer as it serves the interest of both. Collaboration leads to stimulation of participation in CPD (Brekelmans et al., 2013:4).

4.4.2.3 Subcategory 3: Acknowledgement of different levels of knowledge

The participants agreed that the diversity of knowledge levels needs to be considered during the planning of a CPD programme. According to them, they became frustrated when attending a CPD programme together with lower category or rank colleagues. (This statement refers to trained CCNPs versus non-trained CCNPs). The following quotes pertaining to CPD support the findings related to the acknowledgement of different levels of knowledge.

Supportive quotations:

- *“ ... topics need to be of the practical level of category ...”*
- *“ ... coming for basic nursing lecture with lower category ... newly qualified RNs is very much irrelevant for a CCNP ...”*
- *“ ... there should be an assessment done in the unit and then decided on the level of the courses ...”*
- *“ ... need assessment should be according to levels [of knowledge] ...”*

Discussion: Topley (2009:321) confirms that finding the appropriate level of CPD for all levels of personnel’s experience and backgrounds require creativity and broad programme objectives. The difference between the learning needs of experienced and those of qualified nurses provides challenges. According to Henderson and Eaton (2013:198), participants need to be accepted according to their abilities as this will encourage participation and their capabilities will be advanced through constructive feedback.

Marzlin (2011:47) maintains that the goal of all CPD is to improve patient outcomes through a change in practice. She affirms that changing practice is a challenge for nurses at all developmental levels. Marzlin (2011:47) infers that the novice practitioner has difficulty integrating new information into practice because the focus at this level is often on task

accomplishment. On the other hand, the experienced practitioner may be equipped with critical thinking skills, has years of practice preferences and biases that often interfere with the processing of new ideas or changes required. This author therefore believes that effective strategies for knowledge and practice integration are a critical component for planning a CPD programme by keeping in mind the different knowledge levels.

4.4.3 Category 3: Implementation

There are various factors which influence the effective implementation of a CPD programme as identified by the participants. These factors can be categorised into one of the following three subcategories: the facilitator, teaching strategies and adult learner. The following quotes pertaining to CPD support the findings related to the implementation of a CPD programme.

Supportive quotations:

- “... programme at times too lengthy – impossible to process all the information ...”
- “... some training is boring ...”
- “... the topics presented are not interesting ...”
- “... the courses are not standardised ...”

Discussion: Gibbs (2011:155) indicates that the actual provision of CPD is an area where professionals want more flexible delivery of a CPD programme. In the following sections a more in-depth discussion follows with regard to the subcategories of the implementation of a CPD programme. For CPD to be effective it should occur in a way that is personally meaningful, engaging the practitioners own experiences and previous knowledge in an interactive approach with the relevant content, logic and existing evidence (Kemp & Baker, 2013:1).

As mentioned above, from Category 3 three subcategories emerged. These three categories are discussed in Sections 4.4.3.1 to Section 4.4.3.3.

4.4.3.1 Subcategory 1: Facilitator

The participants all indicated that the facilitators who facilitate the CPD programme play a significant role in the attendance and/or unsatisfactory attendance of the CPD programme. The participants concurred that the facilitator should be a specialist and knowledgeable about the contents of the CPD programme. Additionally, the participants stated they did not have time to teach non-trained CCNPs and viewed it as the role of the clinical facilitator to “*educate part-time staff and newly qualified RNs*” in the unit. The following quotes pertaining to the implementation of a CPD programme support the findings related to the facilitator.

Supportive quotations:

- “... depends on who present the lecture ...”
- “... facilitator [needs] to be enthusiastic ...”
- “... specialists to do the training ... [need to be] practically skilled ... [need to be a] clinical tutor ...”
- “... facilitator to be knowledgeable ...”
- “... not enough clinical facilitators [to attend to everyone] ...”
- “... clinical facilitator to educate part-time staff [agency personnel] and newly qualifieds [RNs]...”
- “... as a CCNP you need to reinforce what juniors learned during CPD sessions and it is time consuming ...”

Discussion: Marzlin (2011:49) declares that nurses need support to apply the new knowledge (acquired by attending a CPD programme) in clinical practice since the practice atmosphere in which practitioners work is frequently not open to change. This view is supported by Henwood and Taket (2008:209) who state an important component of facilitation is support which can impose a positive or negative effect on the participation in CPD. Highly motivated and supported individuals learn and develop more than poorly motivated and supported individuals.

Marzlin (2011:51) further infers that clinical practice changes can occur as a result of knowledge acquisition; it can thus have a positive impact on patient outcomes which is the main goal of

CPD. Marzlin (2011:51) adds that “*teaching is one of the most effective methods for reinforcing learning*”; therefore, utilising clinical experts fortify “*the body of bedside nursing knowledge*”.

The role of the clinical facilitator in the opinion of Omansky (2010:698) is to guide the nurses from simply *knowing* the theory to the *application* thereof; hence, teaching the nurses clinical skills and clinical thinking. Henderson and Eaton (2013:198) state the behaviour of the clinical facilitator directly influences participation in workplace practices. It is Raterink’s (2011:136) viewpoint that the facilitator must consider the work environment aspects that may affect performance and hinder or create a culture for lifelong learning which is, after all, needed for increased competency in practice. Facilitation of learning in the busy contexts of clinical environments requires recognition by the organisation (management teams) of the importance of CPD and it (CPD) needs to be prioritised in the context of clinical care (Henderson & Eaton, 2013:199; Rodger et al., 2008:56).

One of the concerns raised by the participants in the study was that they felt clinical facilitators were not always knowledgeable. With regard to this issue raised, Henderson and Eaton (2013:198-199) explain that facilitators are not always assisted to facilitate others due to the fact that they are often poorly prepared for the role of facilitator. The authors’ stance is that management displays a lack of understanding with regard to the time needed to assist nurses.

4.4.3.2 Subcategory 2: Teaching strategies

From the data collected it was obvious that a need existed for implementing different strategies to stimulate all types of learners (visual, auditory, kinetic, activist, reflective, theorist and pragmatist learners) as, in fact, highlighted by the different views that was shared by the 14 different participants. Some of the participants experienced the CPD programme as too long and boring while others were concerned that the programme did not provide sufficient time to ask questions and not sufficient time to process the information; some felt that they needed repetition of certain CPD activities whereas others experienced frustration when they attended the same CPD activities the next year. The following quotes pertaining to the implementation of a CPD programme support the findings related to different teaching strategies.

Supportive quotations:

- “... some training is boring ...”
- “... programme too long at times ...”
- “... impossible to process all the information ...”
- “... no time to ask questions ...”
- “... same training that is been [being] repeated ...”
- “... certain CPD training must be presented over a short time period but more often in order that information can be better processed ...”

Discussion: The use of multisensory signals (using visual aids together with hearing) during a training session is of value to most learners (Fink & Osborne, 1992:61) and the use of multiple teaching strategies would benefit the attendees (Chipchase, Johnston & Long, 2012:90). In the opinion of Muijs and Lindsay (2008:196) and Jooste and Jasper (2010:706), CPD can encompass a variety of teaching strategies in a variety of settings. Jooste and Jasper (2010:706) add that CPD recognises a range of learning activities through which CCNPs can maintain, improve and develop their knowledge, skills and values to ensure safe, effective and legal nursing practice. These activities include work-based learning opportunities, knowledgeable peer support, in-service training programmes as well as more formal educational activities. If the learning activities involve a problem-solving approach, motivation as well as active participation is fostered. Active participation on the part of the learner results in higher quality learning than a passive, uninvolved experience (Fink & Osborne, 1992:61).

4.4.3.3 Subcategory 3: Adult learner

The participants indicated that they were adult learners and that adult learning principles should be applied during the provision of CPD programmes. They revealed that the fact that they were treated as children did influence their willingness to attend the CPD programme. The participants agreed that if they were to participate actively in the CPD programme they would learn more and that would make the CPD session more interesting and enjoyable. They in fact pronounced that they wanted to be responsible and accountable for their own CPD activities as

it would enhance their motivation to attend the CPD programme. The following quotes pertaining to the implementation of a CPD programme support the findings related to the need to be treated as adult learners during the implementation of a CPD programme.

Supportive quotations:

- “... the company is taking over and do not give us ownership ...”
- “... company takes our responsibility ... [we – the CCNPs] should take responsibility for our own CPD points ...”
- “... we [CCNPs] are treated as children ...”
- “... employees [CCPNs] do not have a say ...”
- “... we [CCNPs] want to choose for ourselves ...”
- “... if you [CCNP] make the decision to go on specific courses then you will attend ...”
- “... the training does not always include the group, only listening ...”
- “... the CCNPs are not motivated ...”

Discussion: Topley (2009:322) holds that adult practitioners take pleasure in learning when it involves active participation and dialogue and which includes the opportunity to ask questions. A non-threatening CPD programme that does not intimidate practitioners has a high probability of being successful. Critical nurse practitioners generally have inquisitive and active personalities and therefore they become easily uninterested; thus, CPD activities which involve expression of opinions and encourage discussions of past experiences and previous knowledge function as an encouragement for active participation (Topley; 2009:322; Chipchase et al., 2013:90). In the opinion of Marzlin (2011:47) interactive forms of CPD presentation seem to be more effective than presentations in lecture format only. Phillips et al. (2013:1228) indicate that the endorsement of student-centred learning encourages independence, self-motivation, critical analysis and reflective practice which are important characteristics in a CCU.

According to Marzlin (2011:47), the participant’s motivation to gain new knowledge and to re-discover previously learned knowledge plays an important role in the actual acquisition of knowledge. Supporting Marzlin’s view, Khomeiran et al. (2006:69) mention motivation as an

important element of participants' desire to successfully complete a CPD programme. James and Francis (2011:133) affirm that motivation has a significant influence on the degree of participation in a CPD programme and Brekelmans et al. (2013:3) believe that individual motivation is fundamental to participation in a CPD programme. If a nurse is not motivated then no matter the amount of mandatory or voluntary CPD he or she attends, it will not be effective in changing behaviour.

4.4.4 Category 4: Evaluation

Category 4 focusses on the evaluation of the CPD programme which the CCNPs referred to as vital. Category 4 is subdivided into two subcategories: evaluation of CPD session and evaluation of knowledge transfer. These two subcategories are discussed in Section 4.4.4.1 and Section 4.4.4.2.

4.4.4.1 Subcategory 1: Evaluation of CPD session

The evaluation of a CPD programme is necessary to identify areas for improvement and to determine whether the CPD programme was of value to the learners. Unfortunately, this was not done during the implementation of the CPD programme. From the data collected it was evident that it would have been beneficial if it had been done by the participants. Various comments made by the participants indicated that an evaluation of the CPD programme is essential. For the CCNPs to be able to evaluate the CPD programme will also allow them to give inputs or suggestions for future use which may lead to improved attendance of the CPD programme. The following quotes pertaining to the evaluation of a CPD programme support the findings related to the need for evaluation of a CPD programme.

Supportive quotations:

- “... [CPD sessions are] *too long* ...[and] *boring* ...”
- “... [a CPD session contains] *too much information* ...”
- “... [CPD content is] *irrelevant to CCNPs speciality* ...”

Discussion: Boud and Hager (2012:17) state it is easier to measure attendance than anything else, as professional organisations mandating CPD led to the fact that CPD became synonymous with participation in courses or seminars. In Muijs and Lindsay's (2008:208) view the evaluation of a CPD programme is most likely to take the form of measuring the participants' satisfaction. Marzlin (2011:47) admits that the evaluation of the CPD programme outcomes is difficult due to various reasons which include the lack of reliable tools as well as the existence of outside factors that have an effect on clinical practice.

Although it might be challenging at times, Muijs and Lindsay (2008:195) feel that it is essential that the effectiveness of the CPD programmes are evaluated due to the fact that CPD is progressively becoming more and more recognised as important for all health practitioners to maintain and develop their competence. Although agreeing that it is challenging to assess the impact of a CPD programme on the clinical practice, Gibbs (2011:153) state it is nonetheless possible to assess formal learning but it does not reveal how the practitioner will use the newly gained knowledge in the clinical practice, and thus the impact of informal learning is often believed to be subjective. The study conducted by Gibbs confirms that practitioners believe that CPD affects their practice, but they are frequently unable to delineate precisely how or why.

Limited studies were found on the evaluation of CPD activities, and the studies found tended to be on small scale with the main focus on the process and the teaching strategies used instead of on the direct impact of a CPD programme on patient care delivery or practitioner competence. In the following section the focus of the discussion is on the evaluation of knowledge transfer.

4.4.4.2 Subcategory 2: Evaluation of knowledge transfer

It was clear from the collected data there was opposing views with regard to the evaluation of knowledge transfer. Some of the participants expressed the need for evaluation of knowledge transfer whereas some of the participants were against the evaluation. Those who were in favour of the evaluation of knowledge transfer concurred that it was not done on a regular basis and that they required feedback afterwards as they would want to know whether or not they had grown professionally. The participant against the evaluation of knowledge transfer stated they fear for the evaluations which followed certain CPD programmes due them feeling insecure if

they were perceived as not being “up to date”. The following quotes pertaining to the evaluation of a CPD programme support the findings related to the evaluation of knowledge transfer.

Supportive quotations:

- “ ... it [CPD] is not evaluated ...[due to] lot of pressure in the units ...”
- “ ... [some CCNPs are] afraid of the evaluation factor following certain courses ... [some CCNPs are] afraid [that we] are not up-to-date and are going to lose position/work ...”
- “ ... If you [CCNP] attended a CPD programme, it is expected that you are knowledgeable afterwards – [therefore you] do not want to expose yourself ...”
- “ ... where CPD occurs, implementation follows and there is no time to fill in the ‘work books’ ...”
- “ ... feedback to be given ...”

Discussion: Knowledge transfer is a systematic, dynamic and iterative process to capture, collect and share tacit knowledge in order for it to become explicit knowledge (Graham et al., 2006:15; Kitto et al., 2013:147). Knowledge transfer is concerned with the transferring of good ideas, achieving results and skills to enable innovative new practice development. According to Graham et al. (2006:15) successful knowledge transfer involves much more than a “one way, linear diffusion of knowledge and skills”. This view of Graham et al. is supported by McKibbin et al. (2010:16) and Légaré et al. (2010). Continuous professional development should be based on the “best available knowledge” and must employ strategies revealed to be successful at transferring knowledge state Graham et al. (2006:22).

To assess the transfer of knowledge an evaluation is needed. According to Snell et al. (2000:862), an evaluation is a vitally important endeavour and can be the source of support and motivation. Evaluation assists in improving facilitating skills which in turn may lead to improved learning, improved patient care and an improved programme. To reduce the fear related to evaluation, the objectives of the evaluation must be well-defined and clearly articulated (Snell et al., 2000:863). This view is supported by Collins (2009:616) who states “evaluation is not an end product” but it directs to renewed orientation, other learning activities or a change in goals.

Muijs and Lindsay (2008:195) observe that it is extremely important that the effectiveness of a CPD programme is evaluated due to the fact that CPD is progressively recognised as important for all health practitioners to maintain and develop their competence. In the further opinion of Muijs and Lindsay (2008:196), evaluation with regard to the impact of CPD on the clinical practice is rarely undertaken in a systematic and focussed manner. These authors identified various frameworks for the evaluation of CPD programmes and advise that if the main goal of a CPD programme is to change clinical practice, it is essential to evaluate whether the practitioners actually use the new knowledge and skills acquired (Muijs & Lindsay, 2008:197-199). This important factor is further emphasised by Marzlin (2011:46) who states CPD must bring about a change in clinical practice to be considered effective. Marzlin (2008) concludes that integration of knowledge has taken place when information/knowledge is combined with performance since the main goal of CPD is for participants to link newly acquired knowledge to clinical practice.

Schostak et al. (2010:589) contribute that an effective CPD programme involves learning and *“being fit to practice knowing both the why and the how”* and applying both in clinical practice. According to Schostak et al. (2010:589), effectiveness is facilitated when practitioners are able to establish their *“own learning needs, through reflection, within the totality of their practice”*. They further claim that *“being fit to practice is different of being safe to practice”* (Schostak et al., 2010:589). This statement of Schostak et al. (2010:589) led to the question *“whether the purpose of CPD is to raise everyone to a minimum standard or to allow individuals to pursue learning interests more generally”*.

According to Clynes and Raftery (2008:405), feedback is a fundamental element of teaching and learning; it is an interactive process with the aim to provide insight to the individual regarding their performance. Feedback is important for professional growth, provides direction and helps to increase confidence, motivation as well as self-esteem. Clynes and Raftery (2008:409) points out that having an awareness of and by understanding the components of feedback delivery aid in the process and ensure that the facilitator as well as the individual has a positive interactive experience.

4.5. PRIORITY 3: CLINICAL TRAINING

From the data collected it was evident that the participants classified CPD and training as two separate activities. Some indicated that CPD occurred outside the unit and clinical training occurred within the unit. The participants also referred to these activities as “*on the spot*” training. Thus, clinical training is discussed as a separate theme.

Based on the data collected the following two categories emerged under Priority 3: clinical training: planning and implementation. A discussion of each category including its subcategory is presented in Section 4.5.1 and Section 4.5.2.

4.5.1 Category 1: Planning

The planning of a clinical training programme has a major influence on the attendance of the clinical training programme. The following quotes support the findings related to the planning of a clinical training programme.

Supportive quotations:

- “... *it also comes back to planning, ... you [CCNPs] can make your own need planning as well ...*”
- “... *poor planning ahead [on management side they should] – try to plan early in [the] year ...*”
- “... [CPD is] *not planned on times which are suitable to everyone ...*”

Discussion: In the view of Henderson and Eaton (2013:200) clinical learning in the work setting is an essential component of CPD. Lammintakanen and Kivinen (2012:45) state a basic tool for recognising CPD needs, planning CPD and evaluating performance is through appraisal and employee reviews. During the planning of clinical training, it is important to realise that there is not a “*scientific, best way to learn and work because real problems are ill-defined*”; but by integrating working and learning, people learn within the context of their work on real-life problems (Collins, 2009:615). This view is supported by Boud and Hager (2012:22) who state

that “*learning is a normal part of working*” and “*occurs through practice in work settings from addressing the challenges and problems that arise*”.

Based on the data collected, it was perceived that the planning of a clinical training programme was divided into three subcategories: need assessment; relevance of the topic and collaboration with regard to training topics. A detailed discussion of each subcategory is presented from Sections 4.5.1.1 to Section 4.5.1.3.

4.5.1.1 Subcategory 1: Needs assessment

The participants strongly agreed that it was important that a thorough need assessment should be done before the planning of a clinical training programme. Their viewpoint was that no need assessment had been done before the planning and thus the needs of the CCNPs were not considered. From the collected data, it was evident that some of the participants preferred that training to take place in the unit whereas others indicated it was a problem to attend training in the unit due to disruptions. The following quotes pertaining to clinical training support the concerns raised by the CCNPs related to the requirement for a thorough need assessment.

Supportive quotations:

- “... [CPD] *not as good as ‘on the spot’ training ...*”
- “... *if training is done in the unit, you are pressurised because you’re attention/help is needed somewhere else in the unit ...*”
- “... *topics need to be of practical level of category ...*”
- “... *no thorough evaluation [need assessment] is done to determine the need for improvement of specific ranks and categories ...*”
- “... *employees’ needs for improvement are not met ...*”
- “... *individual’s needs differ from person to person ...*”

Discussion: Cochrane et al. (2007:94) indicate that there is a significant gap between research recommendations, scientific evidence and clinical practice. The gap exists between what is

known and what health care professionals implement and it (the gap) influences the quality of care. Cochrane et al. (2007) advise that an accurate assessment of needs is required.

In Boud and Hager's (2012:24) view practice provides useful ways to structure professional development activities and the learning which accompanies it if the context in which this occurs is considered. The clinical environment itself creates challenges and opportunities which drives learning. Thus, training opportunities need to be utilised more effectively to be valuable and ways have to be identified to overcome challenges. Boud and Hager (2012) believe that there is nothing else which influences learning more effectively and unconsciously than the everyday circumstances of work itself.

Topley (2009:322) states a unit-based educator operates as a link to the "*human factors*" that each practitioner brings to the critical care unit and can present "*personal education programmes*" which are personalised according to the needs of each individual practitioner instead of extensive, all-encompassing educational programmes. Nevertheless, it still requires that the facilitator must be flexible in any endeavour to involve the CCNPs because of the limited time available for focussed learning in the unit.

Schostak et al. (2010:589) give the impression that there is a widespread concord on the "*value of on-the-job learning*"; however, they also state it is an extensive challenge to evaluate it. Another challenge pointed out is that tension exists between organisational (service delivery) needs and the training opportunity. This tension is due to the scarcity of human resources which results in the organisation needs taking precedence over the training opportunities, although the quality of training is inextricably linked to improvement in the practitioners' practices. Thus, the challenge for implementation of successful training is in the "*dynamic relation*" between clinical practice and the intricacy of the clinical settings where training opportunities and organisational needs intermingle with each other (Schostak et al., 2010:591).

4.5.1.2 Subcategory 2: Relevance of the topic

The participants strongly agreed that most often clinical training is not relevant to the CCNPs' speciality. They verbalised that a need assessment would help to identify the needs of the different CCUs to make the training relevant to the CCNPs' specific units. The following quotes support the findings related to the requirement for a thorough need assessment.

Supportive quotations:

- “... training not in your [CCNP]speciality ...”
- “... the training is at times not applicable to speciality ...”
- “... content is most of the time irrelevant and not valuable to one [CCNP] or unused [in the unit]...”

Discussion: Légaré et al. (2010) explain that if training is to maintain its relevancy, it must be adjusted to accommodate the ever-changing needs of the CCNPs, the patients and the society it serves. A training programme may be taught in a most sufficient manner, but the content is not applicable to then it is unlikely to improve the knowledge and skills of the attendees. Chipchase et al., (2013:90) advise that practitioners should elect to participate in courses that are evidence-based. Additionally, in the study conducted by Schostak et al. (2010:588) the respondents suggested that practitioners attempt to stay within their comfort zone instead of utilising training as an opportunity to discover “*their unknowns*” when selecting their training activities.

4.5.1.3 Subcategory 3: Collaboration with regard to training topics

Data collected from the participants indicated that if there was collaboration as regards the clinical topics presented, the attendance and participation in the CPD programme would have been more positive. The following quotes pertaining to clinical training support the findings related to the collaboration regarding to the clinical training programme topics.

Supportive quotations:

- “... if you [CCNP] make the decision to go on specific courses then you will attend ...”
- “... if an employee needs to improve a certain skill ... not always taken into consideration ...”
- “... training is not applicable to speciality ...”

Discussion: According to Newton et al. (2012:95), collaboration means to work together and every member of the health team makes a unique contribution to achieve a common goal. Newton et al. (2012:95) maintain it is the process of communication and decision making which enable “*separate and shared knowledge and skills*” to synergistically influence the healthcare provided through changed attitudes and behaviours. The responsibility of training involves a variety of stakeholders, all with different agendas, which may not necessarily be very similar. Gibbs (2011:153) indicates that one of the main principles of training is that each professional practitioner must take responsibility for planning and undertaking his or her own training and making sure that it is relevant to his or her current practice; but the consequence should always be to improve patient care.

A training programme needs to provoke a sense of ownership and responsibility within the learner (Gibbs, 2011:156). Effective training should lead to the development of the professional practitioners to become “*self-directed, hands-on lifelong learners*” (Gibbs, 2011:156). By developing these qualities professionals will be able to apply learning and boost their practice to the benefit of the patient. In order for these qualities to develop, personnel require support from their employers to allow them to incorporate training into clinical practice.

In the study conducted by Schostak et al. (2010:588) training was perceived as significant to effective practice as well as to a practitioner’s development within the profession, even if it does not necessarily influence career progression. Training was linked to personal learning needs that resulted in learning outcomes being translated into practice and it was frequently associated with appraisals “*which were typically seen through the perspective of gap filling in skills, attitudes/behaviours or knowledge*”.

4.5.2 Category 2: Implementation

There were various factors identified by the participants which influence the effective implementation of a clinical training programme. Based on the data collected these factors were categorised into two emerging subcategories: the clinical facilitator and teaching strategies. These two subcategories are discussed in Section 4.5.2.1 and Section 4.5.2.2.

4.5.2.1 Subcategory 1: Clinical facilitator

The participants claimed that there were not enough clinical facilitators or that the clinical facilitators were not sufficiently visible in the CCUs. In the view of the participants the clinical facilitator should be a specialist and should be practically skilled in the speciality. Additionally, the participants believed the role of the clinical facilitator was to “*educate [orientate] part-time staff and newly qualified CCNPs*” as they pronounced that the CCNPs did not have time to teach other members of the team. The following quotes pertaining to the implementation of a clinical training programme support the findings related to the clinical facilitator.

Supportive quotations:

- “... *not enough clinical facilitators [in the CCUs]...*”
- “... *specialists to do [provide] the training and should be practically skilled ... being a clinical tutor ...*”
- “... *the clinical facilitator to educate part time staff [agency personnel] and newly qualifieds [CCNPs]...*”
- “... *[need] more facilitators in the unit ...*”

Discussion: According to Topley (2009:321), the provision of continuous training to CCNPs in a busy CCU can be a relentless challenge facing clinical facilitators. The clinical facilitator’s goal with the provision of continuous training at the bedside is to improve patient outcomes “*by teaching critical knowledge and skills at the point of use*”. Topley (2009) points out that it is essential for CCNPs to be updated on new technology as well as the application of critical thinking skills that accompany its use. Conversely, the author agrees that CCNPs have limited time available during a shift to leave the patient care setting for CPD/training purposes; for the CCNPs to leave the patient’s bedside she or he must find another practitioner to care for 1 to 2 critically ill patients. During the attendance of CPD programmes held outside CCU, the CCPNs’ “*attention and information retention are compromised*” due to the fact that they think about the patient(s) and the tasks that remain to be completed (Topley, 2009:321). By providing ‘In-unit’ 5 to 10 minute educational programmes which can be held in a specified location in the unit, the clinical facilitator can provide frequent and needed information.

According to Marzlin (2011:49), the utilisation of bedside practitioners as clinical instructors promotes the culture of lifelong learning. The author claims that teaching is one of the most effective methods for *“reinforcing learning; thus, utilizing clinicians as instructors strengthen the body of bedside nursing knowledge”*. This view is supported by Henderson and Eaton (2013:197) who state that it is expected that all nurse practitioners are able to facilitate others learning. Ideally nurse practitioners directly involved with patient care are supported so that they in turn can share their skills and knowledge with colleagues during their professional practice.

4.5.2.2 Subcategory 2: Teaching strategies

The participants agreed that different teaching strategies need to be applied during the implementation of a clinical training programme in order for them to gain from the clinical training programme. Teaching strategies should cater for all types of learners, as currently there are participants who at the end of the training programme depart without understanding the given information. The following quotations pertaining to the implementation of a clinical training programme support the findings related to the need for different teaching strategies to be used.

Supportive quotations:

- *“ ... some training is boring ... ”*
- *“ ... the topics presented are not interesting ... ”*
- *“ ... impossible to process all the information ... ”*
- *“ ... do not understand the topic ... ”*

Discussion: Continuous training allows for a wide variety of approaches as well as teaching and learning styles in a variety of settings inside and outside of the workplace environment (Muijs & Lindsay, 2008:196; Collins, 2009:616). An interactively structured training programme is more effective than education which is provided in a lecture format only. Interactively structured training (education) results in moderately large changes taking place in practice states Marzlin (2011:47). Additionally, Marzlin (2011) further points out that although the completion of a CPD programme does not guarantee the application of newly acquired

knowledge in practice, the more active the CCNPs participate in the training programme the more effective the training will be.

The results of a study conducted by Tynjälä (2008:150) on perspectives into learning at the workplace confirmed that adult learners learn differently from each other. Tynjälä (2008:150) summarised the different ways of adults' learning as:

- through the execution of the task by oneself
- through collaboration with colleagues
- through working with the patients (clients)
- through the acceptance of challenges and new tasks
- through reflection and evaluation of one's work experiences
- through formal education
- through extra work contexts.

Due to the different ways in which adults learn it is necessary to utilise different methods to facilitate learning (Lammintakane & Kivinen, 2012:37; Taylor & Hamdy, 2013:e1561; Morgan, Cullinane & Pye, 2008:235; Tanjälä, 2008:150). In the opinion of Topley (2009:321) adults learn best in situations which are informal, comfortable, flexible and non-threatening. During the progression of learning, the adult learner starts to participate actively in identifying his or her own needs, objectives, activities and evaluation. Gradually the adult learner starts to move away from a subject-centred approach to a problem-solving approach by applying the newly acquired knowledge. Normally adults intend to immediately and directly apply what they have learned: *"Problem based learning builds on prior experience and provides practical real-world application"* (Topley, 2009:321).

4.6 PRIORITY 4: TIME CONSTRAINTS

The participants strongly agreed that one of the factors which had a great impact on the attendance of the CPD programme was time constraints. From the data collected this priority is divided into two categories: scheduled time for CPD and personal time. In Section 4.6.1 and Section 4.6.2 follows a discussion of the two categories.

4.6.1 Category 1: Scheduled time for CPD

Participants strongly agreed that scheduled time played an important role in the non-attendance of CPD programmes. They indicated that CPD activities were scheduled on the CCNPs off duty roster without being discussed with them first. Their argument was that since the CCU needs to be “covered” (ensuring that there are sufficient CCNPs on duty per shift) additional hours would be added for attendance of the CPD programme; they would therefore work longer than the normal required hours per month. Consequently, the staffing levels also had an influence on the scheduled time for CPD because the CCUs needed shifts to be “covered” before any CCNP could be scheduled for attending a CPD programme. The following quotes pertaining to time constraints support the findings related to the concern regarding scheduled times for CPD.

Supportive quotations:

- “... [CPD is] *not always planned on times which are suitable for everyone to attend ...*”
- “... [CPD] *should be included into the week’s shift days ...*”
- “... *time constraints coupled with the impact on the unit’s staffing levels ...*”
- “... *even though you [CCNP] get the hours from the hospital it is seen as ‘I am giving up my time because I still have to work my shifts’ ...*”
- “... *units are busy [the CCNP] do not have time to sign work books, documents/procedures ...*”
- “... *when training occur[s] in the critical care unit you [CCNP] are hurried to finishing ‘learning’ because you are needed in the unit ...*”

Discussion: According to Sturrock and Lennie (2009:13), barriers identified to influence the participation in a CPD programme include the lack of support from management, staff shortages and the time practitioners feel they have to devote to attending CPD programmes rob them of achieving a “*desirable work-life balance*”. The majority of literature consulted with regard to barriers or challenges to the attendance of CPD programmes lists time constraints only as a reason for reluctance to attend CPD programmes; none explicitly discusses or elaborates on the practical or personal concerns attached to time constraints (Gould et al., 2007:607; Skees,

2010:107; Leggate & Russels, 2002:468; Barnes et al., 2013:9). The responsibility to put aside time for professional growth and learning through the participation in CPD programmes remains with the individual practitioner states Chipchase et al., (2013:91).

4.6.2 Category 2: Personal time

Participants concurred that the attendance of the CPD programme also influenced the CCNPs' personal time; this issue played an important role in the attendance of the CPD programme. The standpoint of the participants was that the attendance of the CPD programme interfered with their personal lives. One of the participants verbalised that the fact that CPD was during their on duty time did help a little but it still had a significant impact on the CCNPs' family time and negatively influenced their opportunity to work overtime. The following quotes pertaining to time constraints support the findings related to the concern regarding personal time.

Supportive quotations:

- “... it [CPD] *interferes with your family time and [personal/family] responsibilities ...*”
- “... [leads to] *lack of time to attend family matters ...*”
- “... *are often scheduled on the days on which you [CCNP] were supposed to be off duty ...*”
- “... *interferes with their [CCNPs] personal life or time to rest ...*”
- “... *company is stealing family time ...*”

Discussion: In various studies conducted the social responsibility and family commitments were identified as barriers for undertaking CPD activities (Jaradeh & Hamdeh, 2010:318; Lee, 2010:392; Marzlin, 2011:47). One of the areas singled out by participants in the study conducted by Gould et al. (2007:607) were the amount of personal time individuals felt they were expected to contribute towards CPD. This data are supported by Sturrock and Lennie (2009:13) who indicate that the amount of time CCNPs are expected to contribute towards the attendance of a CPD programme results in conflict between home and domestic commitments which were seen as a barrier to achieve a desirable work-life balance (Gould et al., 2007:607; Skees, 2010:107).

Brekelmans et al. (2013:4) also observe that “*the most critical factor, according to nurses themselves*” is the quantity of private time that is used to participate in CPD programmes; Gallagher (2007:470) adds that the demands of undertaking CPD conflict with domestic commitments. According to Jaradeh and Hamdeh (2010:319), time is also one of the major barriers to the participation in CPD programmes as family commitments hinder participation outside of duty hours.

4.7 PRIORITY 5: FINANCIAL IMPLICATIONS

From the participants’ perspective the attendance of the CPD programme had an impact on the CCNPs’ financial status. The financial implications are divided into two categories: personal financial implications and organisational financial implications. A discussion of each category including its subcategory is presented in Sections 4.7.1 and Section 4.7.2.

4.7.1 Category 1: Personal financial implications

The participants concurred that the attendance of the CPD programme had personal implications with regard to the CCNPs’ financial status. They agreed that to attend CPD programmes in the form of symposiums, congresses and conferences were very expensive; the arrangement for transport to the venue where the CPD activity was scheduled to be held as well as arranging additional day care for the CCNPs’ children added extra expenditures. The following quotes pertaining to financial implication support the findings related to the concern regarding personal financial status.

Supportive quotations:

- “ ... *transport ... children – day care ...*” [were listed on individual worksheet and flip chart as reason for unsatisfactory attendance]
- “ ... *training of the hospital grounds, like symposiums are expensive to attend ...*”
- “ ... *costs, for example, annual conference is every high and hospital only pay for certain amount [for the CCNPs] ...*”

- “... *overworked underpaid, economy ...*” [were listed on individual worksheet and flip charts as reason for unsatisfactory attendance]

Discussion: The costs involved in CPD are high for individual nurses and therefore it is important that CPD must be made as cost effective as possible whilst still satisfying the existing need for nurses to further their knowledge and skills (Dyson et al., 2009:821). Obviously then it is important that evidence of value for money in CPD must be emphasised by sound data, information and planning. Collins (2009:615) refers to learning in the competitive global marketplace of the 21st century as “*lifelong earning demands lifelong learning*”. In the past, hard work and loyalty led to a secure future whereas in modern times a premium is placed on those who continuously acquire skills and knowledge and who have the resilience and flexibility to adjust to the growing needs of the global labour market. According to Brekelmans et al. (2013:4), professional nurses will experience difficulties in their professional development without the support and encouragement of their employer. The overwhelming majority of nurses need support and advice for participation in CPD programmes (Murphy et al., 2006:370) which undoubtedly includes financial support (Gallagher, 2007:470; Hegney et al., 2010:148).

None of the consulted literature explicitly discusses the effect of the attendance of CPD programmes in relation to personal financial implications. But, the majority of literature sources list financial implications as a barrier or challenge experienced by CCNPs to attend CPD programmes.

4.7.1.1 Subcategory 1: Overtime

Participants concurred that the attendance of the CPD programme not only interfered with the CCNPs’ personal time but also with their time available to work overtime. Currently, attending the CPD programme influences the available time that the CCNPs have to work overtime; their time is restricted, overtime is reduced and the participants voiced that to consider working overtime versus attending a CPD programme the former was financially more attractive. The following quotes pertaining to financial implications support the findings related to the concern regarding the time to work overtime.

Supportive quotations:

- “... *working overtime and being paid versus coming for CPD [as part of normal duty time not receiving immediate reimbursement] ...*”
- “... *the fact that CPD count[s] for on duty time help[s] ... but it reduce[s] the time for overtime which have [has] a financial implication ...*”
- “... *rather work overtime and get something [paid] for it ...*”

Discussion: In the literature search there was no information found with regard to the direct impact participation in CPD programmes may have on working overtime. However, in all the research articles found on CPD, it was indicated that financial and time constraints influence participation in CPD programmes. In the study conducted by Jaradeh and Hamdeh (2010:319) the authors found that time and money formed a major barrier to participation in CPD activities. The nurse participants in Jaradeh and Hamdeh’s (2010) study indicated that the costs related to the attendance of a CPD programme was higher than their monthly income.

4.7.1.2 Subcategory 2: Job performance management system

There were mixed opinions from the participants in this study regarding the job performance management (JPM) system. Some of the participants’ viewpoint was that a nurse’s JPM should be linked to the CCNP’s attendance of the CPD programme. Other participants disagreed, arguing that the JPM score would ultimately impact negatively on earnings if the CCNP was unable to reach the set objectives regarding the attendance of CPD programmes. The participants remarked that staff shortages played a role in the possibility of CCNPs not achieving the set attendance requirements for CPD programmes. They described that the CCUs needed to be equipped with sufficient personnel before any CCNP can be relieved from duty to attend CPD programmes. The CCNP participants were therefore concerned that if their CPD requirements were to be connected with their JPM, it would influence their annual salary increase, especially if they were not able to achieve their set CPD requirements. The following quotes pertaining to financial implications support the findings related to the JPM system.

Supportive quotations:

- “... make it [CPD attendance] part of JPM ...”
- “... it [CPD] affects JPM ...”
- “... the company will know according to your JPM are you on your goals that you have set for yourself ...”
- “... they [CCNPs not attending CPD] will lose money ...”

Discussion: In order to relate job performance management to the CPD programme, it is important to ensure that the purpose of the CPD programme is about the development of professional knowledge that will ultimately improve the nursing care of patients and therefore the strategic aims of the employer (Munro, 2008:959). Kajermo et al. (2008:312) view the lack of clear and realistic goals for the workplace as a factor influencing participation in CPD programmes; the workload and shortage of staff are also problematic issues as far as attending CPD programmes is concerned (Jaradeh & Hamdeh, 2010:318).

Brown (2010) makes a distinction between performance management and performance appraisal by stating:

Performance appraisal has a reputation as punitive, top-down control device, an unloved system ... performance management is a holistic, total approach to engaging everyone in the organisation in a continuous process to improve their performance and thereby the performance of the whole organisation.

The study conducted by Lammintakanen and Kivinen (2012:44) indicates that healthcare organisations provided enormous opportunities for CPD, but the nurses did not make use of it systematically. This finding led to the question whether CPD activities “are explicitly accepted as practices of CPD or are they just ‘things that have to be done?’”

4.7.2 Category 2: Organisational financial implications

The participants acknowledged that CPD programmes did have a financial implication for the organisation. From the obtained data, it seemed as if the CCNPs were willing to pay half of the costs if they (CCNPs) were allowed to attend CPD programmes off the hospital premises, for example, conferences, congresses, symposiums and so forth. The following quotes pertaining to financial implications support the findings related to the financial implications for the organisation.

Supportive quotations:

- “... costs, for example, annual conference is every high and hospital only pay for certain amount [of CCNP] ...”
- “... not supported [financially] if [CCNP] want to go to congresses ...”
- “... even halfway will help financially ...”

Discussion: According to Brekelmans et al. (2013:2), healthcare organisations need to authenticate that their members are “*accountable, efficient, and effective*”. Health organisations want human resources with appropriate skills and knowledge to deliver excellent healthcare (O’Sullivan, 2004:174) and therefore it is imperative that employers construct conditions for professional nurses who will encourage them to participate in CPD programmes (Hallin & Danielson, 2008:65). However, it is just as important that the CPD programmes provided must be cost-effective and lead to improved health outcomes for the patients and communities as CPD activities are costly to organisations (Dyson et al., 2009:822).

Munro (2008:958) is of the opinion that the lack of support for the CCNPs is also a barrier to CPD. Munro (2008) indicates that the benefits and costs to individuals and the organisation on the beneficence-maleficence scale appear to benefit the employer more than the CCNP because the CCNP contributes personal resources to the organisation. From Munro’s (2008) perspective, a lack of resources in terms of little or no funding influences the attendance of CPD programmes negatively. Lee (2011:394) seems also concerned about the resource issue by stating that it is “*debatable how long CPD can be sustained in the context of diminishing resources*”.

According to Brown et al. (2002:652), CPD for healthcare professionals must be cost-effective to prevent a waste of resources even though economic evaluations of CPD are uncommon. This view is supported by Gibbs (2011:55) who points out that due to the financially challenging times, pressure will incline for more cost-effective means to deliver CPD programmes, which will necessitate additional strategic approaches to authorise the participation of CPD activities. Thus, CCNPs will be required to acquire a more strategic view of their training needs and development. Muijs and Lindsay (2008:199) advocate for CPD not to be undertaken if the costs outweigh the benefits as well as if there are other more cost-effective ways to improve performance.

Munro (2008:958) has an opposing view, declaring that learning and CPD are seen fundamentally as the professional's responsibility and duty because of the "*perceived benefit to the individual's professional growth, future employability and ability to do the current job*". Munro's view is supported by Marzlin (2011:49) who comments on the fact that managers have views different to that of the individual professionals regarding the financial responsibility associated with CPD. Marzlin (2011) indicates that professionals have a responsibility to share some of the costs; additionally, managers claim that their current need for human resources exceeds their need for the attendance of CPD programmes. Lammintakanen and Kivinen (2012:36) and Morgan et al., (2008:246) affirm that there is tension between the employer and the employee with regard to CPD programmes due to differing interests.

4.8 CENTRAL THEME 6: ATTITUDE

From the collected data the researcher identified an central theme which was listed by the participants as a reason for unsatisfactory attendance of the CPD programme. The theme, **Attitude**, was identified based on various comments made during the nominal group process and by the written comments of the participants during the silent generation of items session on their individual worksheets. The following quotes pertaining to poor attendance of the CPD programme support the findings related to the additional theme, **Attitude**.

Supportive quotations:

- “... it [CPD] was not a requirement for nurses previously ...”
- “... it [CPD attendance] is compulsory to come ... therefore we [CCNPs] just come or make excuses not to attend – come with a sick note ...”
- “... even though hours are given, [CCNPs] do not want to come, [CCNPs] prefer to attend to other tasks at home ...”
- “... when attending we [CCNPs] are negative, just want to get it over and done with ...”
- “... it is a waste of time, rather spend the day at home ...”
- “... we [CCNPs] are comfortable in doing things the old way unlike to learn new things ...”
- “... most of the nurses can't sit for long periods of time, they [CCNPs] prefer to work ...”
- “... the more I know the more I have to do ... responsibility increase[s] with knowledge ...”
- “... afraid if I learn something I have to explain it to another ...”
- “... already work at a fast pace, do not have time to implement new ideas or changes ...”
- “... as RN often you have to reinforce that what juniors learned in CPD, and it is time consuming ...”
- “... working long hours in a critical care unit – lots of stress so you [CCNP] don't want to add another stress on top ...”

Discussion: According to Henwood and Taket (2008:2010), participation in CPD is largely reliant on the attitude of the individual. Brekelmans et al. (2013:11) urge that “a *change of attitude towards CPD*” among nurses is needed. Tame (2011:482) adds that the degree to which CPD is undertaken also depends on the individual and their previous experience of education. This author infers that if previous educational experiences were negative or created the perception that learning is about passing or failing instead of professional development, it may hinder future education.

The findings of Lee's (2011:392) study confirmed that professional peer attitude may help or hinder learning transfer for CPD participants. Lee (2011:394) asserts it would be easy to recommend that the managers or clinical facilitators within the practice areas should act as facilitators of learning and support the CPD participation through positive change, but the author agrees that this responsibility do not rest with the organisations alone. Moreover, to determine the attitudes of professionals and/or organisations to change is a challenge in itself because attitudes are neither "*tangible nor visible*" (Lee, 2011:392).

Lammintakanen and Kivinen (2012:44) comment that the general attitude towards the attendance of CPD programmes is a major concern. In their study nurses were unsure and hesitant on whose responsibility CPD was. These authors therefore recommend that the healthcare organisation should be responsible for CPD because, they argue, if the individual is left with the responsibility to enhance their own learning, it might inevitably result in the unit being staffed with professionals who lack knowledge and skills to render quality and safe patient care. Lammintakanen and Kivinen's (2012) view is supported by Gibbs (2011:153) who state that the responsibility for CPD lies with a range of different stakeholders, all with different agendas.

4.9 CONCLUSION

The benefits of participation in a CPD programme as well as the challenges preventing participation have been established in many research studies. The successful implementation of a CPD programme is dependent on several factors which include effective communication, sufficient knowledge about the contents of the CPD programme, awareness of what a CPD programme entails, effective facilitation and managerial support as well as a positive attitude towards CPD. The study findings indicate that to increase participation in and the effectiveness of a CPD programme, attention must be paid to the needs and inputs of the CCNPs.

It was further discovered that most CCNPs desired to take responsibility for their own CPD activities. Participants in CPD programmes should be allowed sufficient autonomy concerning their participation in the programme to enhance ownership and taking responsibility for their own CPD. Collaboration between the CCNPs and the clinical facilitator as well as management in the planning and implementation of a CPD programme might further enhance attendance.

Chapter 4 was dedicated to the study findings and included discussions relevant to this study. In Chapter 5 the researcher's recommendations are discussed.

5. CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

"Though no one can go back and make a brand new start, anyone can start from now and make a brand new ending."

- Carl Bard -

5.1 INTRODUCTION

Chapter 4 was dedicated to an in-depth discussion of the study findings and the relevant literature related to the findings. In Chapter 5 the conclusions drawn relating to the aim of the study, the limitations of the study and recommendations based on the study findings are presented.

5.2 AIM AND OBJECTIVES OF THE STUDY

The overall aim of the study was to obtain consensus regarding the reasons for the unsatisfactory attendance of a CPD programme developed for critical care nurse practitioners in a private hospital in Gauteng.

- **Objective 1:** To identify, describe and obtain consensus regarding the reasons for unsatisfactory attendance of the CPD programme by the CCNPs; and
- **Objective 2:** To collaboratively develop strategies to address the unsatisfactory attendance of the CPD programme.

5.3. CONCLUSION

The conclusions made in this study were guided by the identified priorities and the central theme, namely:

1. Communication
2. Continuous professional development

3. Clinical training
 4. Time constraints
 5. Financial implications, and
- Central theme: attitude.

Attitude has emerged as a underlying theme in this study during data collection although the participants did not identify it as a priority. Based on a discussion between the researcher and the supervisors a decision was made to add attitude as a central theme.

A conclusion and the recommendations relating to each priority and theme are provided in Sections 5.3.1 to 5.3.6.

5.3.1. Priority 1: Communication

Effective communication is paramount for the successful implementation of a CPD programme. From the data collected it was evident that communication was considered the biggest hurdle for the CCNPs working in the CCUs to attend the CPD programme. The dire lack of communication on two levels was mentioned, namely communication between the clinical facilitators and the unit management and between the unit management and the CCNPs working in the CCU. It was apparent from the data obtained that if communication on both the aforementioned levels improved and a two-way communication approach was initiated and implemented, the CCNPs' willingness to participate in the CPD programme would be more positive. A two-way communication approach would also enhance collaboration between all the stakeholders involved in the provision and attendance of the CPD programme.

5.3.1.1 Collaboration

The data collected signified that if the CCNPs were allowed to participate in decision making with regard to the content in and the scheduling of the CPD programme that they would be more willing to participate in and attend the CPD programme. Through collaboration the CCNPs' feeling of being pressurised by management to participate in the CPD programme would decrease and their feeling of being valued for their inputs would increase. Increasing the CCNPs' feeling of worthiness would subsequently lead to a sense of ownership for the CPD

programme. Once CCNPs take ownership of the CPD programme it may result in them taking responsibility for their own CPD.

5.3.1.2 Logistic information

Logistic information had an enormous impact on the attendance of the CPD programme. Due to the fact that certain logistic information reached the CCNPs too late influenced their participation and attendance of the CPD programme negatively. The participants were of the opinion that if information was readily available at the beginning of each year, it would help them to plan their participation in advance to fit into their personal schedules thus minimising disruption of their family life and social commitments. The logistic information should contain information pertaining to the topics and/or contents of the CPD programme planned for the coming year including the costs involved, dates, times, duration and venues for these courses.

Recommendations

Since consensus was reached by the participants that communication ranked as the number one priority reason for their unsatisfactory attendance of the CPD programmes it is recommended that the clinical facilitator and the organisation involved:

- ensure that effective communication skills are in place to ensure effective dissemination of information with regard to the CPD programmes
- make use of a collaborative and/or shared decision making process between the management, the clinical facilitators and, most importantly, the CCNPs
- the clinical facilitators providing CPD programmes should have the CPD programmes ready and available at the beginning of the year to allow the CCNPs to plan their activities for the year accordingly.

The suggested strategies to enhance effective communication as well as collaboration can be implemented by taking measures as set out below.

- Providing written communication at the beginning of the year regarding the CPD programme and should include:
 - the topics for the respective days

- the date and the timeframe for the day
- the venue as well as the costs involved
- a contact person with his or her contact details should be given in case a CCNP has queries or questions regarding the programme.
- Circulate a CPD programme booking list with the CPD year programme for the CCNPs to plan their own CPD for the year by indicating which CPD topics they will attend. This will also help the person responsible for working out the duty roster to allocate personnel timeously. It may decrease the conflict and the negative experience of 'feeling forced' to attend.
- Making use of bulletin boards located in prominent places that are accessible to everyone to timeously communicate unforeseen changes that may have to be made to the original CPD programme.
- Discuss changes in the CPD programme during review meetings to ensure that the message reaches all the CCNPs.
- At the end of the year send out a written communication to invite the CCNPs to indicate topics that would be of interest to them and which can then be considered for inclusion in the following year's CPD programme.

5.3.2. Priority 2: Continuous professional development

To many CCNPs in South Africa the concept of continuous professional development (CPD) is relatively new. This is related to the fact that CPD is not yet mandated by the South African Nursing Council (SANC). Yet, participation in a CPD programme has several positive outcomes.

- It ensures that current, evidence-based and quality patient care is rendered to the health service users.
- It helps the individual CCNP by securing future employment.
- It ensures that an organisation remains competitive in the provision of quality healthcare.

Participation in a CPD programme is influenced by various aspects such as awareness, planning, implementation and evaluation. These aspects are discussed in the following sections which include recommended strategies to improve its outcomes.

5.3.2.1 Awareness

For CCNPs to actively participate in a CPD programme it is vital that they are aware of the benefits of participation for them, their employer as well as for the patients trusted into their care. Awareness needs to be raised with regard to the importance of CPD and the influence of CPD on job performance.

To ensure the effective implementation of CPD programmes it is recommended that awareness of CPD is promoted by highlighting specific aspects of CPD.

- What is CPD?
- Why is CPD regarded as so important?
- What are the implications with regard to attendance versus non attendance?

➔ Recommendation

Any strategy developed to increase awareness of CPD needs to include the following essential details.

- At the beginning of a CPD programme always start with a short orientation of what CPD is, why CPD is important and also how to incorporate new information into clinical practice to ensure current clinical skills.
- After the introduction of what CPD is, allow CCNPs to ask questions to clarify uncertainties related to CPD.
- Additionally, exhibiting big posters in the CCUs and tea rooms which highlight the positive outcomes of CPD for the CCNPs, the employer and ultimately the patient, may also be helpful to continuously remind the CCNPs that it is to the benefit of all stakeholders to participate in CPD programmes.

5.3.2.2 Planning

Proper planning is the key to the successful implementation of a CPD programme as it has a major influence on the attendance of the programme. Three important aspects to be considered when planning a CPD programme include a need assessment, collaboration with regard to the topic choices and acknowledgement of the different levels of knowledge.

It is advised that clinical facilitators and managerial personnel make use of collaboration by including the CCNPs in the planning and implementation of CPD programmes. Collaboration may lead to the development of autonomy and a sense of ownership with regard to the CPD programme which, in turn, may increase the attendance and participation in the CPD programmes thereby ensuring that individual and organisational objectives are reached.

➔ Recommendation

The strategies recommended for ensuring the effective planning of CPD programmes are outlined next.

- Conducting a thorough need assessment and making sure that the CCNPs of the CCUs are involved. This may provide them with a sense of involvement in the planning of CPD programme thereby increasing their sense of self value to the organisation. To achieve this, it is recommended that the following strategies are followed.
 - Requesting and arranging a unit meeting on a scheduled time suiting the unit as well as the CCNPs.
 - During the unit meeting, ask the CCNPs to observe and evaluate their own as well as their colleagues' clinical practice for a week. Thereafter, make a list of what training the CCNPs think is required to improve clinical practice. The CCNPs should also be requested to include topics they believe are relevant and/or interesting to be included in the next CPD programme. These should then be handed in to the clinical facilitator.
 - Remind the CCNPs that the topics on the lists should be realistic. They should be reminded that the ultimate goal would be that attending CPD programmes developed around these topics must empower them to conduct their nursing care activities with more current knowledge, skills and self-confidence thereby influencing patient outcomes positively.

5.3.3.2 Implementation

The effective implementation of a CPD programme is dependent on effective facilitation by a competent, knowledgeable facilitator through the use of effective teaching strategies and by acknowledging that the CCNPs are adult learners.

➡ Recommendation

The recommended strategies to ensure the effective implementation of a CPD programme are as follow.

- The facilitator should be knowledgeable regarding the planned CPD programme's contents. The facilitator should utilise scheduled time for preparation optimally to ensure that he or she is well prepared for the facilitation of the CPD programme to be considered knowledgeable.
- The facilitator should know his or her abilities and field of expertise well. If the topic planned for the day is not one of the facilitator's strong points, he or she must arrange for a person knowledgeable in the field to present/facilitate the topic, even if it is one of the CCNPs him- or herself.
- During a CPD programme the clinical facilitator should employ different teaching strategies to ensure all participants gain by attending. For example, some of the contents should be facilitated through active group discussions and feedback followed possibly by a brief PowerPoint presentation to highlight/reinforce information discussed during the group discussion. Real life case studies are also useful to include in the discussions.
- Different CPD programmes should be scheduled for different categories of CCNPs. For example, if possible separate trained and qualified CCNPs from newly qualified CCNPs to decrease frustration and boredom in the group (related to different levels of knowledge and skills) during the CPD session.

5.3.2.4 Evaluation

Foremost to the measurement of success is the application of evaluation. Evaluation is an integral component in determining whether the CPD programme provided was truly successful. Therefore, it is crucial to evaluate the CPD programme provided to identify gaps for improvement but also to evaluate the attendees of the CPD programme to ascertain whether knowledge transfer has taken place and, importantly, that knowledge translation into the clinical practice has indeed occurred. Evaluation can be a source of motivation to improve where improvement is needed to ensure quality patient care and an improved CPD programme.

➔ Recommendation

Recommended strategies to improve evaluation of a CPD programme and whether the transfer of knowledge did take place are set out below.

- Improving the CCNPs awareness regarding the importance of CPD as well as maintaining knowledge that is current may lead to their willingness to be evaluated on newly gained knowledge.
- After the attendance of a CPD programme the participants should be allowed to evaluate the CPD programme with regard to the quality and relevance of the contents of the programme, its added value as well as the effectiveness of the facilitator to convey and explain the new information adequately.
- Collaboratively, the facilitator and the CCNPs must decide how much time is required for the CCNPs to practice the new clinical skill before being evaluated on the skill (if the CPD programme entails an evaluation of the new knowledge and skill).

5.3.3 Priority 3: Clinical training

Clinical training was viewed by the CCNPs as training occurring in the unit and not as part of CPD. Clinical training was referred to as on the spot training by the CCNPs. For clinical training to be effective it is essential that a need assessment is carried out to ensure that the training provided is on the appropriate level of knowledge as well as to ensure that relevant, applicable training is provided to the CCNPs functioning in the specific unit.

5.3.3.1 Planning

It is essential that proper planning precede the implementation of a clinical training programme. The planning of a clinical training programme has a major influence on the attendance of the clinical training. To ensure effective clinical training it is essential to perform a need assessment beforehand in order to determine the relevance of the planned training as well as the appropriate knowledge level of the proposed participants.

➔ Recommendation

The following aspects should be borne in mind for recommended strategies to improve the planning of clinical training.

- The planning of clinical training should occur in collaboration with the CCNPs working in the CCU to identify the topics which would be most valuable to the CCNPs. The need assessment can be carried out utilising the same principles used in Section 5.4.2 under the planning category of CPD.
- Collaboratively, the clinical facilitator and the CCNP should decide on the most suitable time for the clinical training to take place in the unit to ensure that the CCNPs are able to participate.
- Effort should be made to create more awareness of the CCNPs roles as educators and their knowledge and expertise should be utilised. Focussing on their ability to facilitate may increase their willingness to participate in CPD programmes. Moreover, the fact that the CCNP is the one next to the patient's bedside implies they have better clinical expertise than the clinical facilitator who may not be in the clinical setting on a full-time basis.

5.3.3.2 Implementation

The effective implementation of a clinical training programme is not only dependent on the effective planning thereof but also on the character of the clinical facilitator and the teaching techniques used. The clinical facilitator needs to be flexible, approachable as well as able to collaborate with the CCNPs to ensure participation in the clinical training programme. Furthermore, the clinical facilitator needs to employ various teaching strategies to accommodate all types of different learners and to ensure capturing the attention and interest of the CCNPs.

➔ Recommendation

Recommended strategies to ensure effective implementation of clinical training are presented below.

- It is recommended that the clinical facilitator who facilitates clinical training should employ various different teaching strategies during the implementation of clinical training to ensure

that all the CCNPs (no matter what type of learners there are) gain by attending, for example, combining short discussions with demonstrations.

- It is advised that the skill is demonstrated by the clinical facilitator or a CCNP who is willing to demonstrate it to her or his colleagues; this is followed by a discussion and finally the skill is re-demonstrated again by other CCNPs in the group.
- The training must be kept short and within the timeframe agreed upon.

5.3.4 Priority 4: Time constraints

From the data gathered and analysed it was evident that the attendance of CPD programmes had a huge impact on the CCNPs' time and its management. Two categories emerged from the priority: time constraints, namely scheduled time for CPD and personal time.

5.3.4.1 *Scheduled time for CPD*

The time scheduled for CPD had a negative impact on the work-life balance of CCNPs as indicated by the participants. The time scheduled for CPD did not necessarily fit in with the CCNPs' time schedule although it did fit in with the activities in the CCU. Staff shortages and high levels of activities had a negative impact on how time was scheduled for the attendance of a CPD programme. This was due to the fact that the CCU's need to be 'covered' for each shift leading to decreased off-duty time as the attendance of the CPD programme is scheduled as on-duty time.

5.3.4.2 *Personal time*

From the data collected it was clear that the CCNPs strongly felt that the attendance of CPD programmes had a huge impact on their personal time. The attendance of CPD programmes interfered with their family time as well as the time they had available to work overtime.

Recommendation

As the attendance of CPD programmes influence work-life balance it is important to look at how the CPD programme is scheduled. To ensure successful implementation of a CPD programme the following strategies are recommended.

- The attendance of a CPD programme should be scheduled as part of the total work hours per month required by the organisation's policy/contract as the organisation gain skilled CCNPs resulting in improved patient outcomes.
- When the attendance of a CPD programme adds up to extra hours to be worked, it should be negotiated with the CCNPs involved. Attendance of CPD programmes should not simply be scheduled on the duty roster without the CCNPs input/consent.

5.3.5 Priority 5: Financial implications

The collected data indicated that the attendance of CPD programmes had financial implications for both the CCNPs as well as the organisation (the hospital).

5.3.5.1 *Personal financial implications*

For the CCNPs the attendance of CPD programmes had negative as well as positive financial implications. The negative implications were related to the costs involved to attend CPD programmes when these were not presented on the hospital premises; if conferences and congresses had to be attended it was a major concern to the CCNPs when the hospital was not able or willing to financially support them to attend it. Furthermore, the attendance of CPD programmes decreased the available time to work a 12-hour overtime shift which had an impact on their immediate financial status. The positive financial implications of attendance were related to the CCNPs' job performance management (JPM) score. Attending CPD programmes resulted in an annual salary increase. This implied on the one hand that if the CCNPs had attended the CPD programme their knowledge and skills were viewed as 'current' which improved their performance and thus improved their annual salary increase. On the other hand, if the CCNP had failed to attend it resulted in a nominal increase in her or his annual salary. Furthermore, proof of having attended CPD programmes could influence the individual CCNP's career progression as it allowed him or her to build up an attractive curriculum vitae showing that he or she took responsibility to maintain current clinical knowledge and skills in his or her field of practice.

5.3.5.2 Organisational financial implications

The attendance of CPD programmes by CCNPs also had negative as well as positive financial implications for the organisation (the hospital). Considering that it costs the organisation money to train CCNPs and keep their knowledge and skills up to current standards, if the CCNPs attend a CPD programme which does not have a direct influence on patient outcomes and productivity (for example, if the topic is irrelevant), it is a waste of money for the organisation to encourage attendance of such programmes. Thus, if the CPD programme does not add value to the organisation, it has a negative financial implication for the latter.

On the other hand, when the organisation invests in the CCNPs to attend relevant CPD programmes the organisation gains human resources which are up-to-date, knowledgeable and clinically skilled. With the high quality human resources the organisation remains in a competitive market since high quality service delivery is provided.

➔ Recommendation

Considering the current economical status of the workforce, it is important to ensure that attendance of CPD programmes benefit both the employees (CCNPs) as well as the employer (the hospital). Recommendations made with regard to financial implications follow.

- Link the attendance to and participation in a CPD programme to the CCNPs' JPM scores. This will encourage CCNPs to take responsibility for their own CPD. (This strategy was suggested by the CCNPs themselves. It was their observation that often individuals who needed training or the acquirement of a new skill were the ones who did not attend any CPD programme).
 - Linking CPD programme attendance to the JPM score should only be done after:
 - the unit manager has had a discussion with the CCNPs and explained the implications of linking CPD to the JPM score
 - the CCNPs understand that they have to be able to provide a portfolio of evidence compiled during the attendance of a CPD programme.
- CPD programmes facilitated must be cost-effective for both the individual CCNP as well as for the organisation. Therefore, discretion must be used on both sides when considering

whether the CPD programme will add value to the required skills and knowledge of the CCNP in order to positively influence patient outcomes.

- This can only be accomplished if a thorough need assessment has been done from the organisation's as well as the CCNPs' perspectives.
- More research studies need to be conducted to establish the cost-effectiveness of CPD as limited studies were available in literature on the cost-effectiveness of CPD.

5.3.6 Central theme: Attitude

The central theme, attitude, was identified by the researcher after she had worked through the collected data (individual worksheets, verbatim transcripts and flip charts) again. The general impression gained from the data was that attitude also played a role in the attendance of the CPD programme. The attendance of the CPD programme was dependent on factors such as who presented it; who attended it; was there a possibility that the CCNP needed to go back to the CCU and share the new information gained with other CCNPs. Additionally, the attendance of the CPD programme was seen as a waste of time by some participants because the “*old ways*” were working so why “*change it*” and “*where CPD occurs implementation follows*”.

From the data collected it was evident that the CCNPs had a negative attitude towards the attendance of the CPD programme. However, as the researcher found in literature and research studies previously conducted, the attitudes of the CCNPs and the clinical facilitator may determine the success of the CPD programme. Even if the CPD programme has been well developed, thoroughly thought through and contains the input from the CCNPs, if a negative attitude from either the facilitator or the CCNPs or both prevails, it will influence the attendance and participation by the CCNPs and the programme itself will not be successful. The recommendations made with regard to attitude are noted below.

➡ Recommendations

- The clinical facilitator should display a positive and motivated attitude to generate CCNPs' interest and participation in a CPD programme.

- The clinical facilitator should also be energetic and positive about the CPD programme to influence participants to display similar energy and enthusiasm when it is time to implement what has been taught or re-learnt.
- The clinical facilitator needs to identify CCNPs in the CCUs who are dynamic and able to positively influence other CCNPs with whom he or she is working. By displaying a visibly enthusiastic and energetic attitude may help to encourage other CCNPs in the unit to participate in the CPD programme. If disinterested CCNPs realise that attending CPD programmes can lead to a change in the unit and positive patient outcomes can result, they may willingly and actively participate in the programme.
- The clinical facilitator should focus on what is done correctly and successfully in the CCU and emphasise it. She or he then has to guide the CCNPs to identify the areas where there is room for improvement. Through the identification and appreciation of what is done right, the CCNPs' sense of value may increase and they would inevitably willingly want more of what is right.
- The clinical facilitator should attempt to ensure collaboration with the CCNPs throughout the entire process; from the planning to the evaluation of the CPD programme to ensure buy-in, ownership and participation in the CPD programme.
- To overcome the fear/negative attitude of unwillingness to teach/reinforce knowledge CCNPs should be assured that if they are unsure about what action to take, or if they need more information on something they are not familiar with, it is not wrong to admit it. The CCNP must then be referred to someone from whom she or he can obtain the information/knowledge.
- It is recommended that the CCNPs are made aware of their educational role as set out in the scope of practice of the registered professional nurse as well as the role of the clinical facilitator.

5.4 FUTURE RESEARCH

It is recommended that future research studies pertaining to the attendance of CPD programmes should include the topics mentioned next.

- Exploring whether the strategies developed in this study contribute to the improved attendance of a CPD programme.

- Monitoring and evaluating whether the attendance of CPD programmes actually improve the knowledge and skills of the CCNPs.
- Monitoring and evaluating whether the attendance of a CPD programme actually improve patient outcomes.
- Monitoring and evaluating the costs versus the benefits involved in the attendance of CPD programmes.
- Exploring the CCNPs' attitudes towards attendance and participation in CPD programmes.

5.5 LIMITATIONS

The study was planned and conducted to improve the current attendance of the CPD programme in the CCUs in a private hospital. Participants were selected from the CCU setting in the particular hospital only. The sample size was small because of the limited number of nurse practitioners working in the setting. Due to the above mentioned facts, the transferability of the study findings was marginalised. However, it was not part of the aim of the research study to transfer the study findings to other settings.

5.6 PERSONAL REFLECTION

Over the last three years my involvement in this study rejuvenated my passion for the nursing profession. My interest in the provision of CPD in the critical care setting stems from my role as a clinical facilitator in our hospital group. In my current role, I have the opportunity to observe, reflect upon and critically analyse the nursing interventions occurring at the patients' bedsides. As a provider of clinical education and that of a CCNP, I had the opportunity to do research within the field of critical care nursing practice related to participation in CPD.

The past three years was a journey of personal and professional growth. In the planning phase of the study my aim was to use appreciative inquiry as my conceptual framework. Later, after many months of reading all about the appreciative inquiry process, I realised that the use of the nominal group technique would be more valuable. However, the months I used to read, study

and write about the appreciative inquiry process was not a waste of time and energy. Appreciative inquiry became part of my outlook on life. I previously I tended to mainly concentrated on looking at “*what is wrong*”; however, as the study progressed I started looking at my interactions with my colleagues through a magnifying glass and I realised I had unintentionally acquired new insights on how I interacted with them. It dawned on me that my outlook was ‘what was wrong’. I deliberately adapted my outlook and started to focus on ‘what worked’ in practice.

During the course of the study I discovered that collaboration with the CCNPs would be the key to the successful implementation of the CPD programme. Initially I expected that I would encounter disinterest or even resistance from the CCNPs when they were invited to participate in this study – but I was proved wrong. Of all the CCNPs whom accepted the invitation to participate in the study only one was unable to attend the nominal group technique. Their genuine eagerness to be part of this journey led me to the realisation that the mainstay of the successful implementation of a CPD programme was collaboration and appreciation.

I observed and experienced that collaboration with the CCNPs had a positive impact on them as people and as professionals. It was only by conducting this study that I truly came to understand that the importance of working together, of being valued as an able and competent member of a CCU team cannot be underestimated. The CCNPs did not attend the CPD simply because they felt that their input was not valued. If the CCNPs’ feelings, opinions and suggestions were considered and attended to by the clinical facilitators and the organisation, it would make them feel more worthy and increase their sense of being valued. I realised that in order to engage CCNPs willingly in the CPD programme requires a collaborative as well as an appreciative approach. Such voluntary participation would not only empower them take charge of their own CPD, but would also bring about positive change in clinical practice and patient outcomes.

Undertaking and completing this study filled me with an overwhelming sense of achievement and pride, both in my personal and professional life. The completion of this study was made possible by the selfless efforts of all the CCNPs who willingly participated in the study. I acknowledge the contribution of every participant and thank all those who were involved in this study.

5.7 SUMMARY

In the South African context, mandatory CPD for the nursing profession is still a relatively new concept. Recognising that there are various challenges with regard to the attendance of CPD programmes the researcher opted to explore the reasons related to unsatisfactory attendance.

A qualitative descriptive research design was used to guide the study and the nominal group technique was used to collect the data. Inputs from all the participants were included and consensus among the participants was reached with regard to the reasons for unsatisfactory attendance of the CPD programme. In total six themes were identified, namely communication, continuous professional development, clinical training, time constraints, financial implications and attitude. Based on the collected data, strategies were recommended for each theme to enhance attendance as shown in Table 5.1.

Table 5.1 Strategies to enhance the attendance of a CPD programme

STEPS	ACTION RECOMMENDED	REFERENCE
Establish effective communication	<ul style="list-style-type: none"> • Allow two-way communication: ask input from CCNPS and give feedback. • Provide written CPD programme at beginning of year. • Circulate a booking list for CCNPS to schedule/plan their attendance. • Use bulletin boards to post CPD programme on. • Invite CCNPs to communicate their CPD needs. 	Section 5.4.1
Create awareness regarding CPD	<ul style="list-style-type: none"> • Use bulletin boards to post posters on regarding importance and advantages of CPD. 	Section 5.4.2

STEPS	ACTION RECOMMENDED	REFERENCE
Planning of CPD	<ul style="list-style-type: none"> • Conduct a collaborative need assessment. 	Section 5.4.2
Implementation of CPD	<ul style="list-style-type: none"> • Facilitate dialogue among peers geared towards problem-solving. • Utilise CCNPs' variety of experiences as learning opportunities. • Keep topics relevant and applicable rather than 'nice to know'. • Provide options and alternatives to support different learning styles. 	Section 5.4.2
Evaluation of CPD	<ul style="list-style-type: none"> • CPD attendees to evaluate CPD programme at end of session. • CCNP and clinical facilitator should collaboratively identify timeframe to be allowed for CCNP to practice new skill before being evaluated. 	Section 5.4.2
Planning of clinical training	<ul style="list-style-type: none"> • Conduct needs assessment collaboratively. • Collaboratively identify suitable timeframe for clinical training. 	Section 5.4.3
Implementation of clinical training	<ul style="list-style-type: none"> • Utilise CCNPs' variety of experiences as learning opportunities. • Keep topics practical and applicable rather than theoretical. 	Section 5.4.3

STEPS	ACTION RECOMMENDED	REFERENCE
Time management	<ul style="list-style-type: none"> • Ensure CPD programme fits into set timeframe during implementation. • Add CPD hours as part of required on-duty hours. 	Section 5.4.4
Financial status	<ul style="list-style-type: none"> • Discuss the consequences of linking CPD attendance to JPM scores. • Link CPD to JPM scores. • CCNPs and organisation to meet each other halfway to cover the expenses for CPD attendance. 	Section 5.4.5
Improve attitude	<ul style="list-style-type: none"> • Clinical facilitator to display positive, motivational and energetic behaviour towards CPD programme. • Identify CCNPs who are positive and energetic to influence peers regarding CPD. • Utilise CCNPs' variety of experiences. • Allow CCNPs to provide input about topics for CPD. • Acknowledge appropriate, correct behaviours/skills. 	Section 5.4.6

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ANNEXURE A

ETHICAL APPROVAL



ANNEXURE A.1

UNIVERSITY OF PRETORIA



The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

29/07/2013

**Approval Notice
New Application**

Ethics Reference No.: S62/2012

Title: Strategies to enhance attendance of a continuous professional development programme for critical care nurse practitioners at a private hospital in Gauteng. Dept. of Nursing Science, University of Pretoria (SUPERVISORS: Dr IM Coetzee / Dr T Heyns)

Dear Myra Elizabeth Viljoen

The **New Application** for your research received on the 01/06/2012, was approved by the Faculty of Health Sciences Research Ethics Committee on the 25/06/2012.

Please note the following about your ethics approval:

- Ethics Approval is valid for 3 years, till the end of June 2015.
- Please remember to use your protocol number (**S62/2012**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

Standard Conditions:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

◆ Tel:012-3541330

◆ Fax:012-3541367 Fax2Email: 0866515924 ◆ E-Mail: manda@med.up.ac.za

◆ Web: //www.healthethics-up.co.za

◆ H W Snyman Bld (South) Level 2-34

◆ Private Bag x 323, Arcadia, Pta, S.A., 0007

ANNEXURE A.2

THE HOSPITAL





4/6/2011

Dear Myra

RE: REQUEST TO DO RESEARCH AT THIS HOSPITAL

It's our pleasure to inform you that permission to do your proposed research study has been granted.

We would like to wish you success in your studies.

Yours sincerely

A handwritten signature in black ink, appearing to be 'L. Engelbrecht', written over a horizontal line.

L. ENGELBRECHT
NURSING MANAGER

ANNEXURE B

PARTICIPANT LEAFLET AND CONSENT



Participation leaflet and informed consent

Dear critical care nurse practitioner

You are invited to participate in a research project for nurse practitioners working in the critical care unit that will take place at your hospital. This information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher at any time.

TITLE OF STUDY

Exploration of the reasons for, and the development of strategies to overcome poor attendance of a Continuous Professional Programme for critical care nurse practitioners working in a private hospital in Gauteng.

1) The purpose and objectives of the study

The overall aim of this research is to, by means of Nominal group technique; collaboratively explore and describe the poor attendance of the Continuous Professional Development (CPD) programme by Critical Care Nurse Practitioners (CCNP's) working in the critical care units.

In order to achieve this aim, the specific objectives of the research are:

- **Objective 1:** To identify and explore the reasons why CCNP's do not attend the CPD programme;
- **Objective 2:** To develop strategies on how to overcome these challenges with regard to poor attendance;

2) Explanation of procedures to be followed

You are invited as a critical care nurse practitioner to participate in a study to explore and describe why the CCNP's poorly attend the CPD programme for the critical care units in a private hospital in Gauteng. The data collection process of the proposed research study involves a nominal group interview session of approximately 60 to 90 minutes to collect data.

3) Risk and discomfort involved

As a participating critical care nurse practitioner, you will experience no discomfort. There is also no risk involved in this study. However, your input into this research will require some of your time (approximately 1 hour and 30 minutes in total) and effort.

4) Benefits of the study

The benefit of the study would lay in the fact that once the challenges experienced by the CCNP's to the attendance of the CPD programme have been explored and described, strategies can be developed to overcome these challenges leading to improved attendance of the CPD programme. Improved CPD programme attendance has benefits to the individual professional in the sense of up to date knowledge and skills as well as personal satisfaction for improving/ maintaining knowledge/skills already mastered. For the hospital, it means competent personnel leading to quality patient care service delivery.

5) Voluntary participation in and withdrawal from the study

Participation occurs on a voluntary basis, and you can withdraw from the research without stating any reason should you no longer wish to take part. No penalties will be implemented should you wish to no longer participate.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of Pretoria, as well as the private hospital in Gauteng, has given written approval for this study.

7) Additional information

If you have any questions about your participation in this research, you should contact the researcher, Mrs M.E. Viljoen –

Work telephone: (012) 334 2659

Cell phone: 082 904 4957

Email address: myra@qcomp.co.za

8) Confidentiality

Even though a tape recorder will be used during data collection, no names will be used during data analysis and reporting. Your input into this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous. Data collected for the study will be kept safely at the University of Pretoria for the prescribed period thereafter data will be destroyed.

9) Consent to participate in this study

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. As participant in the proposed study your only responsibility is to provide truthful data.

INFORMED CONSENT

I have read the above information leaflet and fully understand what is expected of me. Its content and meaning have been explained to me. I have been given the opportunity to ask questions and received satisfactory answers. I hereby volunteer to take part in this research.

Participant's name (Please Print)

Participant's signature**Date**.....

Investigator's name (Please Print)

Investigator's signature**Date**.....

Witness's name (Please Print)

Witness's signature**Date**.....

ANNEXURE C

DATA COLLECTION



ANNEXURE C.1

INVITATION TO PARTICIPATE IN NOMINAL GROUP TECHNIQUE



ANNEXURE C.2

PHOTOS OF NOMINAL GROUP TECHNIQUE



NOMINAL GROUP TECHNIQUE

Silent generation of ideas



ANNEXURE C.3

WORKSHEETS



WORKSHEETS

Participant 1

Step 1: Silent generation of ideas in writing:

Question 1

The reasons why CCNPs do not attend the CPP Program?

- People or personnel don't see the importance of it they are not educated enough on why they need CPD Points especially the lower categories don't get it.
- I work out the off duties and the ICU must be covered so CPD programmes is scheduled on their off days which also causes a problem because it is like now you have to come to class on your off day and you feel tired because you have been working very hard the past few days.
- CPD programmes is not seen as part of your off duties it is seen as something you do extra on your own time because of the ward or ICU has to be have enough staff. Even though you get the hours from the hospital it is seen as "I am giving up my time because I still have to work my shifts"
- In the end CPD is not taken serious enough and people feel it interfere's with their personal life or time to rest.

WORKSHEETS

Short notice given



Ranking

- ① CPD
- ② Communication
- ③ Time
- ④ Training
- ⑤ Cost effectiveness

WORKSHEETS

Participant 2

Step 1: Silent generation of ideas in writing:

- Reasons why CPD programs is not attended:
- Afraid of stigmatisation.
 - Not positively orientated for improvement
 - Set in ways (comfort zone)
 - Old things work - why change.
 - As ek meer weet moet ek meer doen.
 - Verantwoordelikeheid word meer en is nie almal altyd reg daarvoor nie.
 - Bang as iets getel het moet jy dit vir ander leer en het dalk nie goed genoeg verstaan om weer te gee nie.
 - Hoar "op die spot" gesel word - jou "Sij weet mos!" en wil nie die verantwoordelikeheid daarvoor neem.
 - Welc reeds leer 'n pos, het nie tyd om nuwe idees of veranderings te implementeer nie.
 - As jy 'n CPD bygewoon het, verwaag meeste mense jy moet nou alles weet tenyde jy nie dit weet nie - so jy wil nie janself blootstel nie.
 - Die feit dat dit as "we" tel help maar dit is gewoonlik nog op "Af" stasie wat jou min tyd. gee vir gesin tyd of oortyd. met meer finansiële implikasie het.
 - As dit in die lewensd gesiek word jy aangejaag om klaar te "leer" want het het dit nodig

WORKSHEETS

- As RN moet jy baie keie dit wat junior in CPD geleer het weer verduidelik wat tydrowend is
- Selver CPD Trainings moet korter tye maar meer keie lees sodat inligting beter geabsorbeer kan word
- Beries is nie die "evaluasi" faktor by selver trangs by. "refresher course" is beries is nie "up to date" en gaan posisie / werk verloor.
- Sak / eenhede is besig in het nie tyd uit boeke / dokumente / prosedures "af te teken" nie - veral nie vir spes tyd!

-
- ① CPD
 - ② Communicatia.
 - ③ Training
 - ④ Time.
 - ⑤ Cost

WORKSHEETS

Participant 3

Step 1: Silent generation of ideas in writing:

Q = Give REASONS WHY CCNP's DO NOT ATTEND CPD PROGRAMME

A = Working in a critical care unit is very challenging psychologically, physically and emotionally. It is very tiring to come in for a CPD after a three day's shift of hectic unit therefore it is discouraging to come for a CPD then be one day off and return to work the next day.

① * CPD's should be included into the week's shift days i.e. if the said week is 3 day shift week one day needs to be a CPD day so as to get normal 2 days off.

② * Content is most of the time irrelevant and not valuable to one or unused and coming to attend feels like a waste of time i.e. coming for basic nursing lecture with lower category i.e. staff nurses or newly qualified RN's is very much irrelevant for a CCNP. Yes it is good to go back to basics from time to time but topics needs to be of practical level of category.

→ ③ * It is not pre arranged with staff and discussed before hand the needs to improve or needs to train
→ everything is just pushed down upon the staff
→ NO thorough evaluation is done to determine the need of improvement for specific ranks and categories.

④ Employees needs of "improvement" are not met i.e. if an employee needs to improve a certain skill
→ it is not always taken into consideration to materialise that instead one is stuck with inservice training that is given or offered by the hospital.

⑤ It is compulsory to come and threats are made i.e. "if one does not attend one may be disciplined" therefore we just come or make excuses not to attend - come with a sick note.

WORKSHEETS

- Ranking
- 5* COMMUNICATION
 - 4* TRAINING ✓
 - 3* TIME
 - 2* COST EFFECTIVENESS
 - 1* CPD

WORKSHEETS

Participant 4

Step 1: Silent generation of ideas in writing:

- why
The reasons that CCNP's do not attend the CPD programme? ✓
- ① Dink dit is nie nodig nie, hulle weet bu wat hulle moet doen, byvoorbeeld neurologiese observasies - doen dit elke dag.
 - ② Al word hulle ekstra tyd gegee - ure gegee - wil nie by lesing kom siten luster nie, het ander sake wat hulle graag wil doen, tuie.
 - ③ Die onderwerpe wat aangebied word is nie interessant nie.
 - ④ Indien hulle wel dit bywoon is 'n hulle negatief en wil dit so gou as moontlik voltooi hê, 'is half gedwing om te kom'.
 - ⑤ Wie die lesing aanbied -
 - ⑥ Hoe lank die lesing is.
 - ⑦ Wie die lesing bywoon.
- Ranking -
- ~~CPD~~ Training
 - Communication
 - Time
 - Training CPD
 - Costeffectiveness.

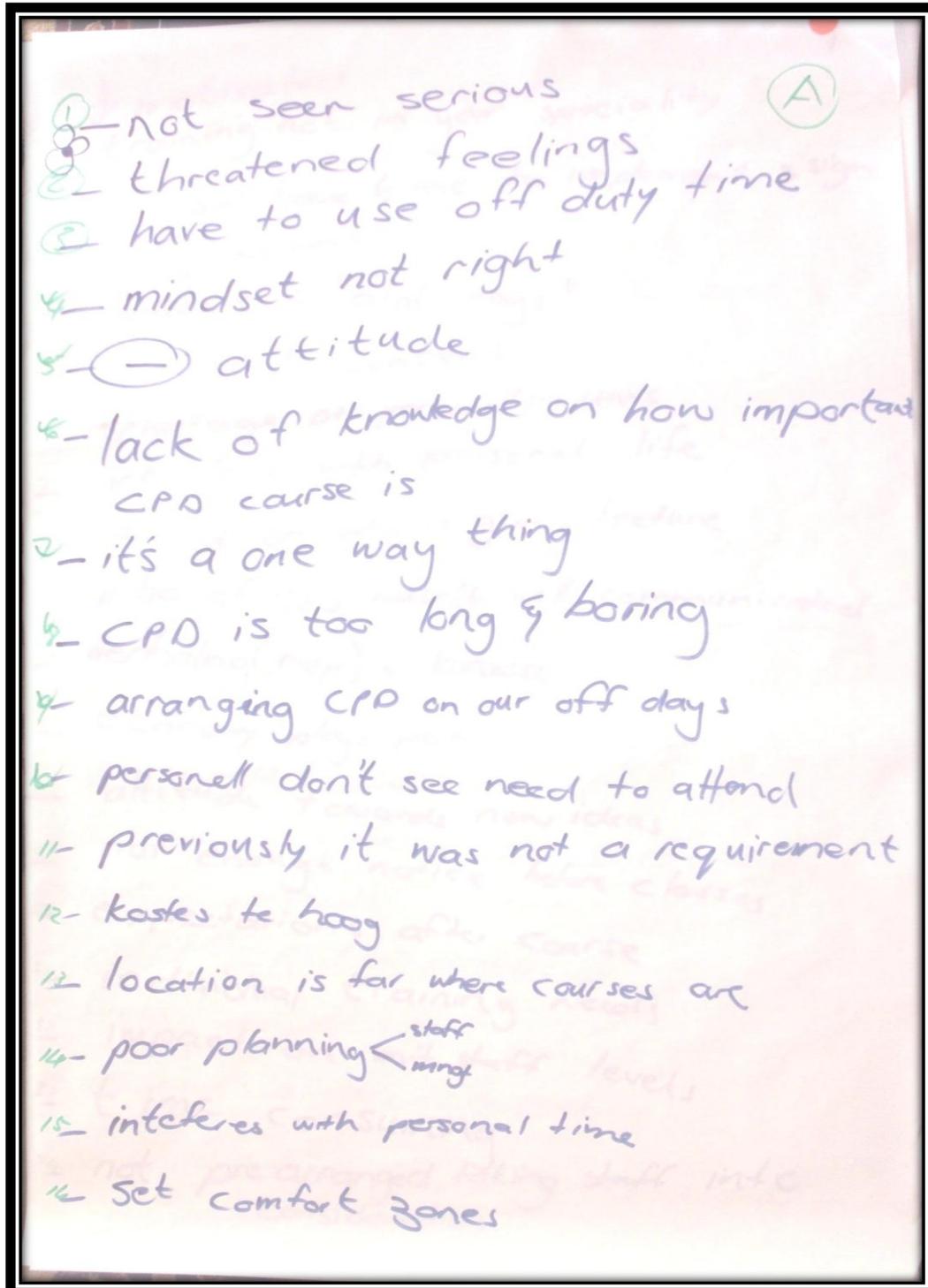
ANNEXURE C.4

FLIP CHARTS



FLIP CHARTS

Round robin recording of ideas

- 
- A handwritten flip chart with 16 numbered points and a circled 'A' in the top right corner. The points are:
- 1 - not seen serious
 - 2 - threatened feelings
 - 3 - have to use off duty time
 - 4 - mindset not right
 - 5 - (—) attitude
 - 6 - lack of knowledge on how important CPD course is
 - 7 - it's a one way thing
 - 8 - CPD is too long & boring
 - 9 - arranging CPD on our off days
 - 10 - personell don't see need to attend
 - 11 - previously it was not a requirement
 - 12 - koster te hoog
 - 13 - location is far where courses are
 - 14 - poor planning ^{staff} _{mgmt}
 - 15 - inteferes with personal time
 - 16 - set comfort zones

FLIP CHARTS

- 17 ↓ motivated
 - 18 training not in your speciality
 - 19 do not have time to implement & sign off procedures
 - 20 comfort in "old ways"
 - 21 irrelevant content
 - 22 shortage of personnel in units
 - 23 interfere with personal life
 - 24 depend on who is giving lecture
 - 25 intro of cpo wasn't well communicated
 - 26 herhaling (rep) v kursusse
 - 27 economy plays part
 - 28 attitude towards new ideas
 - 29 not enough notice before classes
 - 30 expectations after course
 - 31 individual training needs
 - 32 impact on unit staff levels
 - 33 time consuming
 - 34 not pre arranged taking staff into consideration
- (B)

FLIP CHARTS

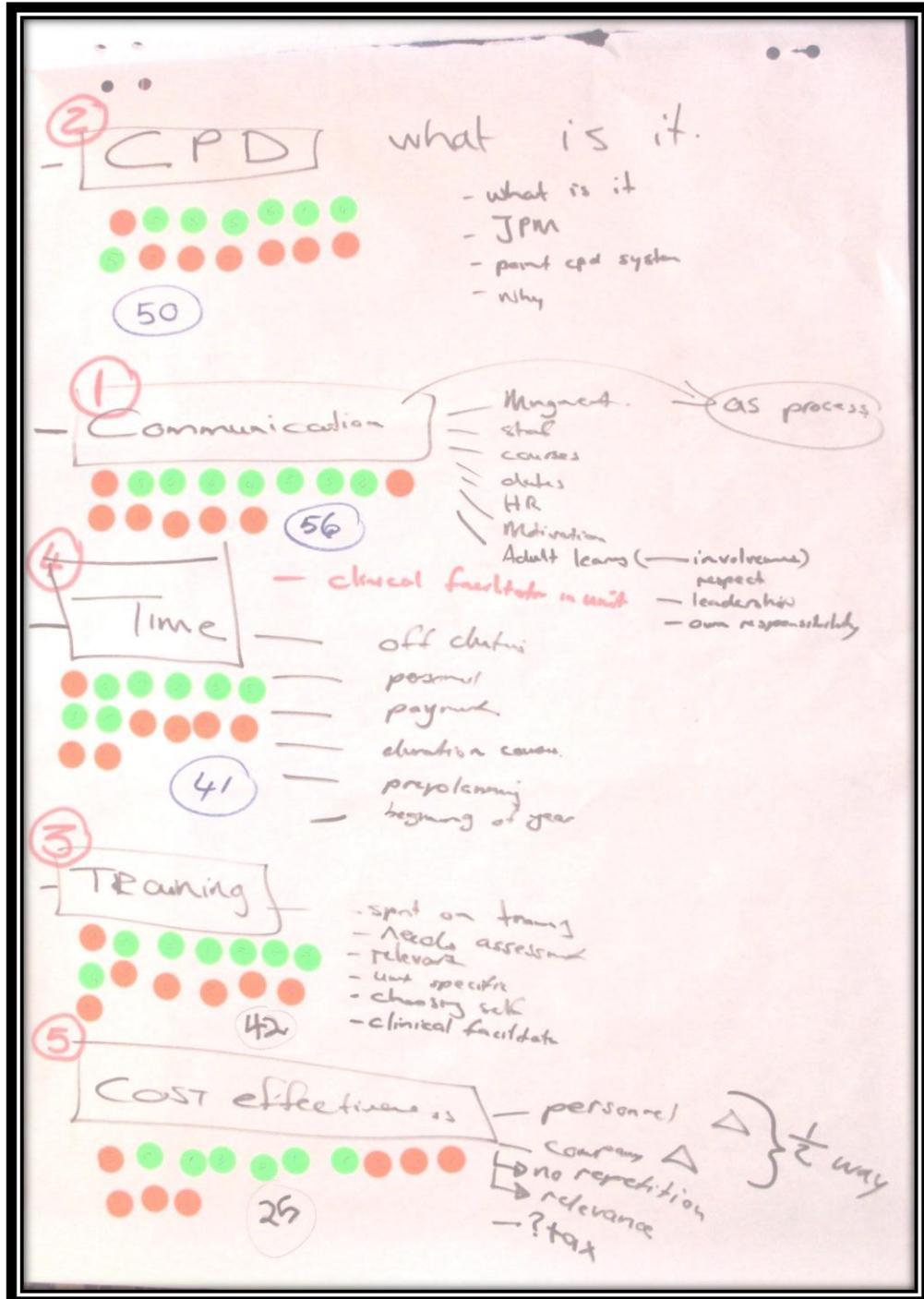
- 45 not communicated on info on CPD
- 46 which programs have points and which don't (confusion)
- 47 request to go is denied
- 48 do not understand reasons for cpd
- 49 time consuming
- 50 programme too long
- 51 too much info in session
- 52 scheduled on off duties
- 53 if practicals/eval after course is not done—
 - 54 impact on post/position
 - 55 threatened if not attending
 - 56 applicability of info
- 56 not as good as on the spot training
- 57 individual needs
- 58 staff feels it is "pushed down" on them
- 59 feeling overwhelmed
- 50 Management's attitude — can't choose
- 51 ↓ child & family time — cost effectiveness
- 52 "overworked & underpaid"

FLIP CHARTS

- 53. WAFS irrelevant courses
- 54. being placed on "spot" once back in the unit
- 55. affects JPM
- 56. off duties not flexible enough
- 57. irrelevant courses
- 58. rather work overtime & get something for it
- 59. view of staff - company is stealing family time
- 60. staff demotivated
- 61. not ^{knowledge level} relevant category
- 62. cost effectiveness for staff - accommodates
- 63. tiring after shifts.
- 64. poor communication.
- 65. people that gives training ↑ specialist.
- 66. no pre-evaluation of training needs.
- 67. do not understand reason why CPD points have to be gathered.
- 68. ? effectiveness of accumulating CPD points done different at different hospitals.

FLIP CHARTS

Ranking and voting results



ANNEXURE C.5

TRANSCRIPTIONS



Nominal Group Session – Transcription

R: This stuff ...

F: (Talking simultaneously) needs assessment.

R: Yes, yes.

R: We need this, and this is what, how many points for this category of staff nurses in ICU with this knowledge and then you arrange the in-service training for them and then for the next category of RNs, so it should be done.

F: So there should be an assessment done in the unit and then decided on the level of the courses being, the need of (talking simultaneously) and the amount of the points.

R: Oh yes.

F: Alright. Anything else that you would like to add here?

R: Nothing.

F: Perhaps we should start with the first one, our first page. I will number them. Otherwise we are going to have some trouble.

Now, can I ask that if you give feedback, let's do it in English, so that everybody can understand, even in this session?

Let's number them. Some of them are going to overlap now, but we will just talk about it briefly. So number 1 is: it's not seen serious. Now you can elaborate on that. Is there something you want to say about it?

R: We don't see the course as serious.

F: I think you mentioned this?

R: Ja. I don't think people are educated why we need this CPD points all of a sudden. They are not told why they need the CPD points now all of a sudden. So they don't know why they have to come to class, because it it's just class, it's not as if I am gonna lose my job when I don't show up for work. They don't get reprimanded so much when they don't show up for class. They did get

reprimanded when they don't show up for work.

F: So you say that they don't take it seriously because there is no reprimanding if they don't go.

R: Ja,

R: (Someone else interrupt) once threatened, they (referring to management) say you're going to be disciplined then they started with, ...

R: (someone else continue) Ja, when they started not showing, they started telling it is as seen as part of your shifts thus you're going to get unpaid leave. So they start threatening the people to go to the CPD otherwise they are gonna get unpaid leave or they are going to be disciplined. But we were not told why we need the CPD, why do we need the training.

R: (Someone else) Their attitude towards this in other words is wrong. Because people think they are going to jump up like a tiger fighting them, whereas it is actually like giving a little milk bowl, telling them why they need to have it, they are going to spin like a little cat (talking simultaneously) wanting to have it.

F: So the way in which this is implemented is ...

R: (Talking simultaneously) mustn't be in a threatened way.

F: Threatened way to staff?

R: Ja,

F: If they don't do it, they will get leave?

R: Get unpaid leave,

R: They will lose money or leave,

R: Ja or I can say their position, (talking simultaneously) written warnings, disciplined.

F: The time is running. Anything else that you want to say about the threatened feeling?

F: Number 2: Use of off duty time

R: Ja, that is the new one.

R: It is scheduled on their off duties, the day they should have been off, because the ICU or the wards must be covered with personnel. There must be enough staff because we always full so we can't let staff that had to work go on classes and stuff so it's scheduled on their off duties.

So this is the day that would have been off. Now they've been working for 3 days already, they are tired and now they will have to come in for class and it's an irrelevant class that something like 'gentle'? (laughing). And now you are really demotivated because you could have slept late, its winter.

R: Why can't they use the off duties in off duty time (talking simultaneously) because you just arrange it, because you are flexible with off duties. So you could arrange to go to the training on duty time as if you're shift.

R: You know what I work out the off duties. So what I get, I get a letter that say that these people I must just put in, the people to go on this training or (talking simultaneously) they must get this classes. So I have to put the people in and when and (talking simultaneously) (someone else talking ??) so I have to put them in duties and I am told is has to be on their off days because we can't afford to have (talking simultaneously)

R: It's their decision it is not our decision.

R: Exactly

R: And at the end of the day it is our time and our families (talking simultaneously).

R: The management doesn't care about our personal life. They only care about us coming to work and doing the training and things.

R: I just get a paper saying the RN's or the EN's must go on this course and I must just put them in, everybody must go before this date. So I put them in, I try to put the temporarily roster so that they can see if it is okay. I put it on the temporarily list so that they see: "okay I have to go to these classes," but sometimes I get the memorandum to late that there has to be training then it's on the permanent roster already and they see it too late.

F: So sometimes, ... (talking simultaneously) usually it's forced but sometimes you even get the roster too late? (talking simultaneously)

R: Ja, or the memorandum.

R: And it also come back to planning, if you know for your specific category this is the points you require, say hundred points of whatever. You can, now, okay if you know what type of courses is available of the 300 courses that is available, you can see this one counted 10, this one counted 20 and you can make your own need planning as well. Okay I need to do the ventilation may be. My need for ventilation is bigger than my need for hand washing. So it is not about the

ventilation course, which is in September. Okay, so if I do this, I need three other courses. So let's plan this on my duty roaster, plan that the person that makes out the off duties to work my points into my duty time. So that it doesn't affect my off duties, off time and it is part of in-service trainings, so beforehand those hours that I would have spent in the ward can be accommodated by people either working overtime but who prefer to work overtime, rather than come to the course and it will be part of my duties. So for me it is not affecting anyone, if the ward is, if the shift is worked out pre-hand to cover the ward then you don't feel you take anyone's opportunity away, actually you're giving someone the opportunity to work overtime rather than forcing him to go for a training session that is not even interesting.

R: And again to add on that, I think management is unreasonable because, uh, like myself, I am talking about myself, this month I am going to work plus my CPD days, 216 hours. So now how come, so how come should I work? I've got to work 182 and stretch it up to 216 hours including these days that I am coming in for and then it is not flexi hours. They might just as well put those 8 hours in between the shifts that I am supposed to work and give me my two days off when I'm supposed get them, covered by 182 hours. Now I am working this 216 hours which I don't need to because I am attending 3 times 8 hours in-service training plus my seven sevens which makes 15 full shifts. So how does it work? Why can't it be included in the normal day shifts?

F: I would just like to ask you, when you do this you have to do it on your days off and you get hours for it or get paid?

R: Yes, yes it is hours. (Talking simultaneously)

R: But if you got too much hours, they tell you, okay you must do something with this hours of yours (talking simultaneously) because it is too much hours.

R: So it comes to time management again.

R: (talking simultaneously), So this month I'm told: "you've worked 48 hours too much," but I have to attend this and this and this, and now they told me it is too much hours that I have worked for the month so I must do something with it. (Talking simultaneously) not when it suits you.

R: I think they must switch it to flat rate because they don't want to lose you on the shift. She still has to work shifts and you still have to go for the training. But you can't let them go on training on the day they have to work their shifts. The point is here ... (talking simultaneously). But the whole problem is they give you a course that is about three months or whatever and you have

to plan all that RNs over those three months, you have to push them in. You don't get enough time to if you have RN's, you have to put over a year maybe then you will not have a problem of the shifts and that will go on.

F: And it also sounds to me as if ...

R: (talking simultaneously) it is type of an autocratic thing

F: But it also creates some conflict between the workers and the shift leaders that has to arrange the off duties (talking simultaneously).

R: The one who is doing the off duties is getting the most moaning and most pressure and it creates conflict (talking simultaneously).

F: Can we now move on to number 4. Mindset not right. It starts mindsets are not right. What would you like to say about that?

We started and we said that the way in which this course ...

R: There is no positive influence towards coming to the in-service training. It's not well marketed into our minds to say we feel 'opgewonde', you know, look forward to come to in-service training, so it's not a positive, it's not a wow thing, like I want to go, I need to know, I want to hear, it is not motivational, jy't nie energy nie (talking simultaneously).

F: What did you say?

R: I would rather be sick than to go to the gentle course. Bubbles and Bees and (talking simultaneously)

F: So and you all say your mindset is not right because it's not applicable to what you have to do?

R: Yes

R: It's like dynamics, (talking simultaneously) ethos of nursing, it is the same blerrie thing.

F: Anything else that you would like to add about the staff's mindset is not right.

R: It is all about communication.

R: Ja. Communication and knowledge. If they really have all the update applicable knowledge about what CPD is about then their minds might change. But now it's a thing hanging in the air and everybody is fighting it because they don't know with, what the ABC, but is actually asked for, from them. Like one of the questions was what is CPD? What is the points? What is asked from me now? Everybody goes and every thought what is forced to go of everything just

because it is CPD. What is the CPD actually? How is it going to implicate on you? That might change your mind.

R: Unfortunately there is a general negative attitude and now it is how to reverse that into a positive. I don't know but we'll get there.

F: The negative attitude is about no communication, what CPD is, how the point system works and it's about coming there and is it going to force you to something that you are not interested for.
(Talking simultaneously)

R: I once asked them, what if you do an outside course not of the hospital situation by going to a Pain Control course or a paying attendance somewhere if it's going to count on your CPD points and then they tell me they don't know.

R: It's not nursing (talking simultaneously, another participant)

R: It is part of nursing (talking simultaneously) so I cannot see how you can't bring it back to your work. So if I go to a Russel Raath's pain congress do I get CPD points for it? They can't answer me that. ? But it is counting for the company? (Talking simultaneously). They told us the only things that we do here at this stage is counting for CPD points that is going to SANC. Because that's what the hospital expect from me. I've put it on the Consultative forum to reflect on because management couldn't answer me. I'm still waiting for three months till they start pointing it out. (Talking simultaneously) ... management does not know. If they don't know much how are we supposed to know?

R: (Talking simultaneously) I think I think as adults we are treated sometimes like children in the company. We are not make responsible for own CPD we are not educated about it. Ja, and how much. We are not empowered about it and we are not told why, and where and how. It's like this company is taking responsibility over for us and they are forcing us to do things we are not interested or applying to ? complaining. (Talking simultaneously) I think they must apply adult learning and principles and we must take responsibility for our own CPD points and we must hand it in ourselves and whatever, send it to the SANC, okay I will have to send CPD points and then they register. If you don't you lose your registration.

F: So we know that we can lose registration if not enough CPD points where accumulated?

R: (Talking simultaneously) It is not a hospital thing; it's not a management thing, that's a government thing. What we expect from management as from the hospital group is to give us the guidelines to say in this category not having any formal statement in the last five years. This

is what we suspect that you to gave 200 points. This is what we give you. So the variety of courses that can give you 3000 points and you can actually select from that, you find it to your need. We can correlate that with your unit manager or your life manager or educational facilitator and arrange how we going to reach those goals for the points that you need in that time. Working it as hours not hours in off duty time, because then you going to combinate it. And I mean you go to Tukkies and you go for a course. They are not going to spoon feed you. They give you what you need and you don't match the criteria leads. Sorry you know, it is up to you. Now they are making us babies and that is why we are fighting.

R: I totally agree with the part that there must be ownership but I wonder if the companies, because most of the companies are regulated so you cannot have the government expects to make sure that their employees, what's the word, they accumulate/comply with certain regulations, so maybe that is the reason why the company is taking over and do not give us some ownership, to say this one I know and I need to go this one.

R: Why you can't, you are not allowed to work in the company if you are not registered. So that is anyway a way of them to control us. So you know if you are not going to get CPD points you are going to lose your registration and you are going to lose your job because that's ? (talking simultaneously).

F: Actually the same as for professions such as doctors. They know that they need 22 points, so they happily responsible to attend.

R: If they can give us the roster at the beginning of the year or whenever saying this is what it came down to, this the course that is available, this is the course, this is how many credits any course is, this is how long it is and then you can give your shift leader or whoever your name saying I want to take this of day and then I will be credited with this many points. So that, at the end of the day you can show them, okay I am planning on doing this. It will give me my 100 points that I need, please make it work with my off duties. (Talking simultaneously)

R: They can make it part of your JPM/study planning. You go for JPM planning twice a year. You can say, okay this is my plans for next year. In six months you can tell them this is what I've reached. So the company will know according to your JPM are you on your goals that you have set for yourself. Not that the company enforced you, but you set yourself.

R: But it is true that the government give the company the certain amount of in-service training that they have to give the people. What the people say, if the company, if, its like this double

thing it is not only the company that's got it is a worldwide thing. This gentle thing. It came from the government and it must be implemented. And they expect the people to have so many people on this course to get some points to prove to the government that there is in-service trainings. They do it.

F: What I hear from you is also you talk about the negative attitude and the mindsets which are not right. I think also and understanding of where it comes from (talking simultaneously).

R: They don't tell the person, listen the government expect the person to have so much in-service training hours and then they don't tell the categories suppose to go the RNs must done this and the ENs must this and the ENAs must done this. If they can explain that to the people I think they would be more open for the thing then they know, okay I must go because they need it for the government, the government expect us to do that. But at this stage they just do it and you have to comply to it. They don't explain to you why the reasons for doing something. They came to you and said from March we going to do CPD points and everybody ask what is CPD points. And now they came back to you and said listen it's the way you do something or, because we still don't know, we don't know about CPD points and you must attend some whatever lectures and what have it, but they don't tell us what is the use for it. We know that the doctors have to do CPD points but we don't know why they have to do, it's their worries, not ours. But they don't come back to us and we don't know what's it all about.

R: I also think if you for instance, out of a critical care point of view, if you go on six courses that interests you, you will have a better attitude to go one course that don't interest you. But if you must go on six courses that doesn't interest you, you fight to go one what courses that actually interests you. Then you're gonna have a negative feeling, then you are going to feel but everyone else getting the chances, but I must go on six crappy courses before I actually get the course that I want. If you make the decision you will be more open to go one crappy course but six others that interest you.

R: And then the management rather give us the in-service training that is local and not valuable for us, other than courses that is valuable that's really were we are going to gain from for example the conference, the ICU conference. Yes it is expensive and things but why they come down to us and say we can meet you halfway, we can pay for this, what can you do as an employee. Then we meet halfway, now where are not going there and then I can arrange accommodation for myself and transport for myself but the hospital is paying for me to attend the conference and I would gain. Instead of going to the bubbles or RN refresher course (talking

simultaneously).

F: Ok, let's just hear.

R: I am just saying that congress that they send us too it's going to benefit the whole of us, the unit and the doctors, but then instead they send us to the bubbles. (Talking simultaneously) Exactly. (Talking simultaneously)

F: You feel that the negative attitude is because of people being a click and only certain people are send on courses? Is that on outside courses?

R: (Talking simultaneously) ? even to the ICU itself, like the, which one is this one, the advanced critical course, not BLS but ACLS, (talking simultaneously). We need to be ACLS trained, exactly, but we are not (talking simultaneously). We are in ICU, instead we have BLS.

R: Okay just one thing, you cannot got ACLS (talking simultaneously) if you don't have BLS.

R: But, we hat, it's expiring, sister.

R: It expire every two years (talking simultaneously).

R: Yes, my son has to be BLS (talking simultaneously). We need it. We asked especially for that people to go that are ICU. So what is going? everybody whose got a? don't do? (talking simultaneously). You have to repeat your ACLS every two years and if you don't do it, you are going start again. Anyway, the people who got ACLS don't do BLS anymore.

F: Okay let's go on otherwise we are not going to finish. Lack of knowledge of how important the CPD course is. Number 7 it is a oneway thing.

R: It is a management thing

R: I think, we've come ? (talking simultaneously) coming from upstairs to downstairs. It's like a water flood. Employees don't have a say to say what are the educational or improvement of skills needs. Management decides.

F: So you feel that the employee don't have a say?

R: Yes.

F: In which courses they want?

R: Yes what they need, it's like what she was saying. I am stuck with BLS for the rest of my stay in ** (this hospital). I am not going to ACLS and I'd love to have an ACLS standard of skill. So that is my need but despite how far I scream and say "kan ek vir ACLS gaan?" only specifics are chosen.

Even PALS.

F: So again, it's again a click thing that only the click is chosen? (talking simultaneously)

R: Only certain people are chosen the whole time. (talking simultaneously) En as jy 'n groterige bek het soos ek sal jy nêrens gaan nie.

F: Let's move on to number 8. There is something in the courses are too long and it is boring.

R: Yah, they are not interesting, or they send you to RN Refresher course, at the end of the day you don't do any RN refresher you do Ethos and EN stuff (talking simultaneously) not on our level.

F: So what you are saying is that when you get there, it's not what you expected.

R: You read bubbles for a RN. We must change it.

F: Sorry can we have some silence please. You only get like, a like this is a course on hand washing. You don't get what is going to be done in it.

R: So I can also say the one that I even always hear is that our audit is bad, this is not on the flow chart, you didn't record this, this is going to focus on the wrong things that we are doing and one day it was more part of that than teaching us on how to do.

F: So they don't focus on teaching but on criticizing.

R: (talking simultaneously) ? took a job ?? someone's house ? At the end of the day you don't have a general knowledge. What they want? What is expected. ?? We expect ?? how to really documents, But (talking simultaneously) and then dealing with what . And especially who is being training, they can give us the same type of training. A different person with things that came out, same copy but the (talking simultaneously) content ?? to get it ??

ANNEXURE D

DECLARATION FROM INDEPENDENT FACILITATOR



Dear Mrs ME Viljoen

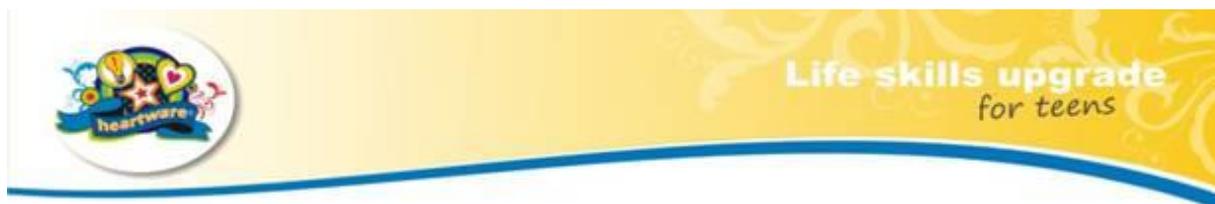
NOMINAL GROUP FACILITATION AND CODING: Why do critical nurse practitioners not attend CPD

Thank you for the opportunity to be of assistance in facilitating your nominal group process as well as coding of the feedback for your research purposes (3 August 2012). Should you require any future assistance in qualitative data collection and analysis you are welcome to contact me.

Regards

Dr S Grobler

Qualitative research consultant



Dr S Grobler

Heartware®

Cell: 083 310 5431

e-mail: sonja@heartware.co.za

website: www.heartware.co.za

ANNEXURE E

DECLARATION FROM THE EDITOR



Suzette M. Swart

FULL MEMBER: Professional Editors' Group

09 December 2013

TO WHOM IT MAY CONCERN

I, Suzette Marié Swart (ID 5211190101087), confirm that I have edited the noted master's thesis. The accuracy of the final work is still the student's own responsibility.

Student:

Ms ME Viljoen

Title:

***STRATEGIES TO ENHANCE ATTENDANCE OF A CONTINUOUS
PROFESSIONAL DEVELOPMENT PROGRAMME FOR CRITICAL CARE NURSE
PRACTITIONERS AT A PRIVATE HOSPITAL IN GAUTENG***

The edit included the following:

- Spelling
- UK vs USA English
- Vocabulary
- Punctuation
- Grammar (tenses; pronoun matches; word choice etc.)
- Language tips
- Correct acronyms (please supply list)
- Consistency in terminology, italisation etc.
- Sentence construction
- Suggestions for text with unclear meaning
- Basic layout, font, numbering etc.
- Logic, relevance, clarity, consistency
- Checking reference list (reference guide supplied by student) against in-text sources

The edit excluded:

- Correctness of crediting another's work – PLAGIARISM
- Proofreading
- Checking style accuracy of reference list
- Content
- Correctness or truth of information (unless obvious)
- Correctness/spelling of specific technical terms and words (unless obvious)
- Correctness/spelling of unfamiliar names and proper nouns (unless obvious)
- Correctness of specific formulae or symbols, or illustrations
- Style
- Professional formatting

Thank you

Suzette M Swart (not signed – sent electronically)
0825533302
smswart@vodamail.co.za

LANGUAGE PRACTITIONER/EDITOR/FACILITATOR:

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