A CONTINUING PROFESSIONAL DEVELOPMENT SYSTEM FOR NURSES AND MIDWIVES IN SOUTH AFRICA

by

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THESIS

submitted in fulfilment of the requirements

for the degree

DOCTOR CURATIONIS

in

PROFESSIONAL NURSING SCIENCE

in the

FACULTY OF EDUCATION

at the

RAND AFRIKAANS UNIVERSITY

Promoter: Prof ME Muller

November 2004

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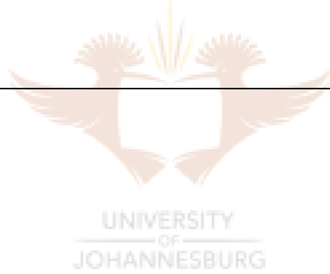
We can do no great things;

only small things

with great love.

(Mother Teresa)



DEDICATION

Dedicated to my husband, Henry,

and

my daughters

Melanie and Micaela

This research study is also a dedication in loving memory of my father, Frank Kaye.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to:

- God for the courage, perseverance and wisdom to complete this study
- My promoter, Prof Marie Muller for her guidance and patience
- My husband, Henry for his love, tolerance and encouragement
- Dr Jakkie Bornman for all the stimulation and words of wisdom
- My dear friend, Dr Bongi Nzama for her assistance in attaining a critical reflection of the Final CPD system from nurses and midwives practising in rural settings
- All the appraisers/validators for their constructive criticism and valuable contribution towards the refinement of the Final CPD system for nurses and midwives in South Africa
- Hester Roets for her assistance with the visual presentations
- DENOSA for the bursary
- SANC for granting me permission to work with them on the Draft CPD system for nurses and midwives in South Africa
- Delene Slabbert for meticulously proofreading this study
- Ina van Wyk for her words of inspiration and the efficient manner in which she organised my appointments
- My previous work colleagues at the SANC and my current work colleagues at Afrox Healthcare for all their love and words of encouragement

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ABSTRACT

Since 1994, the government has engaged in extensive transformative processes that included the reviewing and restructuring of all relevant legislation, organisations, institutions and statutory bodies. These transformative demands resulted in the development and implementation of a new constitution and ensuing transformative legislation and policies. It is for this reason that the Department of Health, in attempting to transform the health system in South Africa, developed a strategy known as the Health Sector Strategic Framework, which sets out a 10-point plan. This plan states amongst others, that health professions and professional bodies develop Continuing Professional Development (CPD) systems/programmes. Over and above this other transformative developments in the education and labour frameworks, professional conduct hearings and national and international benchmarking influenced the need for a CPD system for nurses and midwives in South Africa.

The problem statement is that there is no formalised and regulated CPD system for nurses and midwives in South Africa. The following research questions are relevant:

- What is the international trend with regard to CPD for nurses and midwives?
- What is the national trend with regard to CPD for healthcare professionals in South Africa?
- What will a CPD system for nurses and midwives in South Africa comprise?
- How will a CPD system for nurses and midwives in South Africa be implemented to ensure credibility?

The overall aim of this study was to develop a CPD system for nurses and midwives in South Africa. To accomplish this overall aim the following objectives were formulated:

- To explore and describe existing knowledge frameworks on Continuing Professional Development for nurses and midwives in selected countries, internationally and for health professionals in South Africa
- To describe the draft CPD system for nurses and midwives in South Africa
- To describe a final CPD system for nurses and midwives in South Africa.

This study was conducted within the context of the South African professional, ethical and legal framework for Continuing Professional Development for nurses and midwives in South Africa. A descriptive, exploratory and contextual design was conducted. The description of a draft CPD system was based on the theoretical framework. The draft CPD system was developed from 9 June 2000 until May 2003 and exposed to critical reflection by the stakeholders of the SANC, the profession at large and the human resource directorates in each of the nine (9) provinces in South Africa. The researcher developed the final CPD system for nurses and midwives in South Africa. This final CPD system was exposed to critical reflection to confirm face and content validity, followed by a refinement of the CPD system.

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Emerging from this research and based on the feedback of the validators/appraisers, recommendations are made with reference to practice, nursing and midwifery education and research: The implementation of a formal, coordinated and regulated CPD system for nurses and midwives in South Africa is necessary as part of a quality promotion initiative and to meet the requirements of the transformative legislation especially pertaining to the labour and education legal framework.

OPSOMMING

Die regering is sedert 1994 met uitgebreide prosesse van transformasie besig, soos die hersiening en herstrukturering van alle toepaslike wetgewing, organisasies, instellings en statutêre liggame. Hierdie transformasie-eise het die ontwikkeling en implementering van ‘n nuwe Grondwet en gepaardgaande transformasiewetgewing en -beleide ten gevolg. Om hierdie rede het die Departement van Gesondheid ‘n strategie ontwikkel, met die doel om die gesondheidsdiensstelsel in Suid-Afrika te omvorm. Hierdie strategie staan bekend as die Gesondheidsektor se Strategiese Raamwerk en bestaan uit ‘n tienpuntplan. Hierdie plan stel, onder andere, dat gesondheidspraktisyns en professionele liggame Voortgesette Professionele Ontwikkelingstelsels/ programme (VPO) moet ontwikkel. Bo en behalwe hierdie vereiste, het ander transformasie-ontwikkelinge in die onderwys- en arbeidsraamwerke, professionele gedragsverhore, asook nasionale en internasionale vergelykings, die behoefte aan ‘n VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika beïnvloed.

Die probleemstelling is dat daar geen geformaliseerde en gereguleerde VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika bestaan nie. Die volgende navorsingsvrae is tersaaklik:

- Wat is die internasionale tendens met betrekking tot VPO vir verpleegkundiges en vroedvroue?
- Wat is die nasionale tendens met betrekking tot VPO van gesondheidsorgpraktisyns in Suid-Afrika?
- Waaruit sal ‘n VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika bestaan?
- Hoe sal ‘n VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika geïmplementeer word om geloofwaardigheid te verseker?

Die algehele doelstelling van hierdie studie was om ‘n VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika te ontwikkel. Om hierdie doelstelling te bereik, is die volgende doelwitte opgestel:

- Die verkenning en beskrywing van bestaande kennisraamwerke oor voortgesette professionele ontwikkeling van verpleegkundiges en vroedvroue in geselekteerde lande internasionaal en vir gesondheids-praktisyns op nasionale vlak
- Die beskrywing van 'n konsep VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika
- Die beskrywing van 'n finale VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika.

Die studie is uitgevoer binne die Suid-Afrikaanse professionele, etiese en wetlike raamwerk vir voortgesette professionele ontwikkeling van verpleegkundiges en vroedvroue in Suid-Afrika. 'n Beskrywende, verkennende en kontekstuele navorsingsontwerp is uitgevoer. Die beskrywing van 'n konsep VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika is op 'n teoretiese raamwerk gebaseer en vanaf 9 Junie 2000 tot Mei 2003 ontwikkel. Hierdie konsep VPO-stelsel is vir kritiese refleksie aan rolspelers van die SARV, die professie en menslike hulpbrondirektorate in elk van die nege provinsies in Suid-Afrika voorgelê. Die navorser het vervolgens die finale VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika ontwikkel. Hierdie finale VPO-stelsel is vir kritiese beoordeling en bevestiging van sig- en inhoudsgeldigheid voorgelê, met daaropvolgende verfyning van die VPO-stelsel.

Onderskeie aanbevelings voortspruitend uit die navorsing en gebaseer op terugvoering deur die valideerders/beoordelaars is met betrekking tot die praktyk, onderwys en navorsing opgestel: Die implementering van 'n formele, gekoördineerde en gereguleerde VPO-stelsel vir verpleegkundiges en vroedvroue in Suid-Afrika is nodig as deel van die initisiatief vir kwaliteitsbevordering en om aan die vereistes van die transformasie-wetgewing, veral met betrekking tot die arbeids- en onderwyswetlike raamwerk, te voldoen.

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CHAPTER 1

AN OVERVIEW OF THE STUDY

1.1 Introduction

The nursing and midwifery professions in South Africa are governed by the Nursing Act 50 of 1978, as amended (South Africa, 1978). In terms of this Act the registered nurse and midwife/*accoucheur* is an independent practitioner, accountable for all her[1] acts and omissions. In terms of Chapter 2, Section 16 (1) of this Act: "No person shall be entitled to practise within the Republic the profession of a registered nurse, a midwife, an enrolled nurse or a nursing auxiliary unless he is in terms of this Act registered or enrolled, as the case may be, as a nurse, a midwife, a nursing auxiliary…" (1978:9). It is a criminal offence to practise the profession of nursing and midwifery if one is not registered/enrolled as a nurse and midwife with the South African Nursing Council (SANC).

Over and above being registered/enrolled, the practise of a profession requires knowledge of its *Scope of Practice* and the rules or conditions under which a person may practise that particular profession. In nursing and midwifery, the *Scope of Practice for Nurses and Midwives*, and the *Rules Setting Out The Acts or Omissions*, are defined by two sets of regulations stipulated under section 45 (i) (q) of the Nursing Act 50 of 1978. These regulations are firstly, the Scope of Practice of the nurse and midwife, Government Notice R2598 of 30 November 1984, as amended and secondly, Rules setting out the Acts or Omissions in respect of which the Council may take Disciplinary Steps, Government Notice R387 of 15 February 1985, as amended.

The Scope of Practice regulation for nurses and midwives clearly defines the course of their daily professional activities as nursing and midwifery regimens.

[1] Throughout this paper, in the interests of fluency, only the feminine pronouns have been used. However, they automatically include the masculine, unless expressly indicated otherwise.

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In terms of this regulation 'nursing regimen' shall mean the regulation of those matters which, through nursing intervention, have an influence on the preventive, promotive, curative or rehabilitative aspects of health care, and includes the provision of nursing care plans, their implementation and evaluation thereof and recording of the course of the health problem, the health care received by a patient and its outcome whilst the patient is in the charge of the nurse (*Government Notice R2598 of 30 November 1984, as amended).*

Midwifery regimen shall mean the regulation of those matters which, through midwifery intervention have an influence on the course and management of pregnancy, all stages of labour and the *puerperium* and includes the provision of care plans, their implementation and evaluation and the recording of the course of pregnancy, labour and *puerperium* and of any health problem and the care received by the mother and child whilst in the charge of the midwife (*Government Notice R2598 of 30 November 1984, as amended).*

The ruling setting out the acts or omissions in respect of which the SANC may take disciplinary steps, according to Government notice *R387 of 15 February 1985 as amended*, Chapter 2, No 3): "... authorises nurses and midwives to carry out acts in respect of diagnosing, treatment, care, prescribing, collaborating, referral, co-coordinating and patient advocacy as the scope of his profession admits". Chapter 2, No 18 (1) of this regulation states that: "... except in the case of an emergency a nurse may not perform an act – (a) which does not pertain to his registered profession; (b) for which he has inadequate training or experience".

According to these regulations, the registered nurse and midwife has professional authorisation to perform her nursing and midwifery activities as an independent practitioner and is responsible for Continuing Professional Development to ensure competency. This means that she is accountable for all her acts and omissions within a given situation and is responsible for the consequences thereof (Muller, 2002:64). By implication thus the nurse and

midwife practises in accordance with the following nursing and midwifery practice standards:

- The registered nurse and midwife demonstrates adequate in-depth knowledge of the basic and contextually basic nursing sciences required for quality basic and/or post basic nursing and midwifery practice.
- The registered nurse and midwife demonstrates safe skills/competencies.
- There is evidence of scientifically based comprehensive and holistic nursing, midwifery and health care practice within the relevant service and practice level context.
- There is evidence of timeous, accurate and complete/comprehensive recording of all observations, actions and interventions.
- There is evidence of multiprofessional/multidisciplinary teamwork (including support services) and networking in the interest of the patient.
- The registered nurse and midwife demonstrates health promotion, education, patient advocacy and counselling abilities.
- The registered nurse and midwife establishes and maintain a therapeutic environment focused on the physical, psychological and spiritual needs of the patient.
- The registered nurse and midwife demonstrates accountable professional conduct (Muller, 1992, reviewed 1999).

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In compliance with these standards, the nurse and midwife, who spends more time with the patient, is required to keep abreast of developments that affect her practice. To meet these standards, the nurse and midwife has to engage in Continuing Professional Development (CPD) to render updated and relevant care.

It is evident from these introductory remarks that there are statutory implications for the practice of nursing and midwifery. It would therefore seem logical to consider the rationale for the justification of a Continuing Professional Development (CPD) System for nurses and midwives in South Africa.

1.2 Rationale

Since 1994 the post-apartheid government has engaged in extensive transformative processes that include the reviewing and restructuring of all relevant legislation, organisations, institutions and statutory bodies. These transformative demands have resulted in the development and implementation of a new constitution and various policies and pieces of legislation. The Constitution of the Republic of South Africa, Act 101 of 1996, Chapter 2, No 27 (1) states that: " …everyone has the right to have access to health care services, including reproductive health" (RSA, 1996). To ensure effective access for all patients to health care as provided for in the Constitution of the Republic of South Africa, the Department of Health has published a Patients' Rights Charter as a common standard for achieving this right, so that both patients and health care providers have a clear understanding of the standards of service that patients should receive (Department of Health, 1994-2000:33).

In addition to the Patients' Rights Charter, the policy of the DOH in seeking to transform the public service delivery, based on the *Batho Pele* White Paper (RSA, 1997c:12), attempts to introduce a fresh approach to service delivery: "... an approach which puts pressure on systems, procedures, attitudes and behaviours within the public service and reorients them in the customer's favour, an approach which puts people first, … it enables citizens to hold public servants to account for the service they receive". These consumer charters have raised expectations and by so doing have placed new pressures on professionals to improve their standards of nursing and midwifery care.

There is also the factor of increasing consumer awareness of their right to quality care. The volume and range of information currently available to the public through the medium of the newspapers, radio, television, the Internet or by word of mouth is vast and increasing daily. Patients and clients are better informed and more articulate than ever before. They expect quality health care and, in terms of the common law principle, also expect the nurse and

midwife to possess all the necessary abilities to perform any nursing and midwifery interaction effectively. Every health practitioner therefore has a public as well as an ethical, professional and legal obligation to act in the interest of the patients (Muller, 2002:53).

For this reason the Department of Health, in attempting to transform the health system in South Africa, has developed and implemented legislation and policies that impact directly or indirectly on the delivery of health services. The White Paper for the Transformation of the Health System in South Africa was published as Notice 667 of 1997 in the *Government Gazette no. 17910*. Chapter 4 of this White Paper sets out the principles and strategies for the development of human resources. The key principles listed herein are:

- The training and development of health personnel, with special emphasis on the primary health care approach
- The creation of a caring ethos and various principles and strategies to change the nature of management from autocratic to participative and democratic.

It can thus be argued that the development of a CPD system for nurses and midwives who are registered to practise their professions in South Africa, would contribute to the adherence of the aforementioned principles and strategies.

In pursuance of these principles, the Department of Health developed a strategy known as the ‘Health Sector Strategic Framework’, which sets out a 10-point plan. This plan requires that CPD programmes be:

- Developed by health professionals and professional bodies
- Compliant with the learning needs of individual health professionals
- Developed to measure the competencies of health professionals on a continual basis *(*Department of Health, 2001:3).

Another component of this 10-point plan is to improve the quality of patient care. Among its key objectives to attain this is:

- The introduction of peer review and clinical audits at all health facilities
- The training of health personnel in strategies to improve the quality of care rendered
- Plans for Continuing Professional Development (Department of Health, 1999-2004:31).

It thus becomes evident that there is an identified need to develop a CPD system for nurses and midwives who are registered/enrolled with the SANC to practise their professions in South Africa.

In addition to these national needs within a South African context, there are other compelling imperatives. The trend of well-qualified registered nurses to migrate to overseas countries is a cause for concern. These experienced professionals leave with all their knowledge and skills and therefore create a dearth of expertise. Although the skills profile of people leaving South Africa is not recorded, data from five major recipient countries has been generated by independent researchers, disclosing that between 1989 and 1997 there were a total of 233,609 migrants (Brown, Kaplan & Meyer, 2000 In: Department of Labour, 2002:30). In order to ensure the long-term viability of the health sector and the provision of quality health care in South Africa, this outflow of expertise needs to be addressed through a CPD system by consistently upgrading the knowledge and skills of those nurses and midwives who continue to practise within this country.

The perception of the prevailing preference of health care professionals to be employed in the urban rather than the rural areas increases the pressure on nurses and midwives who are employed in the rural areas to perform acts that are beyond their scope of practice. The Department of Health appointed a Human Resource for Health Task Team (HRHTT) to come up with a strategy "... that will make provision for an adequate supply of human resources with the requisite knowledge and skills to give expression to the vision of an equitable, responsive health system, guided by the primary health care approach" (Pick, Nevhatula, Cornwall & Masuku, 2001:3). This task team

proposes the use of a midlevel worker, namely the enrolled nurse and the enrolled nursing auxiliary, who are available in underserved areas due to family and community ties. They have been identified as a suitable pool from which to recruit candidates for more advanced training. The report of this task team charges all the health professionals councils to: "address the shortage of doctors, nurses, midwives, therapists, etc. in rural areas by widening the scopes of practice for midlevel service providers, with the proviso that continuing training (CPD) and supervision is provided to ensure that they perform their duties competently" (Pick, *et al*, 2001:55).

It is therefore evident, given the 'brain drain' and the perceived dearth in rural areas of registered nurses and midwives, that this paradigm shift from a confined scope of practice for enrolled nurses and enrolled nursing auxiliaries to a scope of practice that would accommodate more advanced primary health care nursing services, has a major influence on the content and relevance of Continuing Professional Development for enrolled nurses, enrolled midwives and enrolled nursing auxiliaries.

Since 1994 there have been other transformative developments:

A The establishment of the National Qualification Framework (NQF) in 1995. One of the stated objectives of this initiative was to align the South African education and training system to emerging international trends of best practice by providing quality education and training and to encourage lifelong learning.

B The establishment of the South African Qualification Authority (SAQA), through the SAQA Act 58 of 1995, to oversee the development and implementation of the NQF by overseeing all education and training, including nursing and midwifery education and training programmes. In its endeavour to monitor quality management systems, SAQA accredits full or provisional Education and Training Quality Assurer (ETQA) status to institutions/statutory bodies. The South African Nursing Council was granted provisional accreditation as an ETQA. One of the conditions set

for the SANC to obtain full accreditation status is the development of a CPD system for nurses and midwives in South Africa.

C The Department of Labour, through the Skills Development Act 97 of 1998 and the Skills Levies Act 9 of 1999, also makes transformative demands. This department has established 25 Sector Education and Training Authorities (SETAs) to realise the goals of the Skills Development Act and the Skills Levy Act. One such a SETA is the Health and Welfare Sector Education and Training Authority (HWSETA), which endeavours to: "... create an integrated approach to the development and provision of appropriately skilled health and welfare workers to render quality services comparable to world-class standards" (HWSETA Sector Skills Plan, 2001-2002:10). While there are numerous potential education and training providers for the HWSETA, it is imperative that a coordinated strategy for the provision of Continuing Education for nurses and midwives in South Africa be provided through a CPD system.

D A variety of social trends have also served to increase public demands for professional accountability. If a professional does not keep abreast of developments in her field of practice, a backlog may develop which will negatively affect her professional effectiveness. It can therefore be argued that there is an identified need for a mechanism that would cause nurses and midwives to purposefully reflect on the competencies needed in their specific area of practice, then to engage in CPD so as to work towards the attainment of such competencies. A CPD system could make provision for such a mechanism.

E Over and above SAQA's demand that the SANC implement a CPD system for nurses and midwives, national and international benchmarking with other health professional councils has also urged the SANC to develop a CPD system. In 1999 the Medical and Dental Board of the Health Professional Council of South Africa set a precedent which implemented a mandatory CPD system for all doctors and dentists practising their professions in South Africa (See section 3.5.1). Discussions and similar

developments have occurred in other professional boards that fall within the ambit of the Health Professional Council of South Africa (See section 3.5). The South African Pharmacy Council is now also developing a CPD system that is evidence based and scheduled for implementation in 2004 (See section 3.5.2).

Up to the time of writing, these rationales reflect on the dynamics prevailing in South Africa. However, the free and rapid interaction and interchange of professionals across the global village has implications for the credibility of the SANC, in that it has to provide South African nurses and midwives with verifications indicating that they are in good standing with their statutory body. It is therefore evident that the SANC has to keep up with international trends of coordinating and administering Continuing Professional Development for nurses and midwives so that it is seen to be issuing licenses to practise to nurses and midwives who are committed to lifelong learning, and who thus qualify for such annual licensing (International Council of Nurses 2000c, In: Initial Draft, March 2001:1).

To facilitate these developments on an international scale, the International Council of Nurses (ICN), founded in 1899, has acted for more than a century as a global advocate for nursing and health care, with the aim of promoting the highest possible quality of health service. During this time the world in which health care is provided has changed dramatically, and the ICN and International Confederation of Midwives (ICM) have not only kept pace with these changes, but have maintained and systematically developed their proactive leadership in nursing and midwifery. The demands of the global market have led to a legitimate interest, across many regions of the world, in seeking international recognition of professional qualifications and related competencies. The ICN and the ICM, by virtue of their leadership roles for the nurses and midwives who are practising in their membership states, have decided that international competencies be established. It is intended that these competencies be used to clarify the roles of nurses and midwives, so as to guide future mutual agreements and multicountry licensure programmes for

which there is a growing demand (ICN 2000c, In: Initial Draft, March 2001:1 and ICM Minutes, April 2002).

1.2.1 Professional conduct hearings

Over and above these national and international concerns, there is also the concern about the ethical and moral conduct of nurses and midwives in the daily discharge of their professional duties. The SANC is duty bound to conduct inquiries into complaints received from various sources. *Government Notice R373 of 13 March 1970*, *as amended*, authorises the SANC to investigate and, when it deems necessary, to conduct formal inquiries into alleged misconduct of all nurses and midwives who are registered with the SANC to practise their professions. Over the years the SANC has conducted many such professional conduct hearings, which involved not only technical professional misdemeanours, but also criminal acts as well as acts and omissions related to negligence and incompetence of an ethical and moral nature (SANC Professional Conduct Report, 2002:2, unpublished). Table 1.1 depicts the professional conduct hearings that were held between 1998 and 2002, by the Professional Conduct Committee of the SANC (SANC Professional Conduct Hearing Report, 2002, unpublished).

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Table 1.1: Professional conduct hearings of the SANC

Year	Number of cases	Misdemeanours
1998	54	Charges ranged from practising without registration/enrolment to one with 25 counts of fraud and theft
1999	82	Charges ranged from practising without registration/enrolment to attempted murder
2000	45	Charges ranged from fraud, incompetence and negligence to practising without being registered
2001	47	Charges ranged from fraud, incompetence and negligence to practising without being registered
2002	80	Charges ranged from fraud, incompetence and negligence to practising without being registered

It can therefore be argued that if a CPD system addresses the civic and public responsibilities of a nurse and midwife, the statutes and regulations pertaining to the practice of nursing and midwifery, and the competencies necessary for effective functioning in a particular area of practice, then it could contribute to the minimisation of the incidence of professional misconduct.

In 1997, at a professional conduct inquiry of the South African Nursing Council (SANC), the words of an aged wife of a deceased patient still have relevance. In her testimony she is quoted as having said to her son, when he questioned the obvious change in his father's medication: "*My son, do not question me about why your father's medicine appears so different. Those nurses have studied and they know what they are doing. We must trust them and do as they say"* (SANC, 1997, Professional Conduct Hearing Transcript, unpublished).

This statement was made at a formal professional conduct inquiry of the SANC. The question is: Are nurses and midwives worthy of such trust placed in them? The charge in the case referred to entailed the administration of incorrect medication to a cardiac patient by an enrolled nursing auxiliary on his discharge from hospital, whilst the registered nurse on duty continued to make beds. The auxiliary nurse decided to administer what, in her mind, was the correct medication, to the patient and his wife. The registered nurse repeatedly denied the evidence presented to the Professional Conduct Committee about the course of events as they had occurred on the date and time the patient was fetched to go home. The wife of the patient (who had since died because of taking the incorrect medication), finally made the following appeal: *"Why do you not give in to the truth, you know that what I am saying is true, how can you just stand there and continue to be dishonest? Yes, my husband is dead and it is because of those pills"* (SANC, 1997, Professional Conduct Hearing Transcript, unpublished).

The nurse in this case was found guilty of disgraceful conduct in terms of the Regulations for the Investigation of Alleged Misconduct and the Conduct of Inquiries, *Government notice No R.373, 13 March 1970 as amended*. She

was suspended from practice for a period of six months, but the execution of the sentence was suspended for a period of five years.

Over the years the SANC has conducted many such formal professional conduct hearings. These were previously known as 'disciplinary hearings'. It has to be noted that these cases involved not only technical professional misdemeanours, but also criminal acts, as well as acts and omissions related to negligence and incompetence of an ethical and moral nature. According to the SANC's Professional Conduct Report of 1999, statistics reveal that in 1998 54 professional conduct inquiries were formally conducted. Of these eight cases involved fraud, which were first heard in a court of law. One case involved a registered nurse and a midwife who were charged with 25 counts of theft and fraud. Another professional conduct hearing involved an enrolled nurse, who was convicted on nine charges of fraud in a court of law. Six enrolled nurses were found guilty of from one to 16 charges of fraud and/or theft (SANC Professional Conduct Report: 1999, unpublished).

Statistics also reveal that in the same year (1998) there were 20 cases involving persons practising without the necessary registration or enrolment with the South African Nursing Council. This constitutes a violation of Section 27 of the Nursing Act 50 of 1978, as amended. Seven of the aforementioned persons were registered nurses, four were enrolled nurses and nine were enrolled nursing auxiliaries (SANC, Professional Conduct Report: 1999, unpublished).

In 1999 there were 82 professional conduct inquiries. Of these 15 were postponed and 10 were withdrawn. In the remainder of the cases there were a variety of charges ranging from practising without the appropriate registration to attempted murder (SANC, Professional Conduct Report: 1999, unpublished).

There have also been cases reported in the print and electronic media of cases of assaults of patients by registered nursing professionals. A few examples of media reports involve:

- A 65-year-old woman, in need of urgent medical attention who was turned away from a private hospital by a registered nurse (without stabilising her), because she did not have medical aid. Her relatives were instructed to take her to the nearest state hospital where she was declared dead on arrival (Peters & Naidoo, 1999:5)
- "Allegations of neglect, incompetence and unprofessional conduct have been heaped against nurses when a two year old boy was left to die an agonising death, despite pleas from his parents to the nurses" (Dube, 2000:2)
- A baby whose foot had been gnawed at by a rat whilst the nurses were sleeping during official duty time (Peters, 2000:4)
- A pregnant woman who was left unattended at the back of an ambulance, and had fallen out whilst the registered midwife sat in the driver's cabin with the ambulance driver. The woman sustained serious head injuries and was found dead at the site where she had fallen out Makgotho, 2001:4).

Media reports such these resulted in a press release in which the SANC expressed its concern about an article published in the S*owetan* on 31 January 2001. This article referred to the alleged assault of a patient by two nurses. The SANC pledged that an urgent investigation and disciplinary action would be instituted against individual nurses found to have committed the offences that were reported (SANC, press release 1/2001).

These and other professional misconduct cases, involve:

- Basic knowledge that the nurse and midwife should have had but did not demonstrate application thereof
- Competent skills that the nurse and midwife should have developed that she had not
- Professional attitudes and values that the nurse and midwife should have displayed that she did not.

1.2.2 Challenges

It can thus be argued that if a CPD system addresses the professional, legal, ethical, civic, personal and public responsibilities of a nurse and midwife; the statutes and regulations pertaining to the practice of nursing and midwifery and the competencies necessary for effective functioning in a particular area of practice, then it could contribute to minimising the incidence of professional misconduct. These cases justify the need for the development and implementation of a CPD system that will cause all registered and enrolled nurses and midwives to constantly upgrade their knowledge, skills, attitudes, and ethical behaviour. There is a definite need, therefore, to develop a CPD system for all registered and enrolled nurses and midwives in South Africa, as they are relied upon to provide for healthcare.

Nurses and midwives constitute the largest group (42%) of South African public sector health care personnel (South African Health Review 1998). The Minister of Health, Dr Tshabalala-Msimang has referred to nurses and midwives as the 'backbone' of the health services, in a speech to the first national nursing summit, August 1997, and in an opening address of the National Congress of the Democratic Nurses' Association of South Africa (DENOSA) on 26 March 2001. The registrar and chief executive officer of the SANC also affirms that: "nurses and midwives are the backbone of the South African health care system and carry the burden of providing health care in very adverse conditions" (Subedar, 2004:1).

Indeed, the challenges facing nurses and midwives are legion and multifarious, particularly when one reflects on the ever-increasing demands imposed on them at the level of service delivery. If there is to be a move towards more equitable health services, then statements made in clinics by nurses and midwives, such as: "I don't know what I'm doing", and "We are confident we could provide quality services if only [sic] given the necessary time or some diagnostic skills" must be heeded (Strasser & Gwele, 1998:83). Are the quoted remarks of these nurses justified? Do basic nursing and

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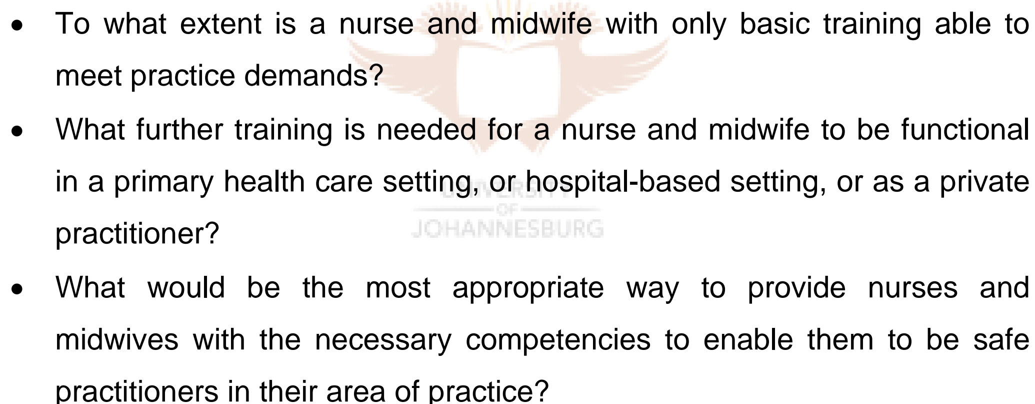
education programmes in South Africa prepare the nurses to render competent primary health care?

Problems in nursing education in South Africa were described as, “Nurse educators and service providers are recognising that nurses are not adequately or appropriately trained to deliver primary health care services” (Strasser, 1999:41). In numerous instances, practical training largely occurs in tertiary hospitals, where the focus is on curative services provided under doctors’ orders. This model of training, although necessary and appropriate for work in hospitals, does not provide nurses with the necessary analytical and problem-solving skills needed for primary health care services. Strasser (1999:41) further affirms the concern that post basic training needs to be better coordinated and based on the priority needs of the country. The following questions arise:



- To what extent is a nurse and midwife with only basic training able to meet practice demands?
- What further training is needed for a nurse and midwife to be functional in a primary health care setting, or hospital-based setting, or as a private practitioner?
- What would be the most appropriate way to provide nurses and midwives with the necessary competencies to enable them to be safe practitioners in their area of practice?

For a major portion of the practical component of their basic nursing and education training, nurses and midwives are based primarily in hospital settings, providing a largely disease-oriented medical service. In many ways, in the public sector, they are filling the gap in a system which lacks key medical personnel, for example, doctors, pharmacists, social workers, psychologists, and physiotherapists who are needed to address the many health needs which nurses and midwives confront daily in the primary health care context. From diagnosing and treating tuberculosis, to counselling patients who had just been tested HIV positive, and to ordering and

dispensing drugs, nurses and midwives bear the brunt of the responsibilities of a health system functioning without an adequate complement of human resources (Strasser & Gwele, 1998:83). Another question yet again arises: Are nurses and midwives being exposed to the Continuing Professional Development that is needed to meet the demands of the National Health Plan and policies?

Sir Christopher Ball (1996) in describing the learner profile that is needed for the 21st century spoke about 'flexible generalists'. Ball maintained that such people are needed to realise the goal of life-long learning, which will characterise the successful citizenry of the next millennium. 'Flexible generalists are people equipped with the necessary knowledge, skills and values to adjust readily to multiple career changes and make, through their own personal development a significant contribution to the country and the world (Ball, 1996 In: SAQA, 2000:3).

At the same time, however, a variety of social trends have served to increase public demand for professional accountability. Professionals are compelled to improve their level of competence. If a professional does not keep abreast of developments in her field of practice, a backlog may develop which will affect her professional effectiveness negatively. Each profession has certain core competencies, and specialised knowledge that have to be continuously updated and enhanced. Thus, a CPD system should be in place for nurses and midwives to address their limitations and enhance their professional growth.

This maintenance and enhancement of professional competence has been a subject of discussion for the past few years, by various health professionals, at national and international level. The researcher witnessed this at a three-day international conference entitled "Ottawa in Africa", held at the Arthur Seat Hotel in Sea Point, Cape Town, March 2000. There was much debate on the significance of having a CPD system and comparisons of various existing systems were also addressed. The Medical and Dental Board of the Health Professionals Council of South Africa (HPCSA) were the only South African

regulatory board for health professionals that were able to present their experience with such a system.

In emulation of what has been transpiring in other sectors of health professions, the South African Nursing Council has been engaged in discussions on CPD for nurses and midwives in South Africa. During the term of office of the South African Interim Nursing Council from 1996 to 1998 (SANC, 1996:9, unpublished) and the first democratically elected South African Nursing Council from April 1998 to April 2003, discussions have been underway about the need to develop a CPD system for all nurses and midwives in South Africa.

Continuing Professional Development, often referred to as 'Continuing Education', is currently entirely optional for nurses and midwives, and consists of the attendance at conferences, seminars, workshops, short courses and formal diploma and degree programmes. The costs for the attendance thereof is in some instances borne by the individual nurse and midwife, or to some extent sponsored by the employers. These interventions represent an attempt to improve the standard of care administered in the public and the private sectors. It is thus evident that the current trend for Continuing Education is fragmentary and nurses and midwives follow a variety of post registration programmes which might have little to do with their daily professional activities or the career pathway they ultimately hope to pursue (Schaay, Heywood, & Lehman, 1998 In: *SA Health Review* 1998:101).

1.3 Concluding statements

With the above in mind, it is therefore evident that there is an ethical, professional and legal justification for the need for a formalised CPD system for nurses and midwives in South Africa. Furthermore, the labour and education legislation and national health policies justify the significance of a formalised CPD system for nurses and midwives in South Africa. Finally, professional conduct hearings justify the need for a formalised CPD system for nurses and midwives in South Africa.

1.4 Problem statement

The problem statement therefore is that there is no formalised, coordinated and regulated CPD system for nurses and midwives in South Africa. The following research questions arise:

- What is the international trend with regard to CPD for nurses and midwives?
- What is the national trend with regard to CPD, for health care professionals in South Africa?
- What will a CPD system for nurses and midwives in South Africa comprise?
- How will a CPD system for nurses and midwives in South Africa, be implemented to ensure credibility?

1.5 Overall aim of this study

The overall aim of this study is to develop a CPD system for nurses and midwives in South Africa. In view of this overall aim, the following objectives are formulated:

- To explore existing knowledge frameworks on Continuing Professional Development for nurses and midwives internationally and for health professionals in South Africa
- To describe the Draft Continuing Professional Development System, for nurses and midwives in South Africa
- To describe a Final Continuing Professional Development System for nurses and midwives in South Africa.

1.6 Assumptions

This study is based on the following assumptions:

- It is a legislative requirement that registered nurses and midwives, who are licensed to practise their professions in South Africa, do this as independent practitioners who are accountable and responsible for their acts and omissions

- Each profession has certain core competencies and specialised knowledge that have to be continuously updated
- The standards of practice for nurses and midwives are based on the South African ethical, professional and legal framework
- The standards of practice of an individual nurse and midwife reflect the standards of practice of the profession and have an effect on the position of the nurse and midwife in the health team
- The Patients' Rights Charter (Department of Health, 1999) necessitates Continuing Professional Development by nurses and midwives
- The Final CPD system for nurses and midwives in South Africa is based on the systems approach: input, throughput and output
- Licensing for practice as a nurse and midwife should be linked to evidence of Continuing Professional Development.

1.7 Definitions

The following are definitions of key terms used in this thesis:

Accountability

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Accountability is the legal and moral obligation to be answerable for, or to give account for, or to be called upon to account for that for which responsibility was taken (SANC, 1994:3).

Continuing Education

A broad term, Continuing Education includes all formal and non-formal nursing and midwifery education programmes following on basic education programmes for registration/enrolment as a nurse or midwife. It includes in-service education, personnel development and post-basic programmes (SANC, 1994:6).

Competence

Competence is the knowledge, skills, attitudes, behavioural attributes and values required to perform a job to a desired standard (Saunders, 2002:37).

Continuing Professional Development

Continuing Professional Development is the maintenance of and enhancement of knowledge, expertise and competence of professionals throughout their careers, according to a plan formulated with regards to the needs of the professional, the employer, the profession and the society (Madden and Mitchell, 1993 In: Wallace, 1999:28). Continuing Professional Development is identified as intentional learning.

Continuing Professional Development (CPD) System

A CPD system is a structured, well-planned and organised flow of a series of components (input, throughput and output) with role players who will effectively influence each other to achieve a desired output of continuously updating and mastering nursing and midwifery competencies (adapted form Du Toit, 1995:41).

Enrolled nurse/nursing auxiliary/midwife

A person enrolled as a nurse, nursing auxiliary or as a midwife in terms of section 16 of the Nursing Act 50 of 1978, as amended. Such a person functions within the relevant professional, ethical and legislative framework, under the direct or indirect supervision of the registered nurse or registered midwife (SANC, 1994:8).

Employer

An employer is a person that employs people (The Concise Oxford Dictionary, 2001:467). For this study, it means a person that employs nurses and midwives; who could be either from the public or private sector or self-employed.

License

License refers to the granting of authorisation to a nurse and midwife to practise her profession.

Midwife

According to *the* Nursing Act 50 of 1978, *as amended*, a midwife means a person registered or enrolled as such under section 16, and includes an *accoucheur*. According to the International Confederation of Midwives, a midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery, and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She has to be able to give the necessary supervision, care and advice to women during pregnancy labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in the mother and the child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education, not only for women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood, and it extends to certain areas of Gynaecology, Family Planning and Childcare. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service (International Confederation of Midwives, 1992 In: Myles, 1993:4).

Midwifery

Midwifery is a service specifically aimed at assisting the individual, family and community to maintain, promote and restore health during the events surrounding childbirth, by means of preventive, promotive, curative and rehabilitative health care (Nolte, 1998:3).

Nurse

According to the Nursing Act 50 of 1978, as amended, a nurse refers to a 'registered nurse', that is a person registered as a nurse under section 16. For

the purpose of this study the term nurse refers to the registered nurse, enrolled nurse and the enrolled nursing auxiliary.

According to the ICN, a nurse is a person who has completed a programme of basic nursing education and is qualified in her country to practise nursing (ICN Initial Draft, 2002:2).

Nursing

A caring profession, nursing supports, cares for and treats the patient, ill or well, at all stages of life, so as to achieve and/or maintain health or, where this is not possible, care for the patient so that she lives in dignity until death (SANC, 1994:17).

System

A system is a complex whole; a set of things working together as a mechanism or interconnecting whole, an organised scheme or method (The Concise Oxford Dictionary, 2001:1453). A system is also defined as: "A set of interdependent parts having a common purpose in which the behaviour of each element of the system has an effect on the behaviour as a whole" (Ackoff, 1981 In: DOH, 2001:5).

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1.8 Research design

Having clarified the key concepts and definitions, an exploratory, descriptive and contextual research design will now be conducted.

1.8.1 Exploratory research design

Firstly, international literature on CPD systems and other sources will be explored and analysis will be conducted on how Continuing Professional Development within the context of nursing and midwifery is done in Australia; the United Kingdom; the USA: California; Canada: College of Nurses of Ontario; and Africa: Kenya.

Secondly, national literature and CPD systems will be examined and analysed to determine how Continuing Professional Development is done for health professionals who are practising their professions in South Africa. Thirdly, the national dynamic factors that will influence a CPD system for nurses and midwives in South Africa will be analysed. This information will be used as a theoretical framework for the development of the Draft CPD system for nurses and midwives in South Africa and for the Final CPD system for nurses and midwives in South Africa.

1.8.2 Descriptive research design

A description of the CPD systems for nurses and midwives in selected countries internationally, for health professionals nationally and the national dynamic factors that will influence a CPD system for nurses and midwives in South Africa, will comprise the theoretical framework in Chapter 3 of this study. This will be followed by a description of the Draft CPD system, according to purpose, structure, process and outcome. Thereafter a description of the Final CPD system for nurses and midwives in South Africa, for this study, will also follow according to this format.

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1.8.3 Contextual research design

This study will be conducted within the context of the South African professional, ethical and legal framework for Continuing Professional Development of nurses and midwives in South Africa.

1.9 Validity and reliability

The content/theoretical and face validity of the CPD system are briefly highlighted.

1.9.1 Content/theoretical validity

The researcher will use inductive results and trends suitable for the South African context, from the theoretical framework in Chapter 3 of this study to

develop the Draft CPD system and the Final CPD system for this study, for nurses and midwives in South Africa.

1.9.2 Face validity

The Draft CPD system will also be exposed to critical reflection at workshops and conferences (See Table 2.1). All the stakeholders of the SANC will be exposed to the Draft CPD system during the planned, national workshop of the Education Committee of the SANC. A copy of the Draft CPD system will be distributed to each delegate at this workshop so that they are provided with an opportunity to critically reflect on it and to verbalise their queries during the plenary session of the workshop. It is then expected of the representatives to disseminate the information to their constituencies. A report on the workshop will be presented to the SANC and decisions will be made on the refinement of the Draft CPD system.

A group of purposively selected validators/appraisers will evaluate the Final CPD system for this study, based on Chinn & Kramer's five criteria for conducting a critical reflection (Chinn & Kramer, 1995:125). The feedback will be critically analysed to determine the suggestions that will be used to refine the Final CPD system.

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1.10 Ethical considerations

The conduct of research not only requires expertise and diligence, but also honesty and integrity. Conducting research ethically starts with the identification of the study topic and continues through the publication of the study (Burns & Grove, 2001:132). It would be appropriate to reflect on how the researcher identified the topic of the research study.

The researcher served on the Professional Conduct Committee of the SANC for approximately five years, from 1994 to the end of November 1998, accepting the appointment to the position of senior manager at the offices of the SANC on 1st December 1998. It was during the researcher's term of office on the Professional Conduct Committee of the SANC with the consequential

exposure to incompetent nursing and midwifery practices, that the motivation to conduct a study on Continuing Professional Development was identified and eventually pursued. In October 2000, the SANC resolved to develop a CPD system for nurses and midwives in South Africa and as this decision occurred when the researcher had registered for this study, the SANC agreed that the researcher could work with the Education Committee of the SANC to develop CPD system (See Annexure B).

As the senior manager of the Professional Development Section at the offices of the SANC, the daily duty of the researcher included written and telephonic communication to Nursing Boards/Councils internationally. The management of the Professional Development Section involved, amongst other duties the management of national and international registration of nurses and midwives and the monitoring of education and practice standards of nurses and midwives on a national level (reference only made to those management tasks that influence the credibility of this study).

As a result of these duties, both the identity and the position of the researcher are well known nationally, and in some instances internationally. She was also expected to participate in networking activities with national and international visitors to the offices of the SANC. This afforded the researcher opportunities to direct discussions around Continuing Professional Development for nurses and midwives abroad and to request for and obtain information on CPD, thus securing verbal permission.

For the purpose of this research study, the following ethical issues as described by Babbie and Mouton, (2002:528), will be adhered to. Approval to implement the study was obtained from the Faculty of Education and Nursing of the Rand Afrikaans University (See Annexure A). The researcher will strive to:

- Adhere to high technical standards whilst conducting the research.
- Indicate the limits of the research findings and the methodological constraints that determine the validity of findings.

- Report the findings fully and not misrepresent results in any manner.
- Disclose the research methodology and techniques of analysis accurately and completely.
- Acknowledge any limitations, omissions and failures of the study.
- Consider ethical issues in presenting the sources. The content from sources will be presented honestly. The various authors' works will be accurately documented so that they receive credit for their publications.
- Include in the reference list only those sources that have been consulted, either directly through a quote or indirectly; only those that have been cited in the development of this thesis will be reflected.
- Seek permission from the SANC, to work in collaboration with them to develop a system for CPD for nurses and midwives in South Africa (See Annexure B).
- Avoid, under any circumstances, changing any data or falsifying or fabricating as this is regarded as a serious transgression of the scientific code of ethics.
- Manifest accountability in science in fulfilling the responsibility of publishing the research and acknowledging the sponsors of the research. Because ethical issues in social research are important, most of the professional associations have created and published formal codes of conduct describing what is acceptable and unacceptable professional behaviour (Babbie and Mouton, 2002:528). The researcher will adhere to the ethical standards for nurse researchers as prescribed by the Democratic Nursing Organisation of South Africa (DENOSA).

The researcher further ensured that:

- The criterion of informed consent was considered. Participants were provided with a written explanation of the purpose of the study, the nature and the procedure of the study and their expected role as participants of this study (See Annexure Y). Verbal agreement to participate in this study was accepted as the participants' consent.
- The principles of autonomy and fairness were upheld in that those participants, who wished to withdraw, could do so during any stage of

data collection. Participants were assured that they would not be coerced to continue and that they would not be disadvantaged in any way by the researcher or the outcomes of the study.

- Anonymity and confidentiality were maintained during the analysis and reporting on the Draft CPD system and for the Final CPD system of this study.
- Works of the various authors are acknowledged and documented accurately. The reference list includes only those sources that have been used in the development of this thesis (Burns & Grove, 2001:132).
- The fundamental ethical principles of beneficence, justice and respect for human dignity, which are also espoused by DENOSA, will also be upheld during all the stages of this study (DENOSA, 1998).

1.11 Delineation of the study

Chapter 1	An overview of the study
Chapter 2	Research design
Chapter 3	Theoretical framework for a CPD system for nurses and midwives in South Africa
Chapter 4	A Description of the Draft Continuing Development System for nurses and midwives in South Africa
Chapter 5	A Description of the Final Continuing Professional Development System for nurses and midwives in South Africa
Chapter 6	A critical reflection of the Final Continuing Professional Development System for nurses and midwives in South Africa

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Chapter 7. Justification, evaluation and recommendations.

1.12 Concluding statements

Professional, ethical and legal requirements necessitate the need for a formalised CPD system for nurses and midwives in South Africa. Professional conduct hearings confirm the need for a CPD system for nurses and midwives who are licensed to practise their professions in South Africa. There is a international and a national trend for regulatory bodies of health professionals to expect their membership to subscribe to a CPD system. There is no formalised CPD system for nurses and midwives in South Africa. A descriptive, exploratory and contextual research design will be used to develop a CPD system for nurses and midwives in South Africa.

Chapter 1 focused on the rationale, problem statement, objectives, assumptions, definitions, research design and the ethical considerations. The next chapter will be devoted to the research design.

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CHAPTER 2

RESEARCH DESIGN

2.1 Introduction

The aim of this chapter is to describe the research design that will be used for this study. The research design will be described according to the research strategy and context, whereas the methods will indicate the way data will be collected and analysed whilst ensuring validity of this study.

2.2 The overall aim of the study

The overall aim of this study is to develop a CPD system for nurses and midwives in South Africa. In view of the overall aim, the following objectives are listed:

- To explore existing knowledge frameworks on Continuing Professional Development for all nurses and midwives internationally and for all health professionals in South Africa
- To describe the Draft CPD system for nurses and midwives in South Africa
- To describe a Final CPD system for nurses and midwives in South Africa.

2.3 Research design

The researcher will design a strategy firstly, on what information to obtain on Continuing Professional Development, and secondly, on determining the best way to obtain such information (Babbie & Mouton, 2002:72). An exploratory, descriptive design will be appropriate, as there is no formalised CPD system for nurses and midwives in South Africa. The researcher's discoveries will be organised for analysis and interpretation. An explanation of each strategy, namely, exploratory, descriptive and contextual follows.

2.3.1 Exploratory approach

An exploratory approach will enable the researcher to obtain actual and thorough information on the real, practical situation of the subject of Continuing Professional Development (De Vos, 2002:214). Exploratory research will provide an opportunity to investigate the full nature of the phenomenon, i.e. Continuing Professional Development, the manner in which it is manifested, and other factors to which it is related (Polit & Beck, 2004:20). As a CPD system for nurses and midwives in South Africa is a relatively new phenomenon, an exploratory strategy will be used to examine existing CPD systems for nurses and midwives in selected international countries, and for healthcare professionals nationally, to provide theoretical validity (Babbie & Mouton, 2002:79).

Firstly, international literature on CPD systems and other sources will be explored. This is followed by an analysis of how Continuing Professional Development is done within the context of nursing and midwifery in Australia; the United Kingdom; the USA: California; Canada: College of Nurses of Ontario; and Africa: Kenya.

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Secondly, national literature on CPD systems and how Continuing Professional Development is conducted for health professionals who are practising their professions in South Africa will also be explored and analysed. Thirdly, the national dynamic factors that will influence a CPD system for nurses and midwives in South Africa will be explored and analysed. The information from all these exploratory approaches will comprise the theoretical framework in Chapter 3. This theoretical framework will be used for the development of the Draft CPD system for nurses and midwives in South Africa and for the Final CPD system for nurses and midwives in South Africa.

2.3.2 Descriptive approach

Descriptive studies are designed to gain more information about characteristics within a particular field of study, and in this instance, Continuing Professional Development. Their purpose is to provide a picture of

situations as they naturally happen, to determine what others in similar situations are doing (Burns & Grove, 2001:248), or give an accurate portrayal (Polit & Beck, 2004:716) of the various CPD systems. The descriptive approach will afford the researcher an opportunity to describe the various CPD systems for nurses and midwives in selected countries internationally, and for healthcare professionals nationally, so as to obtain an understanding of each CPD system according to purpose, structure, process and outcome.

The description of each of the selected CPD systems will comprise the theoretical framework in Chapter 3, and in each instance this will be followed by a table of recommendations for consideration for the proposed CPD system for nurses and midwives within the South African context:
Table 3. 4 (Australia)
Table 3. 5 (United Kingdom)
Table 3. 6 (USA: California)
Table 3. 7 (Canada: College of Nurses of Ontario)
Table 3. 8 (Africa: Kenya)

This will be followed by the description of the various dynamic aspects that can influence a CPD system for nurses and midwives in South Africa. The following national dynamic aspects are described: human rights, national programmes and priorities identified by the Department of Health, management training, dispensing and prescribing of medicines by nurses and midwives, the first national nursing summit and evidenced-based nursing and midwifery practice. These pertinent dynamic factors will be regarded as being critical to the development of a CPD system for nurses and midwives within South African context.

2.3.3 Context

The context defines and describes the setting in which the research actions occur; the aim being to understand events within the context in which they occur (Babbie & Mouton, 2002:272). The context of this study is the South

African professional, ethical and legal framework affecting the practice of nurses and midwives in South Africa.

2.4 Research methods

Research methods consist of the systematic, methodical and accurate execution of the design, the research process and the kind of tools and procedures to be used (Babbie & Mouton, 2002:75). Such procedures will also include population, samples and sampling methods.

2.4.1 Population

The term 'population' refers to the aggregate or totality of all the objects, subjects or members that conform to a set of specifications (Polit & Beck, 2004:727). Population for the purpose of this study also refers to the following sources that will be used for obtaining information on CPD systems:

A. International sources of information on CPD systems for nurses and midwives will be obtained through:

- Textbooks that focus on the subject of CPD
- Pamphlets/brochures that will be requested through written letters and received through the postal services from the various Nursing Boards
- Research reports that will be obtained on the websites of the various nursing boards/councils, on the Internet
- Electronic mail from the various nursing boards/councils in response to the researchers electronic request for initial or specific follow-up information on this subject
- Summarised notes on information obtained through telephonic engines during telephonic enquiries on CPD or validation of information received to establish correct interpretation of data received electronically or through the postal services.

These methods will provide a rich blend of sources to develop a comprehensive understanding of existing CPD systems (Polit & Beck, 2004:430).

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B. National sources of information on all healthcare professions:

- Brochures and a CPD information booklet from the Health Professions Council of South Africa (HPCSA)
- Annual report of the HPCSA for 2002
- Articles on CPD in the Pharmacopoeia
- Four fact-finding site visits to the HPCSA and two site visits by the CPD manager of the HPCSA, to the SANC, for follow-up discussions with the researcher and the senior managers for human resources and information management at the SANC, on the administration of the CPD system for the Medical and Dental Professions Board of the HPCSA
- Two site visits to the Pharmacy Council of SA to obtain information on the CPD system that they are intending to put in place.

C. Validators/appraisers

The Draft and Final CPD systems will be exposed to a population of validators/appraisers that are representative of the role players in this study. The Draft CPD system will be exposed to nurses and midwives at international and national conferences, workshops, seminars and meetings of special interest groups (See Table 2.1). The Final CPD system will be exposed to a purposively selected population comprising:

- Senior nurse researchers from a Nursing Education Department with at least10years of research experience especially with regard to systems, models and theory development
- Organised labour for nurses and midwives in South Africa
- Senior managers from the private and public sector representing the employer
- Various categories of nurses and midwives practising both in urban and rural settings.

Three of the above validators/appraisers are incidentally also elected members of the SANC but in this study they will not be participating in that capacity.

2.4.2 Sampling

Sampling involves selecting a group of people, events, behaviours or other elements with which to conduct a study (Burns & Grove, 2001:365). For this study two sampling methods will be used, namely, convenience sampling and purposive sampling. Convenience sampling will be used for the theoretical framework in Chapter 3 of this study to ensure theoretical validity of the Draft and Final CPD system. Purposive sampling will be used firstly for collecting data from healthcare professionals nationally, and secondly for critically reflecting on the Final CPD system for nurses and midwives in South Africa.

Convenience sampling is the selection of the most readily available information on CPD systems (Polit & Beck, 2004:714). Convenience sampling will be used to collect data on CPD systems for nurses and midwives from international countries; the countries selected will be determined by the researcher's ability to access adequate and complete information on the purpose, structure, process and outcome of the particular countries' CPD system and to obtain responses on queries pertaining to the CPD system for nurses and midwives. Convenience sampling will also be used to determine the face validity of the Draft CPD system at conferences and workshops of nurses and midwives (See Table 2.1).

Purposive (purposeful) sampling is a non-probability sampling method in which the researcher will select participants based on personal judgement about which ones will be more representative or informative (Polit & Beck, 2004:729). Purposive sampling will be used firstly for collecting data from healthcare professionals nationally, and secondly for selecting academic experts, organised labour, human resource management from the private sector and public sector, and a representative sample of all categories of nurses and midwives practising their professions in both urban and rural areas, as validators/appraisers (See section 2.4.1 C.). This purposive sample will be used to critically reflect on the Final CPD system and in so doing provide constructive criticism for its refinement. This critical reflection is described in detail in Chapter 6.

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2.4.3 Data collection

The researcher will draw on and combine a variety of data-collection strategies to obtain a rich description and an understanding of the implementation of CPD for nurses and midwives in Australia, the United Kingdom, the USA: California, Canada: College of Nurses of Ontario, and Africa: Kenya, and for healthcare professionals nationally that is, doctors and dentists and pharmacists (See sections 3.5.1 and 3.5.2).

Whilst international and national data is gathered, it will be analysed simultaneously and grouped according to purpose, structure, process and outcome. The inclusion of the following methods of data collection in this research project is likely to increase the reliability of the observations as one method will compensate for the limitations of another (Mouton, 1998:157):

A. An extensive literature study will assist the researcher to obtain information and an understanding of the CPD systems for nurses and midwives internationally and health professionals nationally. It will also provide a theoretical framework as well as a benchmark for comparing CPD systems and identifying aspects appropriate for use for nurses and midwives in South Africa (Creswell, 2003:30).

B. Unstructured and unscheduled interviews with nurses and midwives from abroad who visit the offices of the SANC either to seek information on the application for registration with the SANC or for follow-up visits to forward outstanding information pertaining to their application for registration with the SANC. This will be based on Burns and Grove's (2001) interviewing principles (Burns & Grove, 2001:420).

C. Informal and unstructured interviews with representatives/delegates from various countries, at international conferences, to affirm the information received on the CPD.

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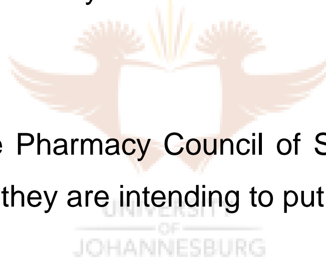
D. Unstructured telephonic interviews will also be held with relevant officers employed at the Nursing Boards of selected countries internationally. (Burns & Grove, 2001:420). Although there will no formal instrument, reference will be made to a list of types of information needed on CPD systems, namely purpose, structure, process and outcome (Polit & Beck, 2004:318). Although the unstructured interviews will be conversational and interactive Polit and Beck's (2004) recommendation that it is critical to let participant's tell their stories with little interruption, will be adhered to (Polit & Beck, 2004:340).

E. Four fact-finding site visits to the Health Professions Council for SA (HPCSA) and two site visits by the CPD manager of the HPCSA, to the SANC, for follow-up discussions with the researcher and the senior managers for human resources and information management, on the administration of the CPD system for the Medical and Dental Professions Board of the HPCSA.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F. Two site visits to the Pharmacy Council of SA to obtain information on the CPD system that they are intending to put in place.

2.4.4 Data management

Data management consists of those activities aimed at achieving a systematic, coherent manner of data gathering, storage and retrieval. How data is stored and retrieved is at the heart of data management. A good storage and retrieval system is critical for keeping track of what data has been collected, for permitting easy and reliable use of data so that the study can in principle be verified (De Vos, 2001:335). For the purpose of this study a manual filing method will be used and data will be filed according to the respective countries internationally and according to a particular health profession grouping nationally. This data will be made available for an audit trail to verify the researcher's design and methods.

2.4.5 Data analysis

The researcher will logically account for data analysis and ensure truth-value of the results (De Vos, 2001:345). The analysis of data will be a 'hands on' process. The researcher will become 'immersed' in data or what is also referred to as 'dwelling' with them. This will require a significant degree of dedication to reading, analysing, synthesizing and documenting of what is discovered. The researcher will engage in data analysis concurrently with data gathering and this process will be ongoing (De Vos, 2001:345). Through the process of inductive thinking, the boundaries of the study will be reformulated and defined as initial queries related to CPD are answered.

The overall aim of analysis is to search for patterns, be they descriptive or analytic, simple or complex that emerge from the information obtained about CPD systems for nurses and midwives in selected countries internationally and the CPD systems for health professionals in South Africa. The systems approach will be utilised for the initial organisation of the data into input, throughput and output (Du Toit, 1995:41). Ultimately the Final CPD system will be arranged in a structured systems-based format of purpose, structure, process and outcome.

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2.5 Validity and reliability

Validity is the degree to which an instrument measures what it is intended to measure (Polit & Beck, 2004:735). In this study content/theoretical validity and face validity will be applied to the development of the Draft CPD system and the Final CPD system for nurses and midwives in South Africa. Reliability will not be tested in this study.

2.5.1 Content/theoretical validity

The researcher will use inductive results and trends suitable for the South African context, from the theoretical framework in Chapter 3 to develop the Draft CPD system and the Final CPD system for this study. The findings from the literature study, research studies on CPD and specific consumer

discussion documents on existing CPD systems for nurses and midwives internationally, will be used to guide the process of developing the Draft CPD system and the Final CPD system for nurses and midwives in South Africa.

- A summary of recommendations for consideration in the South African context will be derived from the theoretical framework of the following selected international countries as outlined on page 31.

These recommendations will be used to inform the process of developing the Draft CPD system and the Final CPD system for this study, for nurses and midwives in South Africa. A summary of recommendations for consideration from CPD systems for the following health professions in South Africa, is presented in Table 3.10: The Medical and Dental Board of the Health Professions Council of South Africa (HPCSA), and Table 3.11: The Pharmacy Council.

These recommendations will also be used to further inform the process of developing the Draft CPD system and the Final CPD system, for nurses and midwives in South Africa. The Draft CPD system will also be used to inform the process of developing the Final CPD system for nurses and midwives in South Africa. Over and above this the content validity will also be demonstrated through exposing the Draft CPD system and the Final CPD system through a process of critical reflection to selected validators/appraisers.

2.5.2 Face validity

Face validity is the extent to which a measuring instrument looks as though it is measuring the appropriate construct. Although face validity should not be considered as primary evidence, it is helpful to have face validity if other types of validity have also been demonstrated (Polit & Beck, 2004:423). This is true for this study, as content/theoretical validity will also be applied. The Draft CPD system will be exposed to critical reflection during the following workshops/conferences reflected in Table 2.1.

Table 2.1: The process of validation of the Draft CPD system for nurses and midwives in South Africa

Event	Province and Target Group
International Midwifery Conference Heads, Hearts and Hands of Midwives in the New Millennium	Northern Midwives from the 9 provinces
Staff Development Programme	Gauteng Community health Nurses
Conference: Practical Solutions for Peri-natal Problems	Gauteng, Northern Province, Mpumulanga Midwives 300 delegates
TECHNEDSA (Technicon Nursing Education Departments, South Africa)	Representatives of the various Technicons in the 9 provinces of the RSA
International Midwifery Congress: "Midwives Bringing Light to the Nation"	Midwives from the 9 provinces of South Africa 1, 500 delegates
National Workshop of the Education Committee of the South African Nursing Council	All stake holders of the SANC (All nine provinces represented
Fundisa	Representatives from the Nursing Department in the universities of the 9 provinces of the RSA

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Table 2.1. (continued)

Event	Province and Target Group
2nd International Health Conference: Reshaping The Nursing Landscape (University of the Witwatersrand. Department of Nursing Education)	All Health care professionals (national and international representatives)
Presentation and workshop	Western Cape Private sector: Med clinic
Presentation at ECSACON Conference in Dar es Salaam, Tanzania	Nurses and Midwives of the 14 countries that form the East, Central and Southern Africa College of Nursing (ECSACON)
Nurse Educators/Administrators forum	Nine provinces represented

A plenary session will be accommodated at each conference/workshop to accommodate queries and clarification on the Draft CPD system.

For critical reflection of the Final CPD system experts will be used to evaluate and document content validity of the Final CPD system (Polit & Beck, 2004:423). For the purpose of this study, various experts (academic, organised labour, senior management in the public and private sectors) in the development of a system will be included in the group of validators/appraisers who will be requested to critically reflect on the Final CPD system proposed for nurses and midwives in South Africa. Key issues in such a critical reflection of the Final CPD system will be for the identified experts to provide written responses in accordance with the following five criteria of Chin and Kramer (1995:125):

1. Clarity of the CPD system
2. Simplicity of the CPD system
3. Applicability of the CPD system
4. Accessibility of the CPD system
5. Importance of the CPD system.

The purpose of this critical reflection is to validate and refine the Final CPD system for this study. Tapping the experience of experts usually offers many

advantages. The utilisation of experts will help to gain valuable information on the more technical and practical aspects of the Final CPD system for nurses and midwives in South Africa and alert the researcher to possible unforeseen problems (De Vos, 2001:181).

In addition, the purposive selection of validators/appraisers will be from various health sectors, public and private, in South Africa so that not only expertise but also perspective will be included, and so that attention will be given to significant detail with regard to the content of the Final CPD system. This purposeful selection will cause differences to emerge and the uniqueness of their positions and work circumstances will result in a rigorous critical reflection of the Final CPD system for this study. To this effect all categories of nurses and midwives from urban and rural healthcare settings will be included. Feedback from validators/appraisers will be analysed and appropriately motivated changes will be effected to refine the Final CPD system for this study (De Vos, 2001:181). The purpose of the critical reflection is to improve the success and effectiveness of the CPD system. This critical reflection will be described in detail in Chapter 6 of this study.

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2.5.4 Reliability

Reliability will not be tested in this study because the CPD system is not tested.

2.6 Summary

In Chapter 2 an exploratory and descriptive research design was discussed with specific reference to the development of the Draft CPD system and the Final CPD system for nurses and midwives in South Africa. Chapter 3 will comprise a description of the theoretical framework for the Draft and Final CPD system for nurses and midwives in South Africa.

CHAPTER 3

THEORETICAL FRAMEWORK FOR A CONTINUING PROFESSIONAL DEVELOPMENT SYSTEM FOR NURSES AND MIDWIVES IN SOUTH AFRICA

3.1 Introduction

In Chapter 2 the research design and methods that will be used to develop a CPD system for nurses and midwives in South Africa was described. The theoretical framework that was used to inform the process of developing the Draft CPD system and the Final CPD system for nurses and midwives in South Africa, is described in Chapter 3 under the following subheadings:

- 3.2 Professional, ethical and legislative context
- 3.3 The systems theory as a theoretical base
- 3.4 A descriptive analysis of CPD systems for nurses and midwives in selected countries internationally and for healthcare professionals nationally
- 3.4.1 A descriptive analysis of CPD systems for nurses and midwives in selected countries internationally
- 3.4.2 A descriptive analysis of CPD systems for healthcare professionals nationally
- 3.5 The national dynamic aspects

The international and national descriptive analyses of CPD systems in selected countries will be described according to purpose, structure (legislative aspects, administration, forms and budgets), process, outcome, and summary.

This will be followed by an overall descriptive synopsis of the international scene of CPD systems for nurses and midwives, in selected countries, and then the national scene of CPD systems for healthcare professionals in South Africa.

3.2 The professional, ethical and legislative context of nurses and midwives in South Africa

The SANC, as the statutory body for nurses and midwives, reaffirms its commitment to carry out its duty to the people of South Africa, namely to ensure that the education of nurses and midwives are such that the South African public receives knowledgeable, competent, safe and ethically based nursing care (Kotze, 2000:iv).

The profession has a particular duty to ensure that practitioners are aware that the standards of practice of the individual nurse and midwife reflect the standards of practice of the profession because it has a major effect on the status of the nursing and midwifery professions and on the position of the nurse and midwife in the health team (Searle & Pera, 1995:209). In nursing and midwifery practice, this status is defined by regulations framed under Section 45, Chapter 5, (1) (q) of the Nursing Act 50 of 1978, as amended – the principal act for nurses and midwives who practise their profession in South Africa.

The regulations (Government Notice R2598 of 30 November 1984, as amended), relating to the scope of practice of registered nurses, midwives and enrolled nurses (See Annexure C), outline the acts (that nurses and midwives should adhere to) and procedures that they should perform competently. Practice of a profession requires knowledge of its scope of practice and the rules or conditions under which a person may practise. These regulations are based on certain premises about nursing science and art and the philosophy and ethics of nursing and midwifery. These premises are that:

- Nursing and midwifery is a profession practised within legal and ethical parameters.
- The nurse and midwife is concerned with homo sapiens as a holistic being from birth to death, within his culture, social milieu and total health status.

- Nursing and midwifery encompass a wide variety of scientifically planned actions based on biological, physical, chemical, psychological, social, educational, medical and technological knowledge and skills ranging from the simple to the highly complex.
- The nurse and midwife is accountable for her professional acts and omissions.
- The nurse and midwife has to have the necessary knowledge, skills and the correct moral and professional attitude to perform all the acts relating to her scope of practice.
- The nurse and midwife has to maintain standards of care, continue to develop her knowledge, skills, and attitude and practise her profession within the ethical norms of her profession and the legal constraints of the practice of nursing (Searle & Pera, 1995:173-174).

The South African Nursing Council further expects the nurse and midwife practitioner to uphold standards of care. Standards of nursing and midwifery practice have to demonstrate what desirable and safe practice is. These standards have to be based on sound principles, firstly, to be applicable to the variety of health care settings (primary, secondary and tertiary levels of care) and secondly, to be within a context of continuing change and development that nurses and midwives encounter in the practise of their professions.

Government notice R387 of 15 February 1985 as amended, Chapter 2, NO 3: authorises "… nurses and midwives to carry out acts in respect of diagnosing, treatment, care, prescribing, collaborating, referral, co-coordinating and patient advocacy as the scope of his profession admits". Chapter 2, No 18 (1) of this regulation states that: "… except in the case of an emergency a nurse may not perform a act – (a) which does not pertain to his registered profession; (b) for which he has inadequate training or experience".

According to these regulations (See Annexure D), the registered nurse/midwife has professional authorisation to perform her nursing and midwifery activities as an independent practitioner. This means that she is

personally accountable for all her acts and omissions within a given situation and responsible for the consequences thereof (Muller, 2002:64). This implies that the nurse and midwife practises in accordance with Muller's nursing and midwifery practice standards as listed in Chapter 1, page 3 of this study.

Over and above the question of competence, there are also issues relating to the ethical and moral conduct of nurses and midwives in the normal discharge of their duties. The Nursing Act 50 of 1978, as amended, Chapter 4, section 28 (1) authorises the Council to "…institute an inquiry into any complaint, charge or allegation of improper or disgraceful conduct against any person registered or enrolled under this Act and, on finding such person guilty of such conduct, may impose any of the penalties referred to in section 29 (1).

Government Notice R373 of 13 March 1970, as amended, provides the details of the Council's functions in relation to the investigation of alleged misconduct and the management of inquiries (See Annexure E). The SANC is thus duty bound to conduct inquiries into complaints received from various sources. It is therefore also mandatory for the SANC to assure the South African public that it is sincere and earnest about its commitment to preserve standards of practice of nurses and midwives so that all concerned receive safe, compassionate and ethically based nursing care from knowledgeable and competent practitioners.

It can thus be argued that if a CPD system addresses the professional, legal, ethical, personal, civic and public responsibilities of a nurse and midwife; the statutes and regulations pertaining to the practice of nursing and midwifery; and the competencies necessary for effective functioning in a particular area of practice, then it could contribute to minimising the incidence of professional misconduct.

Professional misconduct cases justify the need for the development and implementation of a CPD system that will cause all registered/enrolled nurses and midwives to constantly upgrade their knowledge, skills, attitudes, and

ethical behaviour. It is therefore clear that there is a definite need to develop a CPD system for all registered/enrolled nurses and midwives in South Africa.

The challenge which then arises is what approach should be applied to include all the essential steps namely, purpose, structure, process and outcome that was identified as a necessary format for the CPD system. It follows therefore that the application of the systems theory as described by Smit & Cronje (2001:64) is appropriate for the development of a CPD system. This systems theory would facilitate the operationalisation of a CPD system for nurses and midwives in South Africa.

3.3 The systems theory applied as a theoretical base to this study

The development of a CPD system for nurses and midwives in South Africa is based on the systems theory, due to the interrelatedness of the components that encompass the system. "The particular value of the systems approach is that it emphasises the fact that the activities in one part of an organisation affects the activities in other parts" (Smit & Cronje, 2001:64).

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Inherent in a system is the movement from one component to the next, as well as a feedback system within a cyclical whole, with subsystems and components influencing each other and the external environment (Du Toit, 1995:41). A continuous flow of information, materials and energy flow in, through, and out of the system, representing the basic components, namely input, throughput and output. It can be illustrated in Figure 3.1 as follows:

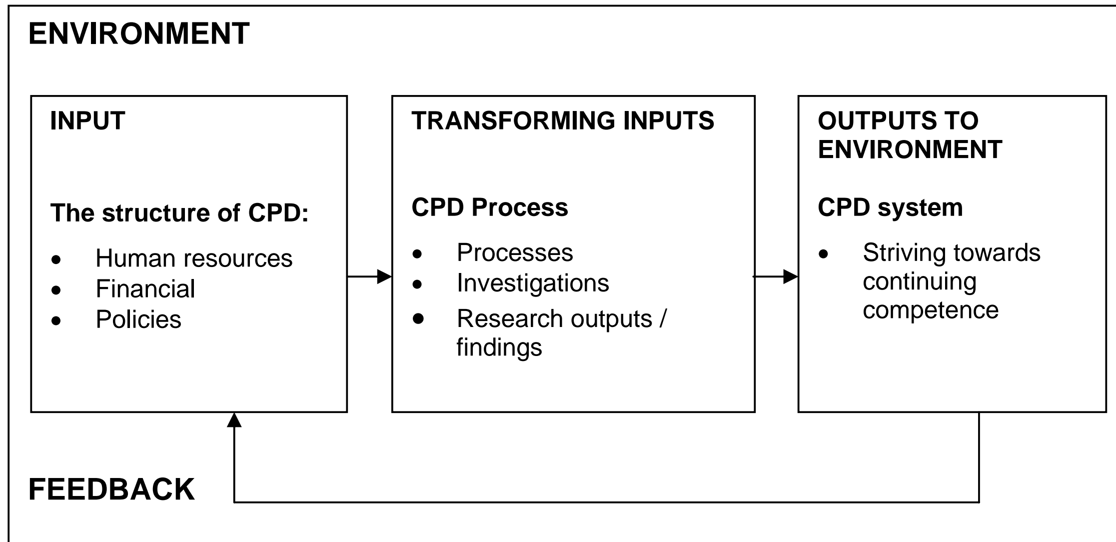

Figure 3.1 The systems approach (adapted from Du Toit, 1995:41)

In this study, the components of the system will be applied as follows:

3.3.1 Input (structure)

This will include the structures, legislation and policies of the principal role players namely, the nurses and midwives, the SANC and the employer. They all make a significant input into the proposed CPD system for this study. Incorporated in the structure is legislation such as:

- Nursing Act 50 of 1978, as amended, regulations such as Government Notice R378 of 15 February 1985, as amended and Government Notice R2598 of 30 November 1984, as amended, etc
- Proposed budget that could be allocated to implement the proposed CPD system
- Forms for the administration of the CPD system, documentary evidence.

3.3.2 Throughput (processes)

This will describe the roles and responsibilities of the three principal role players (See Figure 5.1). **Output** refers to the outcome of the structure and the throughput, namely a CPD system with the achievement of its purpose,

the nurses and midwives in South Africa striving towards Continuing Competence (See Figure 5.1).

Validating the CPD system and giving feedback complete the cycle of the proposed CPD system for nurses and midwives in South Africa. **Evaluation of the efficacy of the CPD system is not the intention of this study**. What is however intended is a descriptive analysis of Continuing Professional Development for nurses and midwives internationally, for healthcare professionals nationally and how the acquired information can inform the development of the Final CPD system for nurses and midwives in South Africa, for this study.

3.4 CPD systems for nurses and midwives in selected countries internationally

In this section a descriptive analysis of CPD systems for nurses and midwives in selected countries internationally is provided. CPD systems for healthcare professionals in South Africa will be analysed accordingly in Section 3.5.

Firstly, the research design of this study will consist of exploring the existing knowledge framework on CPD systems for nurses and midwives internationally. For the purpose of this study the CPD systems of Australia, the United Kingdom, the USA: California, Canada: College of Nurses of Ontario, and Africa: Kenya are explored:

Findings on Continuing Professional Development for nurses and midwives in the countries named above will be under the following headings:

a) Purpose
b) Structure
c) Process
d) Outcome
e) Summary.

In pursuance of the above objective, the CPD systems for the six states and two territories of Australia are described.

3.4.1 Australia

It becomes necessary to look at the geo-political situation in order to fully comprehend how CPD is implemented in various parts of Australia. Australia is divided into six states and two territories.

In terms of the statutory arrangements of Australia as a sovereign national state, each state and territory has its own legislative arrangements and thus each of the following states and territories has its own Nursing Act:

1. Nurses' Board of the Australian Capital Territory
2. New South Wales Nurses' Registration Board
3. Nurses' Board of the Northern Territory
4. Queensland Nurses' Council
5. Nurses' Board of South Australia
6. Nursing Board of Tasmania
7. Nurses' Board of Victoria
8. Nurses' Board of Western Australia.

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Reference will thus be made to the Nursing Act of each state and territory as the researcher proceeds to compare and contrast the requirements pertaining to Continuing Competence (the term given to CPD in Australia).

Although each state and territory has autonomy in respect of nursing regulatory authorities, it is important to note that the Australian nurse regulatory authorities established a national body in 1992, the Australian Nursing Council Incorporate (ANCI), as a forum for considering the regulation of nursing and midwifery in Australia within a national focus. Each of the named state and territory nurse regulatory authorities is represented on this Council (ANCI). In terms of the previously stated format, the research proceeds to describe the purpose of Continuing Competence (CPD) in Australia.

(a) Purpose

The primary purpose of the various Nurses' Acts is the protection of the public and the Acts reflect the need for registered nurses to have maintained their knowledge and skills. In the interest of the Australian public, the various Australian Boards believe that the recency of practice provision (except for New South Wales – refer to Table 3.1) is an important initiative to assure the public that nurses who are registered to practise nursing have had recent nursing practice.

The ANCI, developed a set of standards referred to as the Australian National Competency Standards. These are core competency standards, which all registered nurses have to be able to demonstrate. The purposes of the national competency standards also reflect the purpose of Continuing Competence (CPD) in Australia. The purposes of the Australian National Competency Standards are to:

- Communicate to the consumer the standards that they can expect of nurses
- Assess nurses who wish to return to work after being out of the workforce for a defined period
- Assess qualified nurses who are required to demonstrate competence in the nationally identified Australian competencies (ANCI, 2000:3).

(b) Structure

It is a national legal requirement that under each state and territory nurses have to be registered or enrolled in the state or territory in which they intend to practise nursing. Mutual recognition laws in Australia make provision for recognition of registration across state boundaries and the Trans Tasman.

The Code of Ethics for Nurses in Australia and the Code of Professional Conduct for Nurses in Australia make reference to the need for nurses to maintain standards of practice and the responsibility of each nurse to maintain the competency standards necessary for current practice (ANCI, 2003:1).

The following excerpt from the Code of Professional Conduct for Nurses in Australia clearly illustrates the support for Continuing Competence:
"A nurse must practise in a safe and competent manner:

- A nurse is personally accountable for the provision of safe and competent nursing care. Therefore it is the responsibility of each nurse to maintain the competence necessary for current practice
- Maintenance of competence includes participation in ongoing professional education to maintain and upgrade knowledge and skills relevant to practice in a clinical, management, education or research setting…" (ANCI, 2003:2).

The details of aspects in relation to the structure, administration, forms and budgets for Continuing Competence in the various states and territories of Australia could not be obtained. It was thus assumed that the unavailability of such information was because at the time of this study, processes, discussions and debates were underway for nationalizing and refining the system for Continuing Competence in Australia (Ilife, 2000: personal correspondence). However, in some sources of information as is the case with Tasmania, mention is made of forms and specific documents that are required (Nursing Board of Tasmania, 1992:4), but because the information is integrated with the process of Continuing Competence, the researcher chose to leave the two aspects together so that the continuity and flow of the process is captured in its entirety.

(c) Process

Firstly the ANCI's standpoint on Continuing Competence will be discussed and then a comparative overview of the process of Continuing Competence (CPD) in the various states and territories will be highlighted.

The ANCI published a position statement on Continuing Competence in Nursing in 2000. The ANCI acknowledges that there is an increasing demand for greater accountability from all health professionals. Increasing consumer expectations, demographic and social changes, greater focus on research

and evidence based practice underpin the need for nurses to maintain competence. The ANCI has agreed that action taken in relation to its responsibility with regard to Continuing Competence would be underpinned by the following principles:

- That a process of self-assessment be the basis for determining the Continuing Competence of an individual practitioner, and
- That this is implemented with in a quality improvement framework (ANCI, 2000:1).

The position statement also describes self-assessment as an ongoing process whereby a nurse examines her practice against national competency standards. Self-assessment includes reflection, critical incident analysis, peer review and evaluation of client and patient outcomes (ANCI, 2000:1).

The ANCI has formulated national competency standards for the registered nurse and for the enrolled nurse. As previously indicated, the ANCI expects registered nurses and enrolled nurses to conduct a self-assessment against the respective national competency standards. Nurses in Australia are regulated and accountable to the community for providing high quality care through safe and effective work practice. To assist in achieving this, the state and territory regulatory authorities set standards of competence that describe the expected behaviour of nurses. An excerpt of the ANCI national competency standards that relate directly to Continuing Competence is quoted in Table 3.1 (ANCI, 2002:2).

Table 3.1 ANCI Competency Standard on Continuing Competence (ANCI, 2002:2)

"Domain:	Critical Thinking and Analysis
Competency Unit 5	Act to enhance the professional development of self and others
Element 5.1	Uses professional standards of practice to assess the performance of self
Element 5.2	Recognises the need for and participates in the professional development of self
Element 5.4	Contributes to the learning experiences and professional development of others".

Over and above this, nurse regulatory authorities in the various Australian states and territories retain the authority to implement a system for determining Continuing Competence that is relevant to their jurisdiction and legislative framework and all registered nurses in Australia have a professional responsibility to maintain the standards in order to renew their license to practice. A comparative overview of the process of Continuing Competence (CPD) in the various states and territories will be highlighted.

3.4.1.1 Nurses Registration Board of New South Wales

In contrast to the other states and territories of Australia there is no mention in the New South Wales Nursing Act 1991 of the necessity to provide evidence of Continuing Competence prior to annual re-registration; the payment of a fee is the only requirement for re-registration. The provisions do not require recency of practice requirements for continued registration.

It is important to note that recency of practice is a requirement in a majority of the States and territories and it is described as: "…a term applied to the minimal requirement for active practice by which a nurse or midwife can be considered to have current knowledge, skills and experience. For example a

nurse or midwife who has been out of practice for five years is usually considered to be out of safe practice" (Pearson, 1999:22).

Correspondence to the researcher (Cleary, personal correspondence 2000:1) revealed that the Nurses' Act in New South Wales is under revision and it is anticipated that provision for self-assessment and declaration of competence for continuing practice would be addressed, without mandating any specific Continuing Education requirements.

3.4.1.2 Nurses' Board of the Australian Capital Territory

The Australian Capital Territory Nurses' Act, 1988, section 10 states that registration, as a general nurse is conditional on:

(i) "Having graduated from a course of education and training in general nursing that is offered by an Australian institution and accredited by the Board or approved by the registration authority of a state or another territory; and

(ii) Having graduated from that course, or having practised as a general nurse, within the period of five years immediately proceeding the date of application" (Pearson, 1999:12).

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In comparison with South Australia, Western Australia, Northern Territory, Victoria, Queensland and Tasmania the 5-year period of recency of practice also applies. A person may also be required to undertake further education and training, if that person graduated from a course more than five years before the date of application; or has not practised as a general nurse within the period of five years immediately preceding the date of application.

3.4.1.3 Nurses' Board of South Australia

Once again, the 5-year period of recency of practice applies as discussed in the previous territory and state. South Australia Nurses' Act 1984 Section 29 (1) states that: "A registered or enrolled nurse who has not practised nursing for a period of five years or more shall not practise nursing without first obtaining the approval of the Board". Before granting approval to practise the

Board may, under Section 29 (2) require the nurse to obtain qualifications and experience specified by the Board and for that purpose may require the nurse to undertake a specified course of instruction and training in nursing; or make its approval subject to one of the following conditions:

(i) "A condition restricting the places or times at which the nurse may provide nursing care
(ii) A condition limiting the field of nursing in which she may practise
(iii) A condition that she be supervised when providing nursing care by a particular person or by a person of a particular class; or
(iv) Such other condition as the Board thinks fit" (Pearson, 1999:13).

3.4.1.4 The Nurses' Board of Western Australia (NBWA)

When comparing to other states and territories, it is noted that the following is also a prerequisite:

- Five-year period of recency to practise **and** in contrast to others
- Nurses are required to keep a record of their Continuing Competence as from 2001

Since May 2002 developments have been underway at the Board to put a mechanism in place to assess the professional competence of nurses at renewal of registration (Evans, 2000: personal correspondence).

Recency of practice appears in Section 22 (2) of the Nurses' Act 1992 wherein is stated that nurses require renewing their registration annually by 31 December and their date of last practice has to be included. The Board may also require a professional reference and/or written evidence of employment dates. If applicants have not practised nursing and midwifery within the five years prior to the date of renewal, then their registration lapses. If they wish to restore their names to the register then they are requested to undertake a Renewal of Registration programme. Applicants undertaking a Renewal of Registration course are granted provisional registration under section 26 (1) (b) of Act 1992, for the period of clinical placement.

As stated previously, in contrast to the states and territories referred to previously, as from 2001 nurses are required to keep a record of their

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Continuing Competence. When nurses apply to renew their registration for 2002, a percentage will be randomly selected and will be required to provide evidence of Continuing Competence. They will be given provisional registration whilst the process is completed; if evidence is not available, then their registration will not be renewed until the conditions have been met (Evans, 2000: personal correspondence).

Other developments, namely a discussion paper entitled "Assessment of Continuing professional Competence" (May 2002) acknowledges that nurses applying for renewal of registration in Western Australia have not been required to provide evidence that they are safe, competent practitioners, or that they upgrade their knowledge and skills through professional development activities. The Board thus believes that a mechanism should be put in place to assess the professional competence of nurses at renewal of registration (NBWA, 2002:6).

This discussion paper provided an opportunity for nurses, employers and members of the public to comment on the proposed introduction of assessing continuing professional competence of nurses in Western Australia. The closing date for submissions was 28 June 2002. This discussion paper also refers to the considerable debate that has resulted from the issue of mandatory Continuing Education and the assumption that it is related to Continuing Competence (NBWA, 2002:6).

3.4.1.5 Nurses' Board of the Northern Territory

The Northern Territory Act 1982 requires annual registration and payment of a fee. In addition, the Board may require proof of qualifications cited in the application. The applicant may be required to appear before the Board in terms of making decisions as to whether registration or enrolment should be granted or refused. Table 3.2 indicates that nurses and midwives in the Northern Territory are also required to adhere to the five-year recency to practise statement to be eligible for re-licensure to practise their professions. In addition the Board may examine a person under oath, affirmation or

declaration; and may issue a summons requiring the attendance of a person or the production of a relevant document (Pearson, 1999:12).

3.4.1.6 Nurses' Board of Victoria (NBV)

The NBV also compares positively with other states and territories with regard to the five-year period of recency to practise but contrasts with the previously named states and territories with regard to these additional requirements:

- Complete the declaration for renewal of registration stating her continued competence to practise as a registered nurse
- Individuals need to make a decision about their competence, based on self-assessment of their nursing practice over the last five years
- Using the ANCI Competencies that were adopted by all Australian nurse regulatory authorities in 1990, for assessing minimum competence to practise
- A clinical assessment tool is available from the Board to assist the preceptors in their professional judgements about a nurse's competence and eligibility for re-registration (NBV, 2000:2).

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The Recency of Practice Policy Review commissioned by the Board identifies that there are many variables other than time that individuals take into consideration when quantifying Continuing Competence (N B V, 2000:2). To be responsible and accountable for professional practice each nurse has to complete the declaration for renewal of registration stating her continued competence to practise as a registered nurse. Individuals need to make a decision about their competence, based on self-assessment of their nursing practice over the last five years (Lafferty, 2000:1, personal correspondence). Self-assessment may be based on the following:

- Continual assessment of knowledge, skills and professional judgement and where necessary, taking action to improve the quality of practice
- Undertaking professional development activities in the last 12 months that were aimed at enhancing nursing practice
- Reflecting on recent workplace performance appraisals to confirm competence to practice

- Using the ANCI Competencies that were adopted by all Australian nurse regulatory authorities in 1990, for assessing minimum competence to practise (NBV, 2000:3).

Under section 14 of the Nurses' Act 1993, all nurses who have not had sufficient nursing practice in the preceding five years and wish to re-register are requested to undertake a re-entry to practice programme. There are two ways of achieving this:

- A Board accredited re-entry programme; or
- A period of supervised practice at a healthcare facility approved by the Board.

Registered nurses who have undertaken clinical practice within the preceding five years, but have had a break from practice may request a clinical update that is negotiated between the registered nurse and a health care facility.

The following factors are listed for consideration for accredited re-entry programmes and supervised practice:

- Participants have to provide a letter of approval from the Board
- If 10 years or more have elapsed since the nurse last practised, an accredited re-entry programme may be required
- If it is less than 10 years since the nurse last practised, discussion between the nurse and the Director of Nursing will determine the need for either an accredited re-entry programme or a period of supervised practice
- Acceptance or non acceptance of a nurse to undertake supervised practice is the prerogative of the Director of Nursing or her designated representative
- A learning contract and objectives should be developed between the participant and the preceptor that identifies the needs for both the participant and the organisation and is reflective of the ANCI National Competency Standards. The contract should be approved but the Director of the Nursing and/or Nurse Educator

- The learning contract of nurses that qualified overseas has to reflect the Australian Health care system and cultural environment (NBV, 2000:3).

Supervised practice may be undertaken either part time or full time. The Board approves part time supervised practice of less than 16 hours (2 x 8 hour 3 x 6 hour shifts) per week. Night duty is not included as supervised practice. It is anticipated that competence may be demonstrated after a minimum of 6 weeks and 12 weeks maximum. If supervised practice exceeds 12 weeks, the Board needs to be informed of the reason for the extension.

Assessment is based on the ANCI National Nursing Competencies Standards and should be undertaken by a division 1 registered nurse. A clinical assessment tool is available from the Board to assist the preceptors in their professional judgements about a nurse's competence and eligibility for re-registration (NBV 2000:3).

3.4.1.7 Queensland Nurses Council

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When compared with other states and territories named thus far, the requirement is also:

- A five-year period of recency to practice
- A self-declaration
- A self-assessment using the ANCI Competency Standards.
  And in contrast to states and territories previously discussed
- A random audit to monitor compliance with the specified requirements.

In terms of the Queensland Nursing Act 1992, Section 75 (2) (b) details aspects of the renewal process and states that applicants for renewal of registration have to provide proof of practice in the relevant area of nursing in the previous five years. In keeping with the legislation, the Queensland Nursing Council implemented a self-assessment process for recency of practice and Continuing Competence in the 1997/98 annual license renewal periods. Part of this process recognises that individual nurses have the

responsibility for the assessment of their own competence in relation to the annual renewal of their licence. An auditing process was established to enable the Council to monitor the validity of the statements of recency of practice and fitness and competence to practise (Queensland Nursing Council, 1997:1).

3.4.1.8 Nursing Board of Tasmania

When compared with other states and territories discussed, the requirement is also a five-year period of recency to practice; a self-declaration; a self-assessment using the ANCI Competency Standards; and a random audit to monitor compliance with the specified requirements (Nursing Board of Tasmania, 1998:2).

The Tasmania Nurses' Act 1995 states that on granting licensure to nurses to practise, the Board has a statutory obligation under section 22 of the Act to ensure that the applicant "…has sufficient physical capacity, mental capacity and competence to practice". Section 34 of the Act imposes similar obligations on the Board in relation to the practice of midwifery.

The provisions of Section 50 (6) and (7) of the Act require the Board to be satisfied, as far as is practicable, that applicants applying for renewal of their annual practising certificates have maintained their competence to practise. These sections of the Act were formulated in the interests of the public and to ensure that nurses who are approved for continued licensure are safe and competent to practise as part of a wider emphasis on professional practice and accountability (Nursing Board of Tasmania, 1998:2).

Forms of evidence required for a currently practising nurse for the renewal of an annual practising certificate to satisfy audit requirements may include:

- A satisfactory workplace performance appraisal that meets ANCI competencies, or
- A declaration from an employer or superviser confirming the applicant's abilities, or
- Evidence of peer review processes or if currently not practising

- A satisfactory workplace performance appraisal from a previous employer, or
- Evidence of completion of an accredited pre- registration, per-enrolment, post-graduate clinical award or re-entry programme within the preceding five years, or
- Evidence of peer review processes or other documentary evidence, which the applicant believes, demonstrates her maintenance of competence in practice (Nursing Board of Tasmania, 1992:4).

Table 3.2 illustrates a summary of the approaches to re-licensing in the various states and territories of Australia.

Table 3 2: Summary of re-licensing approaches in Australia
(Pearson, 1999:11) *Shaded* areas *indicate the implementation of the content in the appropriate title column*

State or Territory in Australia	Payment of fee only	Payment of fee and requirement of recency to practice	Payment of fee; requirement of recency to practice and self-declaration	Payment of fee; requirement of recency to practise; self-declaration and random audit
New South Wales	■			
Australian Capital Territory		■		
South Australia		■		
Western Australia		■		
Northern Territory		■		
Victoria			■	
Queensland				■
Tasmania				■

The descriptive analysis of the various states and territories of Australia discloses similarities and differences with regard to the maintenance of Continuing Competence. The most common trend is a five-year recency of practice clause. This is fairly meaningless as it does not specify how much practice, either the quality, quantum or type, or whether the practice is relevant to the current area of employment. Some authorities consider that establishing competency to practise is the responsibility of the nurse and the

employing body and so they do not have the recency of practice clause in their legislation (Llife, 2000; personal correspondence). Llife (2000) summed up the situation in Australia at that time as:

> "Generally nurses in Australia do not support mandatory Continuing Education linked to registration. The main reasons relate to there being no research which supports mandatory education as contributing to improved outcomes for patients, concerns about the quality of the educational offerings, the relevance to the area of practice, who bears the costs, access for nurses in rural and remote areas, the contradiction of the concept mandatory linked to education and adult education principles, and the absence of any evidence, based on reports to the nursing registering authorities, or significant instances of incompetence by nurses" (Ilife, 2000: personal correspondence).

The ANCI then determined it necessary to commission a research project entitled "A Study to Identify the Indicators of Continuing Competence in Nursing". Table 3.3 reflects a summary of the findings of this study that are relevant to Australia:

Table 3.3: Summary of consultation findings
(Pearson, 1999:57)

State/ Territory	A (Fee only)	B (ANCI quest)	C (Port-folio)	D (B and C)	E (Decla-ration and audit)	F Recency of Prac	Other comments
Western Australia							Recommend portfolio in response to an audit
South Australia							Recommend portfolio n response to an audit
Victoria							NBV supports E but a single format for audit not practical
Tasmania							Recommend portfolio in response to an audit
New South Wales							Only the public forum group supported option D & E
Queensland							Many recommended portfolio in response to an audit
Australian Capital Territory							Recommend portfolio in response to an audit
Northern Territory							Recommend portfolio in response to an audit

Key:

	Majority support for this option
	A sizeable minority support this option
	There is some support for this option
	There is no strong support for this option

Results of the analysis indicated that the majority of nurses around Australia (with the exception of Queensland) do not believe that the current approach taken by their state or territory addresses the profession's need to guarantee the competence of registered nurses. It was also clear that the option of a fee only was not seen (except for NSW) as having any utility in terms of that options ability to either provide evidence of professional development or evidence of Continuing Competence. Signing a legal declaration annually (based on the document used by the Queensland Nursing Council) was clearly favoured by the nurses surveyed.

The overall findings of the ANCI Final Report, 1999 suggests a need for a national approach to developing a strategy to monitor Continuing Competence in nursing. This would firstly entail that nurses are required to sign a legal declaration in order to be re-licensed or be issued with a practising certificate. This should be a simple declaration to avoid confusion and a high administrative workload. Every nurse needs to be clear on what the declaration entails and the ensuing responsibilities. Secondly, regulatory authorities should conduct a random audit each year (as a quality monitoring process) (Pearson, 1999:65).

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It was evident from the study data that a random audit process would be supported by a majority of nurses if the audit were not directly linked to re-licensure; that is, the audit should be constructed as a quality assurance process by regulatory authorities and not as an adjunct to re-licensing. The proportion of nurses to be audited was not a question of central importance and need not be standard across all jurisdictions; of more importance was the regular, random audit each year. Nurses who are to be audited should be informed in writing and asked to provide evidence, within one month, of their competence to practise as a nurse (Pearson, 1999:66).

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It should also be noted that this study did not find evidence that the profession would support a standardised portfolio as a mandatory format for audit; rather a portfolio in a wider sense as a reliable record for a professional to keep and to use may be useful for auditing purposes, when applying for a new position

or as a means of self- appraisal (Pearson, 1999:67). This national study, involving nursing regulatory authorities, nurses, nurses associations, employers and other key stakeholders, has found broad agreement on monitoring Continuing Competence in nursing that transcends state borders.

On the basis of the findings outlined, the following recommendations (Pearson, 1999:70) are valuable for the purposes of this study:

1. “The ANCI develop a policy which supports the introduction of a requirement for nurses to submit a signed legal declaration of competence annually when applying for re-licensure.
2. The state/territory nursing regulatory authorities introduce a requirement for nurses to submit a signed legal declaration of competence so as to implement the ANCI policy.
3. The ANCI develop a policy which supports the introduction of a random auditing process by nursing regulatory authorities as a quality assurance process.
4. The state/territory nursing regulatory authorities introduce a random auditing process by nursing regulatory authorities as a quality assurance process.
5. The ANCI develop a policy which supports the view that nurses should be free to respond to the auditing process using a format supported by the nurse.
6. The state/territory nursing regulatory authorities develop a policy which supports the view that nurses should be free to respond to the auditing process using a format supported by the nurse.
7. The ANCI develop a policy that supports the view that the professional development component of auditing is the legitimate role of nursing profession and industrial associations.
8. The ANCI develop a strategy to encourage professional associations to assist nurses to develop approaches to assure nurses and regulatory bodies that they can legitimately sign a declaration of competence.
9. The Australian Nursing Federation; the Royal College of Nursing, Australia; the New South Wales College of Nursing; and other generalist nursing organisations develop portfolio designs, workshops and guidelines

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for nurses to support them to develop professionally and to satisfy the requirements should they be audited; and

10. The ANCI, State and Territory nursing regulatory authorities; Australian Nursing Federation; the Royal College of Nursing, Australia; the New South Wales College of Nursing; and other generalist nursing organisations consider these recommendations and generate informed debate in nursing, the health care system and the community to promote Continuing Competence in nursing."

These recommendations serve as a source of information to countries such as South Africa where the processes for developing a CPD system are new and not researched. Despite the realities of differing contexts, socio-political influences and economic factors, the commitment to quality health care is global and sharing lessons learnt could enrich the development of a CPD system for all nurses and midwives and ultimately benefit the communities who rightfully are entitled to service excellence.

(d) Outcome

The aforementioned research project reflects that the desired outcome for Continuing Competence in the states and territories of Australia is safe and competent practitioners that maintain their knowledge and skills through professional development activities (Pearson, 1999:41).

(f) Summary

The purpose of CPD in Australia is to protect the public by at least assuring them of competent practitioners. In South Africa, where healthcare is a primary right in terms of the Constitution (Act 101 of 1996), it also becomes necessary for the South African public to be assured of competent and safe practitioners, which, it is hoped, would provide quality health care.

In order to achieve this purpose, the states and territories in Australia have provided for various Nursing Acts, a Code of Ethics and a Professional Code of Conduct. Since 1994, with the advent of the new democracy, moves in South Africa to transform outdated legislation have been underway to align

them to current developments in public protection and quality assurance. The content of the new legislation and more specifically, the new Nursing Act should, as in Australia, make statutory provisions by way of mandatory provision in the new Nursing Act to regulate and enforce the implementation of Continuing Professional Development. Furthermore, through the development of and the adherence to competency based standards, including Continuing Professional Development in the Code of Ethics and the Code of Conduct for nurses and midwives in South Africa.

The current situation in South Africa is that there are no provisions to stipulate minimum periods for nurses and midwives to re-register after a period of non-practice, except for the payment of a restoration fee. This situation needs to be corrected by applying the lessons learnt in the Australian model, namely, evidence of a five-year recency of practice period. The SANC must stipulate in the necessary legislation, a time frame in which, nurses and midwives may re-register. Should nurses/midwives fail to meet the specified time frame, then evidence of a programme, run at a facility, which is approved by the SANC, should be completed.

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However, it could be argued that the period of non-practice could be adapted to individual circumstances such as, professional qualifications and/or a particular post level. Having stated this, it should emphasised that specific guidelines need to be laid down, so that decisions do not advantage or disadvantage potential applicants and neither are standards compromised.

In May, 2002 the Nurses' Board of Western Australia sent out a 'Discussion Paper' that provided an opportunity for nurses and midwives, employers and members of the public to comment on the proposed introduction of assessing continuing professional competence of nurses and midwives in Western Australia. Although the SANC's membership includes nine community representatives of each of the nine provinces of South Africa, the fact that the SANC works on the principles of democracy, transparency, collaboration and inclusivity should cause the SANC not to lose sight of the significance of wide

and sufficient consultation with its stakeholders and the profession at large. The Australian method of the completion and submission of a declaration for the renewal of registration, stating her competence to practise as a nurse and midwife, should be recommended for adoption in South Africa as nurses and midwives are held accountable for their own acts and omissions and compliance with the proposed CPD system should be the responsibility of the nurses and midwife.

The self-assessment method of the NBV is recommended because it allows the nurse and midwife to critically reflect on her own professional competence. One of the drawbacks of this method is that it is open to subjectivity. A way of counteracting the subjectivity is to put in place monitoring tools with clearly defined criteria. Furthermore, a self-assessment should be supplemented by other assessment methods as is described under the Nurses' Board of Victoria.

The implementation of a random audit to monitor compliance with Continuing Competence requirements, is highly recommendable, provided that the random sampling is scientifically based and stratified in terms of the various categories of nurses and midwives on the register and roll of South Africa.

What lessons could South Africa learn from the system for Continuing Competence for nurses and midwives in Australia? Table 3.4 lists the recommendations for consideration in South Africa.

Table 3.4: Aspects of Continuing Competence in Australia for consideration for nurses and midwives in the South African context

Aspects for consideration:
❑ Wide and sufficient consultation with stakeholders and the profession at large
❑ A national approach to implement and monitor CPD
❑ Evidence of recency of practice – within the 5-year period prior to the date of re registration
❑ Self-assessment method to allow nurses/midwives to critically reflect on her own professional competence
❑ Submission of a signed legal declaration of compliance with Continuing Competence annually
❑ Maintenance of a portfolio of evidence
❑ Professional organisations to assist nurses/midwives with guidelines on the development of portfolios of evidence to satisfy requirements should they be audited
❑ The conduct of a random audit annually by the regulatory authority
❑ The regulatory authority to commission ongoing research on Continuing Competence for nurses and midwives.

Having described Continuing Competence in Australia and highlighted aspects for consideration for the development of a CPD system for nurses and midwives in South Africa, a description of Continuing Professional Development for nurses and midwives in the United Kingdom follows.

3.4.2 The United Kingdom

In contrast to Australia, the United Kingdom has a monarchical system of government consisting of the four interdependent sovereign states, namely England, Scotland, Northern Ireland and Wales.

Untill 1 April 2002 the nurses, midwives and health visitors in the United Kingdom were regulated by the United Kingdom Central Council For Nursing, Midwifery and Health visiting (UKCC). The UKCC worked in collaboration with four national boards for nursing, midwifery and health visiting for England, Scotland, Wales and Northern Ireland respectively. These four boards were:

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1. English National Board for Nursing, midwifery and Health Visiting (ENB)
2. National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS)
3. Welsh National Board for Nursing, Midwifery and Health Visiting (WNB)
4. National Board for Nursing, Midwifery and Health Visiting for Northern Ireland (NBNI) (Wallace, 1999:97).

These Boards were responsible for several aspects of regulation and assisted the UKCC in ensuring that the standards of education and practice of the UKCC, including Post Registration Education and Practice (PREP) – the UKCC's term for CPD, were adhered to. The UKCC was instrumental in implementing PREP on 1 April 1995 after a developmental phase since August 1988 (Wallace, 1999:97).

The Nursing and Midwifery Council (NMC) has replaced the UKCC on 1 April 2002. The four national boards have also been replaced. The NMC has contracted with new bodies to deliver the NMC's educational quality assurance model in England, Scotland, Wales and Northern Ireland (UK Press statement, 2 August 2002, unidentified).

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The findings on CPD in the United Kingdom will be described according to the format of purpose, structure, process, outcome and summary.

(a) Purpose

The purpose for the development of PREP was to put a framework in place which enables practitioners to maintain and develop their professional knowledge and competence" (Wallace, 1999:124), and also "to regulate the professions in as flexible, innovative, yet adult way as possible" (Wallace, 1999:110).

According to the NMC's revised publication, the purposes of PREP are to:

- Help nurses and midwives provide the best possible care to their patients

- Assist nurses and midwives to keep up to date with new developments in practice
- Encourage nurses and midwives to reflect on their practice and
- Enable nurses and midwives to demonstrate to their patients, colleagues and themselves that they are keeping up to date and developing in their specific area of practice (NMC, 2002:1).

The main PREP standards for the purpose of this study are:

The PREP (practice) standard and

The PREP (CPD) standard.

Wallace (1999) delineates the purpose for the PREP (practice) standard as to ensure that practitioners seeking to renew their registration "re-enter practice with up to date competency, current skills and confidence in order to maintain safe and effective standards of patient and client care" (UKCC1995b, 1996b In: Wallace, 1999:124).

This reviewed NMC publication also refers to "PREP providing an excellent framework for Continuing Professional Development, which, although not a guarantee of competence, is a key component of clinical governance" (NMC, 2002:3). In order to ensure effective clinical governance, PREP needs to be arranged and organised into a cohesive structure.

(b) Structure

The structure refers to the systems, policies, forms, staff and budget as a support framework for CPD. Some of the key structural elements are the educational and behavioural requirements. There are four major sets of requirements relating to the UKCC's standards for education and practice following registration:

1. Standards for a period of support for newly registered practitioners, under the guidance of a preceptor
2. Standards for maintaining registration
3. Standards for *return-to-practice programme*s
4. Standards for specialist's programmes (Wallace, 1999:113).

For the purpose of this study, the first standard will be described briefly while the next two standards will be described in greater detail.

The first standard, which relates to requirements for a period of preceptorship, received such widespread and unequivocal support that it was published in advance of the other PREP (CPD) proposals in January 1993 (UKCC 1993 In: Wallace M, 1999:114). It is UKCC policy that all newly registered nurses, midwives and health visitors should be provided with a period of support, where possible under the guidance of a preceptor, for approximately the first four months of registered practice. This period is not regarded as an extension of the formal education and training programme, as individuals would already have met the UKCC's requirements for registration. In all its documentation, the UKCC emphasises that nurses, midwives and health visitors are accountable for their practice from the time of registration, regardless of a support system.

The second standard, which requires maintaining registration, consists of two types of PREP standards, namely:

- The PREP (CPD) Standard and
- The Practice Standard.

This PREP (CPD) standard requires that a record, in the form of a personal professional profile, be kept of the practitioner's CPD activities over the three years prior to the renewal of registration (NMC, 2002:4).

The PREP practice standard requires that nurses and midwives must have practised for a minimum of 100 days or 750 hours during the previous five

years, or have successfully undertaken an approved return-to-practice course – the third standard, referred to in paragraph two on the previous page.

The administration of PREP does not entail the approval of CPD activities, neither is there a need for the submission of attendance certificates. There is also no point allocation. A structured form referred to as the PREP (CPD) summary form will only be sent to nurses and midwives who will be included in the sample for auditing compliance with the PREP (CPD) standard. Only the completed contents of the PREP (CPD) summary form are used for the purpose of monitoring compliance with the PREP (CPD) Standard (NMC, 2002:7).

Other documentation necessary for the PREP (CPD) standard is the personal professional portfolio (PPP) that is kept by nurses and midwives as documented evidence of the learning activities that they were engaged in over the three-year period and how it affected their professional practice. A suggested template has been designed by the NMC as a proposed format for recording evidence of PREP (CPD) learning.

Every three years nurse and midwife has to renew her registration. A completed and signed notification of practice form has to accompany the registration fee to successfully renew registration. The notification of practice form requires that the nurse and midwife sign a declaration that the PREP requirements have been met (NMC, 2002:1).

Information on budgetary allocations for the implementation of the PREP (CPD) standard was unattainable. However, quotations on costs for pursuing the possibility of developing Council profiles for the practitioners, to record their learning activities, was cited in Wallace (1999). An estimated initial lay-out cost of 4 million pounds for the first three years and approximately 1 million pounds thereafter, depending on the number of newly registered practitioners, was reflected. The decision to develop Council profiles was subsequently rescinded in May 1994 because there were too many profiles of all ranges, cost and quality available on the market. It was therefore agreed

that it would not be beneficial or cost effective to spend practitioner's money on providing Council profiles. Instead it was decided to provide detailed guidance to every practitioner on the compilation of a personal professional profile (PPP) and the contents thereof (Wallace, 1999:88).

(c) Process

During the research it was found necessary to introduce the implementation of CPD by first reflecting on the wide consultation process that was followed in the developmental stages of PREP (CPD) in the United Kingdom. This consultative and interactive process is necessary for the successful implementation of the PREP (CPD) standard. Although the UKCC is an independent body, financed by the licensing fees of the registrants, it also needs government support on matters of significant policy change that affects large numbers of the professional workforce (Wallace, 1999:93).

From August 1988 to May 1990 three working groups were established to investigate the nature of professional practice, the processes of professional education and development and the requirements for Continuing Competence to practise. The groups consisted of members of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC); the four National Boards; and nurses, midwives and health visitors with relevant experience and representative of England, Scotland, Northern Ireland and Wales. A professional officer of the UKCC was assigned to service each group (Wallace, 1999:94).

A discussion document was circulated in January 1990, when the wide, six month consultative process began and inputs and comments were invited from the four National Boards (English National Board for Nursing, Midwifery and Health Visiting; National Board for Nursing, Midwifery and Health Visiting for Scotland; Northern Ireland National Board for Nursing, Midwifery and Health Visiting Centre House; Welsh National Board for Nursing, Midwifery and Health Visiting), the professional organisations, trade unions, health

authorities, and all the nurses, midwives and health visitors that were on the registers of the Council.

At this stage, each health authority (as they were then constituted, with a role in service provision) was invited to appoint a 'link officer' who would act as a conduit of UKCC information on PREP. This person would also attend special invitation events designed to ensure the dissemination of as much accurate information possible (Wallace, 1999:118).

To achieve this spread of information, a total of 20 road shows were held, one in each of the then regional health authorities in England and two in each in Scotland, Wales and Northern Ireland. Council officers and members also undertook a wide range of speaking engagements, specifically to discuss PREP (CPD).

PREP was intended to be as inclusive as possible as practice is not intended to embrace only those engaged in clinical activity. In other ways, if practitioners are using a nursing, midwifery or health visiting qualification in some capacity in their daily work, then they are expected to maintain their registration and thus comply with the PREP requirements. The onus is placed on the individual practitioner to maintain her registration. This approach was based on the assumption that all the individuals on the register are professionally accountable and responsible individuals, who all practise under the principles set out in their professional code of conduct (Wallace, 1999:119).

The UKCC's flexible but principled approach was demonstrated in June 1996 when it agreed to extend the notion of being 'in practice' to individuals who are not in remunerative formal employment, but use their professional qualification to care for an ailing dependant at home. PREP in practice terms, therefore also includes the delivery of nursing care in an unpaid capacity to a friend, relative, or dependant provided that:

- The assessment, planning and implementation of physical or psychological care is involved

- The services of a professional care-giver or in-patient care would be required if the individual were not available (Wallace, 1999:120).

It became very important that the road shows, referred to above, had to be supplemented by hard copy mass communication. The implementation of PREP was therefore preceded by wide dissemination of information on the PREP (CPD) standard. The UKCC sent out an information brochure entitled "The Continuing Professional Development Standard" to all the nurses, midwives and health visitors on its registers in July 1999. The first PREP handbook was published by the UKCC in January 2001 and the revised version that replaced all previous publications, was published by the new NMC in April 2002 (NMC, 2002:2).

A. The PREP standards and guidelines

The PREP standards and guidelines, originally developed and published by the UKCC, remain largely unchanged as the new NMC only made a few textual changes and a small number of minor amendments (NMC, 2002:2). The reviewed PREP (CPD) standard can thus be summarised as follows:
The PREP (CPD) Standard requires the nurse/midwife to:

- Undertake at least five days or 35 hours of learning activity relevant to the developmental needs of the nurse/midwife's area of practice, during the three-year period, prior to the renewal of her registration
- Maintain a PPP of the learning activities and the way in which it they informed and influenced the nurse/midwife's practice
- Comply with the PREP (CPD) Standard in order to maintain her registration with the NMC (NMC, 2002:2).
- Comply with any request from the NMC to audit how the requirements have been met (NMC, 2002:2).

In addition a PREP fact sheet (UKCC 1994a) and a booklet titled 'PREP and You' were produced by the UKCC in 1997 (UKCC 1997a). Here the following steps were set out to assist practitioners to identify their developmental needs:

- First review area of competence
- Identify strengths and weaknesses
- Set learning objectives
- Set specific, realistic and attainable goals within particular timeframes
- Draw up an action plan
- Make entries in the personal professional profile- make the link between the activity undertaken and the effect it has on the individual's professional practice (Wallace, 1999:127).

Five days of study activity

The word activity, as used in the booklet referred to above, was deliberately chosen to ensure that practitioners understood that they were not required to be active on formal study days. The five days could be accumulated by engaging in appropriate activities on whole days or by utilising part of a day. A study day had no specific number assigned to it, which allowed for reasonable flexibility. The study did not have to be approved by anyone. The individual could choose an activity relevant to her needs, i.e. a planned visit to a library to do a literature search on a topic of particular interest. This would be acceptable provided that clearly formulated objectives and outcomes were documented in the practitioner's personal professional profile. Alternatively a planned group discussion on a new development in clinical practice could be held (Wallace, 1999:119).

Personal professional profile (PPP)

There is no official UKCC approved personal professional profile so that practitioners have maximum flexibility in what they could choose. The NMC provided a two-page template on a suggested format for recording evidence of PREP (CPD) learning in a PPP. The personal professional profile (PPP), briefly described previously, is a flexible, comprehensive account of a practitioner's development. It is a reflection of how the learning activities actually assisted the practitioner to maintain the needs based knowledge and competence. The profile goes beyond mere descriptions of achievements. It is

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about actively reflecting on and recording what is learned and how it is applied to daily practice (Wallace, 1999:125).

Each learning activity requires a description and record of:

- Its relevance to the practitioner's professional practice and development
- What the practitioner hoped to achieve from it
- The practitioners assessment of the outcomes of the activities
- The time spent on each activity and how it influenced the practitioner's work (NMC, 2002:8).

B. The PREP (practice) standard

The Nurses, Midwives and Health Visitors Act 1997 defines practising as "…working in some capacity by virtue of a qualification in nursing, midwifery or health visiting…". Since 1995, the PREP (practice) standard has required practitioners by virtue of their registration to have practised nursing, midwifery and/or health visiting for not less than 100 days (750 hours) during the five years prior to the renewal of their registration.

A practitioner who is registered as a nurse or a health visitor must have completed a minimum of 100 days (750 hours) of practice irrespective of the number of registrable nursing qualifications. If a practitioner has both a nursing and a midwifery registration and wishes to continue practising as a nurse and midwife, then 100 days (750 hours) of practice is a requisite for each qualification, that is a total 0f 200 days or 1500 hours of practice, divided equally between nursing and midwifery.

Practising midwives have to continue declaring their intention to practise annually in addition to completing their Notification of Practice form every three years when re-registering with the UKCC (Wallace, 1999:133). Since April 1998 practitioners have had to make a declaration on a notification of practice form to the effect: "I declare that I have completed the equivalent of five days of study activity since my last renewal of registration and maintained a personal professional profile" (Wallace, 1999:119).

The explanatory note reminds registrants that this is a formal declaration whereby the individual, as an accountable practitioner, confirms that she has met her legal requirements, in relation to the PREP requirements, for registration. If this standard has not been met then **a return-to-practice course** (approved by the NMC) **has to be completed for a registration to be renewed.**

When considering the needs of the CPD system for South Africa it would be beneficial to reflect on the following standard outcomes, formulated by the NMC, against which the return-to-practice courses are validated:

- An understanding of the influence of health and social policy relevant to the practice of nursing and midwifery
- An understanding of the requirements of legislation, guidelines, codes of practice and policies relevant to the practice of nursing and midwifery
- An understanding of the current structure and organisation of care, nationally and locally
- An understanding of current issues in nursing and midwifery education and practice
- The use of relevant literature and research to inform the practice of nursing and midwifery
- The ability to identify and assess need, design and implement interventions and evaluate outcomes in all relevant areas of practice, including the effective delivery of emergency care
- The ability to use effective communication, teaching and learning skills
- The ability to function effectively in a team and participate in a multiprofessional approach to the care of patients and clients
- The ability to identify strengths and weaknesses, acknowledge limitation of competence and recognise the importance of developing and maintaining professional competence (NMC, 2002:6).

The NMC also requires that an approved return-to-practice programme of not less than 5 days in length be completed by the practitioner. The education

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provider and the practitioner will determine the length and nature of the programme by considering for example, qualifications, previous levels of knowledge and experience. The requirements mentioned above need to satisfy certain expected outcomes. It is therefore necessary to consider the outcome of PREP.

(d) Outcome

The NMC expects that the outcome of PREP (CPD) standards and PREP (practice) standards will contribute to the provision of best possible care for the patients and clients and although **the PREP standards do not guarantee competence, they serve as a key component for clinical governance** (NMC, 2002:3). Emphasis on competency based training (Smith, 1999:1).

The UKCC Annual Report for 2000 to 2001 published the results for the piloting of the audit system, which was implemented from April 2001, to assess how nurses, midwives and health visitors were meeting PREP (CPD) standards. The pilot demonstrated a wide understanding of compliance with 90% of the respondents meeting the standards fully (UKCC, 2001:3).

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(e) Summary

The system for CPD for nurses and midwives who practise their professions in the United Kingdom is referred to as Post-registration education and practice (PREP). PREP is a set of the Nursing and Midwifery Council (NMC) standards and guidance that provides a framework for Continuing Professional Development, which, although not a guarantee of competence, is a key component of clinical governance. The PREP (CPD) standard accommodates a wide variety of settings and circumstances to make it accessible and attainable for all. The following excerpt from an NMC publication highlights this:

“The PREP (CPD) standard can be met in different ways, remember:

- It has to be motivated and it doesn’t have to cost the practitioner any money
- There are no approved learning activities

- No collection of points nor certificates of attendance
- No approved format for personal professional profiles (PPP)
- It has to be relevant to the practitioner's area of practice and explain how it influences current and future practice
- It has to be motivated by the intention to provide the highest possible standards of care for patients" (NMC, 2002:7).

Although PREP has a flexible approach in how the practitioner chooses to meet her PREP (CPD) standard, the following demands have to be met to maintain registration every three years:

- Undertake at least five days or 35 hours of learning activity relevant to the developmental needs of the nurse/midwife's area of practice, during the three-year period, prior to the renewal of her registration
- Maintain a PPP of the learning activities and the way in which they informed and influenced the nurse/midwife's practice
- Comply with the PREP (CPD) Standard in order to maintain her registration with the NMC
- Comply with any request from the NMC to audit how the PREP (CPD) requirements have been met (NMC, 2002:7).

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Over and above the PREP (CPD) standard, the following PREP (practice) standard requirements are also mandatory:

- A practitioner who is registered as a nurse or a health visitor must have completed a minimum of 100 days (750 hours) of practice irrespective of the number of registrable nursing qualifications.
- A practitioner who has both a nursing and a midwifery registration and wishes to continue practising as a nurse and midwife requires 100 days (750 hours) of practice for each qualification
- Every three years practitioners have to submit a completed notification of practice (NOP) form together with the prescribed registration fee.

Practising midwives must continue to communicate their intention to practise annually in addition to completing their notification of practice form every three years when re-registering with the NMC.

Whilst there is an element of protecting the public in the UK, the main purpose for PREP is professional competence. In South Africa, the mandate of the SANC is to protect the public, primarily. This protection is as much dependent on correct professional, ethical and moral standards as on socio-political and practical practices to safeguard the public. So whilst the protection of the public is the prime responsibility of the SANC, one should not lose sight of the emphasis on the professional elements of the purpose of CPD as in the UK.

In terms of the structure of PREP in the UK, South Africa has much to learn from their emphasis and urgency on a need to support newly qualified registered nurses/midwives in a mentor/mentee relationship set up for the first four months of their practice. Keeping a personal professional profile provides a useful tool not only for recording of past CPD activities but also a document for projection into the future of what still needs to be achieved. It also reveals the professional needs of the practice. One of the burdens of such a reflective portfolio is that it requires disciplined paperwork entries. The non-insistence on the approval of CPD activities, submission of attendance certificates and point allocation in the United Kingdom would be highly acceptable in the South African context where there is a dearth of administrative personnel and capacity. The SANC is a case in point: staff is insufficient, systems are lacking and budgetary constraints are prohibitive as the SANC is a nonprofit-making statutory body.

The requirement of evidence of 750 hours of practice for the renewal of registration as a nurse and evidence of an additional 750 hours of practice to register as a midwife, as is done in the UK, might be worth considering in South Africa if the difficulties accompanying it could be eliminated. One of the main challenges would be that nurses and midwives in private practice would have an added responsibility of keeping time sheets as evidence of hours of practice. Is this feasible and realistic in a country such as South Africa with

vastly differing socio-economic communities? Evidence of practice, with specific reference to the area of practice would suffice in the South African context.

Table 3.5: Aspects of the Post Registration Education and Practice Standard (PREP) of the United Kingdom for nurses and midwives in the South African context:

Aspects for consideration:

- Wide and sufficient consultation with stakeholders and the profession at large
- A national approach to implement and monitor CPD
- Evidence of recency of practice – within the 5-year period prior to the date of re-registration
- A *return-to-practice programme*, approved by the NMC, to be completed for a registration to be renewed (if no evidence of recency of practice)
- Self-assessment method to allow nurses/midwives to critically reflect on her own professional competence
- Submission of a signed legal declaration of compliance with Continuing Competence annually
- Maintenance of a personal professional profile where a record of what was learned and how it is applied to daily practice
- The conduct of a random audit annually by the regulatory authority
- The regulatory authority to commission ongoing research on Continuing Competence for nurses and midwives.

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Having described Continuing Competence in United Kingdom and highlighted aspects for consideration for the development of a CPD system for nurses and midwives in South Africa, a description of Continuing Professional Development for nurses and midwives in California in the USA follows.

3.4.3 United States of America

In contrast to both Australia and the United Kingdom, the USA has a federal system of government in which each of the 50 states has its own legislature and its own executive system. This system results in statutory arrangements by which each state decides on those controls which are not subject to central government vetoes. The central federal constitution of the USA deals mainly with human rights issues. Each state has in all other respects jurisdiction over its own affairs. It is the obligation of state legislatures to protect its citizens (Deloughery, 1998:276).

There are 55 state boards of Nursing in the respective states of the USA. Traditionally the state boards have discharged their responsibility to protect the public by licensing qualified individuals to practise nursing, denying licenses to the unqualified and disciplining those individuals who are incompetent, negligent or in violation of the relevant Nursing Practice Act. The usual qualifications for licensure are educational preparation in an approved programme and passing the licensure examination (Deloughery, 1998:276).

In the 1960s and 1970s, the consumer movement questioned the issue of continued competence for licensees, which contributed what was at the time referred to as the 'Sunset legislation'. This legislation challenged regulatory bodies to demonstrate their cost effectiveness. As an outcome of the Sunset review process, professional and occupational boards, including nursing boards, were mandated to establish mechanisms for assuring the continued competence of their licensees. In 1971, California became the first state to pass a law requiring CE for re-licensure (Deloughery, 1998:309).

Several approaches such as peer review, self-evaluation, employer-directed evaluation and re-examination were discussed then and continue to be discussed now. In 1993, a new paradigm was presented, in that licensees and not the regulatory bodies were made primarily responsible for their Continuing Competence. The state boards shifted from being assurer to collaborator with licensees and employers. The licensee became responsible for self-

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assessment and self-limitation. Nevertheless, the increasingly complex healthcare environment, rapid advances in health care sciences and growing public sophistication created an expectation that state nursing boards provide assurance that the licensed nurse is competent (Deloughery, 1998:277).

According to a 1996 annual Continuing Education survey conducted by *The Journal of Continuing Education in Nursing*, 25 State Boards had Continuing Education requirements for license renewal. These requirements were either for all nurses or in some states for those nurses who worked in specialised fields (Deloughery, 1998:317).

In the USA, the term used for the Continuing Professional Development System is Continuing Education (CE). Each state sets up its own standard for the number of Continuing Education Units (CEUs) needed for a re-licensure in a license renewal period. The requirements of most states fall somewhere in the 1.5 to 4.5 CEU range per renewal period (Deloughery, 1998:315). A detailed account of the interpretation of CEUs is given after the next four pages.

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For purposes of this study, Continuing Education in only one of the 50 states in the USA, namely, California will be described. It would be an onerous task and not in the interest of this research to attempt to do a detailed analysis of all the states.

(a) Purpose

The purpose cited in the literature is to build upon the educational and experiential bases of the professional nurse for the enhancement of practice, education, administration, research or theory development, to the end of improving the health of the public (Deloughery, 1998:310). Over and above this health care institutions continue to provide CE because it is:

- Consistent with the mission and philosophy of nursing staff development of many institutions
- An attractive employment benefit that will attract and retain staff when it is provided at the institution's expense
- Compatible with the education standards listed for hospital accreditation by joint Commission on Accreditation of Healthcare Organisations (JCAHO)
- Enforced by the Board of Nursing as minimum standards of practice for public protection (Deloughery, 1998:280).

(b) Structure

California first mandated Continuing Education for nurses in 1971. Since I July 1978, Californian registered nurses have been required to document continued competency by completing a minimum of 30 contact hours every two years in subjects relevant to the practice of nursing in order to be licensed.

The American Nurses' Association describes the content of CE programmes as consisting of concepts, principles, research findings or theories related to nursing that build on the nurse's previously acquired knowledge, skills and attitude. Many states have adopted similar specifications for subject matter that is considered appropriate for Continuing Education. California's content statement is a good example:

A more detailed analysis of CE discloses that:
"The content of all courses of Continuing Education must be relevant to the practice of nursing and must:

- Be related to the scientific knowledge and/or technical skills required for the practice of nursing, or
- be related to direct and/or indirect patient/client care.
- Learning experiences are expected to enhance the knowledge of the Registered Nurse, at a level, above that required for licensure.

- The content has to be current and designed to include recent developments in the subject area being taught.
- Course offerings must be at least one hour in length" (Nursing Practice Act, 1994:58).

> Content which includes the application of scientific knowledge to patient care in addition to advanced nursing courses may include nursing administration, management, education, research, or other functional areas of nursing relating to indirect patient/client care would be acceptable. Courses which deal with self-improvement, financial gain and those courses designed for lay people, are not acceptable for meeting requirements for license renewal" (Nursing Practice Act, 1994:58).

It is important to note that the California Board of Registered Nursing (hereafter referred to as the Board) approves CE providers and not individual courses. Each CE provider is expected to offer course content and utilise instructors that meet the requirements of Sections 1456 and 1457, Title 16, and the California Code of Regulations. The requisite details on forms supplied by the Board have to be completed accurately before submission. A checklist of common mistakes is also enclosed to facilitate the processing of the application (California Board of Registered Nursing, undated).

Each application form carries an additional clause stating that providers who are planning to offer the 30 contact hour pharmacology for nurse practitioners and/or nurse midwives are advised to contact the CE staff at the Board, to ensure that the course meets its requirements (California Board of Registered Nursing, August 2002, personal correspondence).

Conferences and courses offered in other countries may receive credit for continuing contact hours if the CE provider chooses to develop an independent study with the nurse(s) and determine that the course and faculty meet the Board's required information (course/conference objectives, etc.). The certificate of completion would use the CE provider's number. Thorough

planning prior to the attendance of such courses or conferences is encouraged.

The Board must be notified within 30 days of any change in mailing address, organisational structure or the person responsible for coordinating the CE course(s). The CE provider number allocated by the Board expires two years from the date of initial issuance. The Board mails a renewal notice to the address on record approximately three months prior to the expiration date. Failure of the receipt of a renewal notice does not remove the responsibility of a provider to renew her application timeously. A delinquent fee is added to the renewal fee when the renewal fee and form are received after midnight of the renewal date. A detailed analysis of the calculation of contact hours follows.

A. Calculation of continuing contact hours

The following are examples of how continuing contact hours are calculated in California:

- Each contact hour is at least 50 minutes of instruction in an organised learning experience (Title 16, CCR)
- Courses less than one hour (60 minutes) in duration will not be approved (Title 16, CCR)
- Each hour of theory equals one CE contact hour (Title 16, CCR).

The time required to process a completed application is a minimum of four to six weeks. Careful preparation of the required documents will facilitate the review processing time. An application fee of $200 has to be included with the submission of the application. This fee is charged for the evaluation of the application and it is not refundable. A printed certificate containing the applicant's CE provider number will be mailed to the applicant on approval of the application (California Board of Registered Nursing, undated).

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B. Withdrawal of approval or denial of application

The board may withdraw its approval from a provider or deny an application (Title 16, CCR, Section 1459.1) for causes that include but are not limited to the following:

- Conviction of a felony or any offence substantially related to the activities of a provider
- Any material misrepresentation of fact by a CE provider or applicant in any information required to be submitted to the Board
- Any violation of conditions specified in the CCR.

The Board may withdraw its approval of a provider after giving the provider written notice and stating the reason for the withdrawal. Should the Board deny the provider approval, the applicant has the opportunity to formally appeal the action to the Board within a period of 30 days. Other conditions related to CE activities that are specified by the Board for the implementation of CE activities will be described under the subheading, process (California Board of Registered Nursing, undated).

C. Costs

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A cost for the administration of Continuing Education at the Board could not be quantified. It is however perceived to be costly as a result of the precision with which the administration is managed. In terms of costs for the nurses and midwives, reference is made to the competitive market that prevails because of CE activities. Although this competitive market keeps prices low and increases the availability of courses, it also causes problems for accrediting agencies that are obligated to monitor providers who compromise the quality of courses, by cutting costs and offering them at competitive prices (California Board of Registered Nursing, undated).

(c) Process

Before describing the process of Continuing Education it would be beneficial to reflect briefly on how nurses' needs are assessed. Health care agencies,

educational institutions, state boards, accrediting agencies and independent providers all have difficulty in finding the answer to this question (Deloughery, 1998:311). Part of the difficulty lays in the fact that nurses form a heterogeneous group comprising different practitioners. Healthcare organisations access data that provide valuable opportunities to conduct valid needs assessments through:

- Interviews with head nurses and supervisors
- Data collected from nursing care audits of client records
- Reports from quality assurance committees
- Recommendations from Joint Commission on Accreditation of Healthcare Organisations (JCAHO)
- Needs assessment surveys of staff.

Nursing care audits and quality assurance reports when used in conjunction with other assessment tools, provide needs analyses that differentiate perceived learning needs from actual performance needs (Deloughery, 1998:11).

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Although professional nurses remain ultimately responsible for their ongoing professional development, The American Nurses' Association (ANA) as the professional association and a provider of continuing nursing education, shares in this responsibility of providing CE activities (ANA, 2003:1). The ANA's Standards guide the planning, implementation and evaluation of its Professional Development and CE activities for Nursing Professional Development, Continuing Education and Staff Development. The role of ANA with regard to CE will be described further in this chapter.

It would be appropriate to describe the Board's specifications to understand the process issues pertaining to the implementation of Continuing Education. These specifications concern:

A. Advertisements
B. Proof of attendance

C. Provider policies
D. Instructor's requirements
E. Unacceptable course content
F. Record keeping by providers
G. Course evaluations
H. Audits of Continuing Education
I. Providers (California Board of Registered Nursing, undated)

A. Advertisements

Information used by CE providers to advertise CE courses has to include the information noted in Title 16, CCR, Section 1459. Examples of the requisite details are:

- The full statement "Provider approved by the California Board of Registered Nursing, Provider Number__________, for_______ contact hours" has to be included in all advertisements.
- Provider's policy regarding refunds (including time lines) for non-attendance by the registrant.
- A clear, concise description of the course content and/or objectives is required.
- Provider name stated as it appears on the official file of the Board.

It should be noted that if the person attends courses that are not included in her current scope of practice, she is not authorised to add such skills to her practice. Advertisements should not mislead the potential applicants. Failure to monitor this can lead to complaints of false advertising and possible removal of the CE provider's approval (California Board of Registered Nursing, undated).

B. Proof of attendance

Providers have to issue a document, such as a certificate, grade slip, or transcript to each licensee to show that the individual has met the established criteria for successful completion of a course (Title 16, CCR, Section 1458). A document indicating successful completion has to contain the information

listed in Title 16, CCR, Section 1458 (b). Hand written, electronic or stamped signatures on the certificates are acceptable.

C. Provider's policies

Each provider is required to have written policies available on request, describing:

- Refund policy with regard to non attendance and notification of the course
- Notification process if course is cancelled
- Time period within which the full or partial registration fee will be refunded (California Board of Registered Nursing, undated).

D. Instructor's requirements

The following requirements for registered nurses and non-registered nurse instructors appear in Title 16,CCR, Section 1457:

- Registered nurse instructors need to have a current valid license
- Be free from any disciplinary action by the Board
- Be knowledgeable, current and skillful in area of specialty
- Have prior experience in teaching the subject material within the previous two years
- Or at least one year's experience within the last two years in the specialised area in which they are teaching (California Board of Registered Nursing, undated).

Non-nurse instructors have to be:

- Currently licensed or certified in the area of expertise
- Show evidence of specialised training in the subject area
- Have at least one year's experience within the last two years in the practice of teaching of the specialised area to be taught.

E. Unacceptable course content is regarded as:

- Courses which focus on self-improvement
- Economic courses for financial
- Courses designed for lay people
- Liberal arts courses in music, art, philosophy and others when unrelated to client/patient care
- Orientation programmes – orientation meaning a specific series of activities designed to familiarise employees with the policies and procedures of an institution
- Courses which focus on personal appearances in nursing
- CPR, BLS, Basic EKG/dysrhythmia and IV therapy courses that are similar to those used to certify licensed vocational nurses to start intravenous infusions (California Board of Registered Nursing, undated).

F. Record keeping by providers

Each provider is required to maintain the following records for each course offered for a period of four years in one location in the State of California or a place approved by the Board. The requirements of Title 16, CCR, Sections 1454 (d) and (f) include retaining:

- Date(s), place (s) and course outline
- *Curriculum vitae* or résumés for all instructors
- Name and license number of registered nurses taking the course
- Record of any certificate issued to them (California Board of Registered Nursing, undated).

G. Course evaluations

As part of the evaluation process, the Board recommends that all courses be evaluated for at least the following:

- The extent to which the course met the objectives
- The applicability or usability of the new information
- The adequacy of the instructor's mastery of the subject
- The appropriateness of teaching methods used

- Efficiency of the course mechanics (room, space, acoustics, lighting, audiovisuals, handouts, etc.).

H. Audits of Continuing Education providers

In addition to the course evaluations, the Board is authorised to audit records, courses, instructors and related activities of a provider to assure compliance with the law and regulations (title 16, CCR, Section 1454 (i)). Desk audits of courses and the operation of providers are conducted by the Board staff. This can vary from random selection of providers to investigation of complaints. Site visits may be scheduled in a CE provider's office.

The Board also conducts random audits of advertising to assure that it is in compliance with the regulations (California Board of Registered Nursing on line Publication). Having described the specifications with regard to CE activities, it is important to refer other methods that the Board employs to ensure that CE activities are accessible. These methods include:

(i) Independent or home study courses:

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Approved providers may offer independent or home study courses. There is no limit to the number of contact hours that can be completed through this method. It is however recommended by the Board that a description of the methodology used to grant contact hours for these courses be developed and kept on file by the CE provider so that the Board can address questions/complaints raised by those taking the course.

Continuing Education programmes are offered via the media of print, videotapes, computers, interactive videodisc systems, teleconferencing systems and live presentations. These advanced technologies not only influence changes in fields of practice but, also methods of educating professionals about these changes. Nurses have the choice of obtaining Continuing Education according to the following formats:

- Conferences, symposia and seminars
- Workshops

- Home study and self-directed learning projects
- Teleconferences
- Clinical practicums (California Board of Registered Nursing, undated).

These formats are frequently provided for large groups of nurses and marketed to large geographic areas. Health care organisations, professional nursing organisations and university schools of nursing, university departments of Continuing Education, national or state care organisations, or private Continuing Education businesses may sponsor these large-group programmes.

Self-directed learning, in which learners assume the initiative for identifying, developing and evaluating their own learning activities, is also widely used. The American Nurses' Association (ANA) has developed guidelines to assist nurses engaged in this method of Continuing Education (Deloughery, 1998:312).

The ANA offers selected online Continuing Education Independent Study Modules (ISMs) to assist nurses to earn CE contact hours. This will enable them to meet mandatory requirements for license renewal, promotion in their workplace and to pursue their future career goals within the profession. The ANA lists the following goals for the ISM programs/courses:

1. "To enable the participants to be successful in learning and retaining knowledge by selecting this method of participation which enables them to complete the CE/ISM course at their own pace, within their own timeframe and at the computer location of their choice.
2. To engage the participants more fully through:
   – Self-testing and immediate correction of the exam
   – Providing immediate feedback by explaining the correct response to each post-test question and why other options within the question are incorrect
   – Permitting re-reading of the article and re-taking the posttest as many times as necessary until a pass grade of 75% or more is achieved
   – Requesting their evaluation of the CE ISM/course.

3. To immediately provide the ANA Continuing Nursing Education Contact Hour Certificate to participants who successfully complete the CE ISM/course, which will enable them to more readily meet their professional goals and the requirements of the employer, professional association and credentialing and licensing Boards.
4. To assure that the content of the ISM/course is current, relevant and important to nursing as a profession, individual nurses in different practice settings and to the ANA" (ANA 2001-2003:1).

(ii) Continuing education requirements for license renewal

All registered nurses in the State of California who wish to maintain an active license are required to pay a fee of $80 and to submit proof of completion of 30 hours of CE every two years at the time of license renewal. Registered nurses who have paid the renewal fee but have not completed the 30 contact hours will have a license with an inactive status and will thus not be allowed to practise. To place the license on an active status, the registered nurse will have to submit proof of the completion of 30 contact hours (California Board of Registered Nursing, undated).

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In the case of a license that has lapsed or expired for a period of less than 8 years, the payment of a delinquent fee of $117 and provision of proof of 30 hours of CE within the previous 2 years will cause the license to be activated. If the inactive period has been longer than 8 years, the registered nurse may renew by paying the delinquent renewal fee and providing proof of competency to practise. This can either be in the form of a current active license in another state or by retaking the license exam. Included in the details on the form that is to be submitted to the Board are the following:

- Proof of 30 contact hours
- Californian Board of Registered Nurses CE provider Number
- Course name
- Number of contact hours
- Completion date
- Copies of the certificates of completion

- A declaration, which states: “I declare under penalty of perjury under the laws of the state of California, the foregoing is true and correct”. The form must be signed and dated. If the request is not signed the license will not be renewed to active status (California Board of Registered Nursing, undated).

The renewal of a license for the first time, following the passing of the national exam within the previous 2 years, allows for exemption from the CE requirement. However, if the Californian license was obtained by endorsement from another state and a period of longer than 2 years has transpired since the National exam has been passed, then the requirement of 30 hours of CE is necessary for the license to be renewed to an active status.

(iii) Audits of registered nurses

Random audits of registered nurses are conducted regularly (Title 16, CCR, Sections 1451 (c) and (e). CE providers are contacted to verify that each registered nurse completed a specific course on a stated date. Prompt responses to the requested information is sought to facilitate the completion of the auditing process. Failure to comply may lead to withdrawal of the approval for provider status (California Board of Registered Nursing, undated).

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An approved provider accepts full responsibility for each course granting CE contact hours. This includes, but is not limited to record keeping, content of advertisements, course content, issuing certificates, instructor qualifications and all other related matters, as defined in Title 16, CCR, Division 14, Article 5 (California Board of Registered Nursing, undated).
It now remains to assess the functionality of the CE system in the USA.

(e) Outcomes

The effectiveness of Continuing Education in practice has not been documented. Several approaches have been discussed over the years and continue to be discussed. These approaches include peer review, self-

evaluation, employer directed evaluation and re-examination (Deloughery, 1998:276).

The health care workforce and the regulation of these professions in this time of rapidly changing health care delivery systems have been criticised widely. The Pew Health Professions Commission has spurred on national discussions to meet the changing needs of society by encouraging individual development, personal achievement, cross disciplinary problem solving and innovative, practical approaches. The Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century has focused attention on the fundamental transformation of health care delivery and based their work on the following principles and recommendations:

- The public's interest are best served by promoting effective health outcomes and protecting the public from harm
- Holding the regulatory boards accountable to the public
- Respecting consumers' rights to choose their health care providers from a range of safe options
- Encouraging a flexible, rational and cost effective health care system that allows effective working relationships among health care providers and
- Facilitating professional and geographic mobility of competent providers.

Recommendations to reform health care workforce regulation pertaining specifically to CE include the following:

♦ **"Recommendation 3:**

States should base practice acts on demonstrated initial and Continuing Competence. This process has to allow for and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills

♦ **Recommendation 7:**

States should require each board to develop, implement and evaluate continuing competency requirements to assure the Continuing Competence of regulated health care professionals

♦ **Recommendation 8:**

States should maintain a fair, cost effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the interest of the public" (Deloughery, 1998:291).

Deloughery (1998) also further argued that competence is best assessed from multiple sources with periodic demonstration to ensure reliability and validity. In addition, competence most benefits the consumer when it is focused on ensuring knowledge and skills in the current area of practice so that safe and competent care is continually enhanced. It is also stated that a more effective approach to ensuring Continuing Competence of licensed professionals is by assessing random groups or selected groups of licensees based on 'triggers' that identify a particular need for competence demonstration rather than performing superficial sweeps of all licensees (Deloughery, 1998:291).

Deloughery (1998:311) suggests the following methods of evaluation and measuring the success or failure of Continuing Education:

- Decreased incident reports
- Better client care
- Decreased nursing staff turnover
- Fewer costs and liability risks.

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Continuing Education for re-licensure has been questioned. Here are some arguments against it:

- Participation in CE is no guarantee for continued competence
- Education cannot be equated with competence and accountability
- The mandate causes programmes to be geared toward the median needs of all nurses, which are inferior learning opportunities for some nurses
- Making CE mandatory violates the principles of adult learning
- There is no proof that what is taught in CE programmes alter job performance for the better (Deloughery, 1998:319).

Nursing audits have been used to determine the effect on client care. Although some studies show a positive correlation between CE and the impact on client care, the results of most studies are mixed and portray a difficulty in any CE correlation (Warmuth, 1987:4). Nursing audits may measure the impact of CE on client care but other variables that cannot be controlled may be the reason for low impact scores. Some factors that influence positive correlation between CE and job performance include:

- Staffing patterns
- Workload
- Fluctuations in client census
- Variations in hospital and administrative support
- Role modeling and motivational factors

(Meservy & Monsond, 1987:214 In: Deloughery, 1998:315).

Deloughery (1998) recommends that state boards conduct large-scale studies to help establish general needs assessments and the impact of Continuing Education on nursing practice. Because large-scale studies could be used to justify CE for all licensed professions, funds from all the Departments of Consumer Affairs could be used for the studies. States with large nursing populations could pool resources and obtain funds from the Federal Department of Education. Biennial large-scale needs assessments could be conducted. Providers could be required to offer at least one of the topics that were identified in these studies. These initiatives would increase the accountability of the providers and nurses and lead to improved CE systems. If states are to continue mandating Continuing Education for re-licensure, they may find that they need to mandate higher standards (Deloughery, 1998:319).

(e) Summary

The purpose of Continuing Education in the USA is similar to that of the United Kingdom, where focus is on the enhancement of professional competence with the ultimate aim of protecting the public. South Africa could consider adopting the explicit inclusion of research development, as is the case in the purpose of the American Nurses' Association as there is an

ongoing need for South African nurses to be purposefully reminded to actively participate in research activities.

The calculation of CE units consists of a somewhat complex system of amassing a specified number of contact hours, every two years as one of the requirements for re-licensure. This system has the merit of forcing the practitioner to constantly upgrade knowledge, skills and attitudes that are relevant to the practice of nursing. This has the advantage of causing practitioners to keep abreast of new developments in terms of new discoveries, practices and procedures.

A CPD system for nurses and midwives in South Africa has to make provision for regular updating in competences (knowledge, skills and attitudes) in the nurse and midwife's specific area of practice, as is the case in the USA, so that re-licensure is not granted to nurses and midwives whose competencies are outdated. Once again the logistics for the approval of providers and the monitoring of the accumulation of the 30 contact hours, every two years for every nurse and midwife on the register/roll of the SANC is administratively and financially daunting.

The process of the assessment of the CE needs of nurses and midwives in the USA, from a variety of constituents and resources, would be beneficial to the South African context. However, it should be emphasised that one of the chief constituencies in the wide consultation and negotiation processes would be the organised nursing profession.

Although there is much merit in the monitoring and auditing of CE providers, once again the physical, administrative and human resource demands are prohibitive. If the circumstances at the offices of the SANC change for the better and the necessary resources are forthcoming, then the SANC could benefit from conducting audits of records, advertisements and related provider activities (as in California) in response of its chief mandate of protecting the public.

With regards to the outcome of Continuing Education in the USA, there are powerful arguments against CE for re-licensure, namely, that participation in it is no guarantee for continued competence. Deloughery, (1998) further recommends that state boards conduct large-scale studies to help establish general needs assessments and the impact of CE on nursing practice.

Continuing Education has been formally implemented by the Board in California, USA, since 1971. Over the years, there have been arguments for and against mandatory CE. The lesson that South Africa could learn from this experience is that the United States of America, as a first world country, has been constantly reviewing, discussing and interrogating the relevance of Continuing Education to the competent practice of nurses and midwives. It thus becomes evident that the SANC, as the regulatory body for nursing and midwifery in a first and third world country with diverse challenges, will need to be realistic and apply the principles of simplicity, affordability, attainability and practicability to develop a CPD system that would be contextually appropriate for South Africa. Table 3.6 outlines the aspects of Continuing Competence in California for consideration in developing a CPD system for nurses and midwives in South Africa.

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Table 3.6: Aspects of CE in California for consideration for South African nurses and midwives

Aspects for consideration:

- The explicit inclusion of research development, as is the case in the purpose of the American Nurses' Association as there is an ongoing need for South African nurses to be purposefully reminded to actively participate in research activities.
- State boards conduct large-scale studies to help establish general needs assessments and the impact of CE on nursing practice.
- Causing practitioners to keep abreast of new developments in terms of new discoveries, practices and procedures, that is regular updating in competences (knowledge, skills and attitudes) in the nurse and midwife's specific area of practice, so that re-licensure is not granted to nurses and midwives whose competencies are outdated.
- The process of the assessment of the CE needs of nurses and midwives, from a variety of constituents and resources.
- The content of all courses for CE has to be current and relevant to the practice of nursing.
- Conferences and courses offered in other countries are credited.
- The various data that is accessed to provide valid needs assessments for CE.
- Specification of requirements for instructors of CE activities.
- A wide variety of CE activities to increase accessibility over extensive geographical areas.
- The conduct of a random audit annually by the regulatory authority to verify compliance.
- The regulatory authority to commission ongoing research on Continuing Competence for nurses and midwives.

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Having described Continuing Education in California in the USA and highlighted aspects for consideration for the development of a CPD system for nurses and midwives in South Africa, a description of CPD for nurses and midwives in Canada follows.

3.4.4 Canada

Canada is a sovereign federal state consisting of10provinces. The federal government is responsible for a wide variety of national matters such as national defence, commerce and trade and social justice. Many powers are

shared between the federal and provincial governments. Each province has its own parliament with its own legislative arrangements in such matters as education, health and social services. In matters of health, the provinces have statutory provisions for health, in terms of which health matters are regulated and monitored (http://www.cia.gov/cia/publications/factbook/geos/ca.html#Govt date accessed 12 August, 2003).

Unlike the USA, Canada places less emphasis on credentialing and mandatory Continuing Education. For purposes of this study, Continuing Competence in the province of Ontario and more specifically, the College of Nurses of Ontario (CNO) will be described. The CNO is the nursing regulatory board in Ontario.

In 2001, there were approximately 105 900 registered nurses and 32 500 registered practical nurses in Ontario. Registration assures the public and the employers that these individuals are accountable to the College for meeting and maintaining standards of the profession. Once registered with the College, members are registered for life. Members maintain competence through participation in the Quality Assurance Programme of the College. Changes in consumer demands, healthcare, nursing and legislation in Ontario dictate that nurses assume responsibility for the care they provide. Nurses need to review how their practice relates to the consumer, the multiprofessional team and their role in the healthcare system. Nurses are expected to be accountable for their actions and to accept the consequences of such actions (CNO, 1996).

The CNO addresses Continuing Competence through three very different methods:

1. The first component is reflective practice or self-assessment to identify strengths, learning needs, peer feedback and the implementation of an individual learning plan.
2. The second component is a Practice Setting Consultation Programme. It is a unique programme for bringing nurses and administrators together to develop practical strategies for improving the delivery of nursing care in

individual practice settings. The programme can be used in hospitals, long term care facilities, public health and community based settings.

3. The third component of CNO's Quality Assurance Program is known as Practice Setting Consultation Programme (previously Practice Review). This entails objectively assessing a nurse's practice in relation to a set of competencies in areas such as ethics, nurse-client relationship, professional behaviour, advocacy, caring, documentation and medication administration and against the following standards: accountability, Continuing Competence, ethics, knowledge, knowledge application, leadership and relationships – therapeutic and professional (CNO, 2002:3).

For the purpose of this study the Self-Assessment Tool, as one of the recommended ways that nurses can meet the reflective practice requirements of the College of Ontario's Quality Assurance (QA) Programme, will be described. Since 1997, Reflective Practice has been supporting nurses in their efforts to provide quality nursing care.

The purpose, structure, process, outcome and a summary of the use of the self-assessment tool follows.

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(a) Purpose

The purpose of the self-assessment tool is to meet reflective practice requirements so that nurses can create a and implement an annual learning plan with the purpose of enabling them to provide appropriate, effective and ethical care (College of Nurses of Ontario, 1996:1).

(b) Structure

The Regulated Health Professions Act was enacted on 31 December 1993. This Act requires each health authority to have a quality assurance program that addresses the competence of the profession and the Continuing Competence of the members of the profession. The College of Nurses of Ontario (CNO) has developed a quality assurance programme that addresses

both aspects of quality control and quality improvement. The main emphasis in Canada is on continual learning and self- and peer assessment as part of quality assurance initiatives.

Since 1997 all nurses in Ontario have to participate in ongoing reflective practice activities. Nurses are provided with various options to choose from. The CNO provides the self-assessment tool in the format of a questionnaire that relates to a variety of nursing roles, namely, direct practitioner, administrator, educator and researcher.

The self-assessment tool is based on the following seven professional standards that provide an overall framework for the practice of nursing:

1. Accountability
2. Continuing competence
3. Knowledge
4. Application of knowledge
5. Ethics
6. Leadership
7. Relationships (CNO, 2002:9).

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The statement on Professional Service to the Public that appeared in the 1996 version was removed and integrated into the other standard statements (CNO, 2002:9). For the purpose of further clarifying the self-assessment tool of the CNO, it is necessary to reflect on their definition of competence: "Competence combines knowledge, skill, application and judgement, the four areas affect each other…these four are also affected by attitude and values". Competence is assessed through the professional standards as listed above. The role players are the members of the College of Nursing in Ontario, nurses and other members of the health team when there is no other nurse to conduct the peer assessment and members of the public (CNO, 1996:5).

(c) Process

All nurses are required to participate reflective practice. “Reflective practice is a formal process that helps nurses to maintain their competence in today’s rapidly changing environment” (CNO, 2004:1) The Quality Assurance (QA) programme includes a process of self- assessment, assessment by a colleague or supervisor and the completion of ongoing learning projects. Nurses may choose from many options to meet the QA Program requirements. It is however expected of them to choose the option that most reflects the nurse’s area of practice. An assessment tool is forwarded by the CNO to each nurse for completion. The self-assessment tool consists of the following five steps:

Step 1: Complete a self-assessment: the nurse selects the questionnaire that most relates to her area of practice and conducts a self-assessment. The nurse reviews her assessment against the four skill groups namely, communication; critical thinking/job knowledge; leadership; legislation and standards.

Step 2: Obtain peer feedback: the nurse asks a colleague to provide feedback on her practice.

Step 3: The nurse prepares a learning plan by identifying learning activities to improve her area of practice.

Step 4 The nurse applies the learning plan to her area of practice.

Step 5: Evaluation: the nurse examines how the learning activity improved her area of practice (CNO, 2001:1, reviewed by CNO,2004:1).

Each nurse keeps a professional profile with the self-assessment tool and ensuing learning activities as evidence of her reflective practice. “Every year, nurses are required to declare that they have participated in Reflective Practice. The reflective practice declaration appears on the Annual Payment Form” (CNO, 2004:2).

A QA Committee that is made up of elected peers and public representatives will perform an annual audit. This committee conducts an assessment on a

randomly selected sample of nurses. Nurses are not required to send anything to the CNO for review unless randomly selected to do so. This auditing process is necessary to ensure that nurses are meeting the requirements of the Regulated Health Professions Act (CNO.2001:2).

Over and above the self-assessment tool, another essential development is the Employer Support: the Practice Setting Consultation Programme (PSCP) that looks at the environment in which nurses practise; the PCSP was developed to assist nurses and their employers in creating and maintaining workplaces that support professional nursing practice (CNO, 2004:1). Follow-up surveys indicate that the PSCP has produced the desired effects as alluded to in the following statement: "With recognition and action, the nurses have been given the impetus, through knowledge, to change the quality of their work environment ... Supported by the PSCP evidence ... the nurses have become an integral part of the planning, implementing and evaluating process for their practice setting" (CNO, 2004:1).

(d) Outcome

Self-assessment allows nurses to provide safe, ethical and effective health care (CON, 2001:1).

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(e) Summary

The purpose of reflective practice provides much for South Africa to emulate in terms of appropriate, effective and ethical nursing care and with regard to improving the practice setting.

The structure that the CNO needs to implement the self-assessment tool is neither labour nor cost intensive. The practitioner retains the completed questionnaire with the consequent annual learning plan. The monitoring process consists of a random sampling audit by a Quality Assurance Committee.

Any self-reflective practice wherein a practitioner has to critically review her performance redounds to the benefit of the practitioner, the profession and the community at large. A caveat is appropriate here: self-reflective questionnaires may tend to be subjective and practitioners may not be entirely trustworthy, although the follow-up peer review could be a measure of control. To be successful, professional growth and development requires a great deal of maturity.

Table 3.7 outlines the aspects of Continuing Competence in Canada for consideration in developing a CPD system for nurses and midwives in South Africa.

Table 3.7: Aspects of Continuing Competence in Ontario for consideration for South African nurses and midwives

Aspects for consideration:

- Reflective practice in the form of self-assessment or assessment by a colleague or supervisor to identify strengths and learning needs with the aim of implementing an annual individual learning plan.
- The retaining of the completed assessment tool and the subsequent annual learning plan by the practitioner.
- Objective assessment of a nurse's practice in relation to a set of competencies in areas such as ethics, documentation and nurse-client relationship.
- The monitoring process of a random sampling audit by a Quality Assurance Committee that is made up of elected peers and public representatives.

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Having described Continuing Education of the College of Ontario in Canada and highlighted aspects for consideration for the development of a CPD system for nurses and midwives in South Africa, a description of CPD for nurses and midwives in Kenya, on the African continent, follows.

3.4.5 Kenya

Kenya is the only state in Africa that has formally implemented a CPD system for nurses and midwives. Kenya has adopted the terminology of USA, Continuing Education for Continuing Professional Development.

(a) Purpose

The purpose of CE is to improve the quality of healthcare to the patient/client (Mwamuye, 2002:1).

(b) Structure

CE is mandatory although it has not been legislated as yet. All nurses and midwives are expected to have covered a minimum of 20 hours of Continuing Education annually. The practice licence is renewed every three years after the submission of evidence that a minimum of 60 hours of CE has been completed (Mwamuye, 2002:1). The content of CE is not specified nor are CE activities approved. It is, however, emphasised that the content of CE has to be relevant to nursing and/or midwifery, health and more significantly to their current area of practice (Mwamuye, 2002:2).

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(c) Process

Nurses and midwives earn hours from workshops, seminars, conferences and case study presentations. If they present a paper they also earn some hours, as this contributes towards a search for new knowledge. The Nursing Council of Kenya does not work on a point system neither do they approve providers (Mwamuye, 2002:1).

The management of all healthcare facilities was asked to start a CE programme and to appoint a coordinator to organise the running of such a programme. Initially it was only for nurses, but currently the Minister of Health has requested that it be implemented for all health professionals. The topics with accompanying hours are recorded in the logbooks of each professional who has participated in the CE activity. The nurse managers monitor the

activities of the CE programme. The Nursing Council members, during their visits to healthcare facilities monitor the CE programmes and also do sporadic checks on the logbooks of the nurses and midwives (Mwamuye, 2002:1).

The question that may well be asked is: What about nurses and midwives who have not been practising for five or more years? On receiving an application from such a person, the Nursing Council of Kenya issues a provisional licence to them and also prescribes an orientation period of three weeks which requires practical work in:

- Medical, surgical, paediatrics and out-patient departments for general nurses, and
- Antenatal clinic, pre-natal ward, labour ward, postnatal ward, special care baby unit and community midwifery for midwives.
- Only on the completion of this period of orientation and the payment of the prescribed fee, are nurses and midwives restored to the register (Mwamuye, 2002:2).

"It is essential to note that there was resistance to the implementation of mandatory CE. The following concerns were raised:

- Unable to attain 60 hours over a three-year period.
- They are not given time to attend conferences, seminars or workshops.
- How would nurses and midwives working in Dispensaries and Health Centres in remote areas meet the CE requirements?
- They could not afford the licence fee of 500 Kenya Shillings and the Nursing Council was earning money unfairly" (sic) (Mwamuye, 2002:2).

Regular communication, sensitisation and the dissemination of information on the merits of implementing mandatory CE have changed the attitudes towards the profession. The production and issuing of practice licences have motivated many nurses and midwives to apply for retention of their names on the register/roll of the Nursing Council of Kenya (Mwamuye, 2002:2).

(d) Outcome

"The specified hours are a monitoring system that hopes to achieve an outcome that nurses and midwives have learnt and their knowledge has been updated" (Mwamuye, 2002:1).

(e) Summary

In Africa CPD has only been formally implemented in Kenya. However it was fraught with much difficulty, such as the resistance to mandatory Continuing Education. South Africa could learn the lesson of ensuring that wide and adequate consultation with the relevant stakeholders of the SANC (See Annexure O) occurs to prevent resistance to a formal and regulated CPD system.

Although Kenya has attempted to adopt elements of the CE model of the USA, the purpose, structure and process of CE in Kenya appears to be in the rudimentary stages. Table 3.8 outlines aspects of Continuing Competence in Kenya for consideration in developing a CPD system for nurses and midwives in South Africa.

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Table 3.8: Aspects of CE in Kenya for consideration for South African nurses and midwives

Aspects for consideration:

- The content of CE has to be relevant to nursing and midwifery, health and more significantly to their current area of practice.
- Nurses and midwives who have not been practising for five or more years have to complete an orientation period of three weeks and clinical practice is also included.
- Regular communication, consultation and dissemination of information on the merits of implementing mandatory CE.

Having described Continuing Education in Kenya and highlighted aspects for consideration for the development of a proposed CPD system for nurses and midwives in South Africa, a summary of the findings on CPD for nurses and midwives internationally follows.

3.4.6 Summary of findings with regard to CPD for nurses and midwives internationally

South Africa cannot operate in isolation in a world that has been aptly described as a global village. There is much to emulate from international experiences, research reports and discussion papers on issues pertaining to Continuing Professional Development for nurses and midwives. This research focused on Continuing Professional Development in selected parts of the world to inform the process of developing a proposed CPD system for nurses and midwives in South Africa. It was therefore deemed appropriate to examine CPD systems in Australia, the United Kingdom, the USA: California, Canada: College of Nurses of Ontario, and Kenya: Africa.

In all the countries the geo-political, and as a consequence the legislative arrangements impacted on the CPD systems that have been and are still being developed. Each of the countries that the research focused on, the approach has been to reflect on the purpose; structure; process; outcome; and summary.

A comparison of the findings of the CPD systems in these countries reveals the following common features:

- Payment of a registration fee (annually or every three years)
- Protection of the public and this at times is coupled with the enhancement of professional competence
- Keeping a record as evidence of participation in CPD activities
- Auditing procedure to evaluate compliance with the CPD system.

There are, however, significant differences in the various CPD systems not only of different countries, but also different regions within the same sovereign countries. The differences that were identified are:

- Registration requirements
- The structure of the CPD systems from that which is administratively demanding to one that requires minimum administrative detail
- The processes for implementing CPD are varied.

Before implementing a CPD system that would serve the needs of the South African multicultural and multilingual nursing and midwifery professionals who practice in diverse first- and third-world settings, a variety of CPD systems must first be analysed. From this, best practices can be emulated and problematic issues avoided or improved on.

Table 3.9 on the next page provides an overview of Continuing Professional Development of the CPD systems in Australia; the United Kingdom; the United States of America: California; Canada: College of Nurses of Ontario; and Africa: Kenya.

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Table 3.9: A overview of the international CPD systems for nurses and midwives

Country	Purpose	Structure	Process	Outcome
Australia: **Term used:** Continuing competence	❑ To protect the public	❑ Registration is a national, legal requirement ❑ ANCI national standards to measure competence against	❑ Recency of practice ❑ Self-assessment against the ANCI national standards ❑ Self declaration ❑ Random audit to monitor compliance	❑ Safe and competent practitioners ❑ National research – Discussion paper ❑ Consumer response to the discussion paper
United Kingdom **Term used:** Post Registration Education and Practice (PREP)	❑ To maintain safe & effective standards of patient care	❑ Registration every 3 years is a national, legal requirement ❑ Proof of 750 hours of practice (per qualification) during the previous 5 years ❑ .Notification of Practice form every 3 years for all nurses and midwives ❑ Wide consultation on PREP ❑ Preceptorship for 4 months for newly registered nurses	❑ 35 hours of learning activities specific to area of practice ❑ Completion of a declaration ❑ Maintain a Personal Professional Portfolio ❑ PREP booklet disseminated ❑ Midwives have to continue to communicate their intention to practise annually ❑ Random audit by the NMC ❑ > 5 years not practising then return-to-practice programme	❑ Provision of best possible care for patients/clients ❑ Piloting of audit system demonstrated compliance 90%

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Country	Purpose	❑ Structure	❑ Process	❑ Outcome
U S A: California Board of Registered Nursing **Term used:** Continuing Education (CE)	❑ To develop and maintain current competency in the delivery of nursing care, to the end of improving the health of the public	❑ The principal Act specifies the structure and process pertaining to CE ❑ Compulsory licensure of qualified individuals ❑ Mandatory 30 contact hours every 2 years for license renewal ❑ Approval of providers by the Board (application forms supplied and a common-mistake checklist) ❑ Provider approval number lasts for two years; renewal notice from the Board 3 months prior to expiry date	❑ Valid needs assessment conducted ❑ Large variety of activities marketed to wide geographical area ❑ The Board audits records, instructors, advertisements, activities and conducts site visits ❑ The ANA offers on-line CE to increase accessibility to nurses ❑ Inactive license of >8years requires proof of competency to practise or retaking the licensing exam ❑ Random audits of nurses are conducted	❑ Effectiveness of CE has not been documented ❑ Suggestions made on how to evaluate the success or failure of CE ❑ Large-scale studies recommended by state to establish general needs assessment and impact of CE on nursing practice
Canada: College of Nurses of Ontaria (CNO) **Term used:** Quality Assurance Programme	❑ To enable nurses to provide appropriate, effective and ethical care	❑ The Health Profession's Act of 1993 requires each health authority to have a QA Programme ❑ The CNO Continuing Professional Development a self-assessment tool (questionnaire) ❑ Professional standards reviewed regularly through consultation with the profession	❑ Self- and peer assessment followed by the development of an annual learning plan ❑ The QA Panel do an annual audit on a randomly selected sample of nurses ❑ Nurses are not required to send anything to the CNO unless randomly selected to do so.	❑ Improvement of competence in specific area of practice with an ultimate improvement in the standard of patient care
Africa: Kenya **Term used**: Continuing Education (CE)	❑ To improve the quality of health care to the patients	❑ Renewal of license every 3 years with 60 CE hours ❑ C E is mandatory but not legislated as yet ❑ 20 CE hours annually ❑ Content of CE has to be relevant to nursing/midwifery ❑ No approval of providers	❑ Healthcare facilities appoint a coordinator to run CE programmes ❑ Topics with accompanying hours are recorded in each professional's logbook ❑ Nursing Council members do sporadic monitoring ❑ Non-practising for > 5years has to complete a 3 week programme	❑ Nurses and midwives have learnt and their knowledge has been updated

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Having analysed the CPD systems for nurses and midwives internationally, a description of the mechanisms that have been put in place or that are still being developed for health professionals in South Africa follows.

3.5 A national perspective of CPD systems for healthcare professionals in South Africa

This section will provide a descriptive analysis of healthcare professionals in South Africa.

The Health professions Council of South Africa (HPCSA) comprises 12 boards, namely:

1. Medical and Dental Professions Board
2. Professional Board for Psychology
3. Professional Board for Emergency Care Personnel
4. Professional Board for Optometry and Dispensing Opticians
5. Professional Board for Environmental Health Practitioners
6. Professional Board for Radiography and Clinical Technology
7. Professional Board for physiotherapy, Podiatry and Biokinetics
8. Professional Board for Dental Therapy and Oral Hygiene
9. Professional Board for Speech, Language and Hearing Professions
10. Professional Board for Dietetics
11. Professional Board for Medical Technology
12. Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics.

Following the success of introducing compulsory CPD for the medical and dental professions, compulsory CPD was also introduced for:

- Professional Board for Medical Technology (50 CPD points annually)
- Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics (50 CPD points annually)
- Professional Board for Optometry and Dispensing Opticians
- Professional Board for Psychology

- Professional Board for Radiography and Clinical Technology (20 CPD points: 10 points in the case of supplementary diagnostic radiographers and 10 points for restricted supplementary diagnostic radiographers)
- The Professional Board for physiotherapy, Podiatry and Biokinetics intends to implement a CPD system of 30 CPD points annually to the effect that any practitioner whose name appears in the register on 1 April 2002 will be required to comply before 31 March 2004
- Professional Board for Dietetics (50 points annually)
- Professional Board for Speech, Language and Hearing Professions (30 points annually – speech therapists and audiologists that are on a dual register as from 1 April 2003 are required to accumulate 60 points annually)
- The Professional Board for Emergency Care Personnel recognises the need for CPD for all levels of registration in emergency care, however the board is of the opinion that CPD should be implemented on a voluntary basis for a number of years prior to making it mandatory.

Eight of the 12 boards have implemented mandatory CPD and their systems are based on the CPD system of the Medical and Dental Professions Board. A detailed description will thus be given of the CPD system for the Medical and Dental Professions Board.

3.5.1 The Medical and Dental Board of the HPCSA

The Interim National and Medical and Dental Council of South Africa (NMDC) introduced a system of Continuing Professional Development (CPD) for all medical practitioners and dentists on 1 January 1999.

(a) Purpose

"To achieve improved patient care and to benefit the development of the medical and dental professions as whole (HPCSA, 2000:3)".

(b) Structure

Every medical practitioner, dentist or medical scientist registered in terms of the Health Professions Act 56 of 1974 has to comply with the requirements related to CPD. The Medical and Dental Professions' Board administer the CPD system under the jurisdiction of the Health Professional Council of South Africa (HPCSA). However, the responsibility to accredit and review CPD activities according to specific criteria and guidelines for recommendation to the Board is outsourced to professional societies and associations, medical and dental faculties, and other professional bodies such as the Colleges of Medicine of South Africa and the Academy of Family Practice/Primary Care as accreditors of CPD activities. The Board ensures that the responsibilities outsourced are carried out in a fair, equitable and responsible manner. The Board retains the right to review or withdraw any outsourced responsibilities from accreditors, should the circumstances so require (HPCSA, 2000:4).

The staff responsible for the administration of CPD at the Board consist of:

- A senior manager who oversees the registration, records and CPD sections
- Three CPD officials whose duties entail:
  - All correspondence related to CPD activities
  - The logging on of accredited CPD activities
  - The allocation of accreditation numbers electronically to accreditors who have been approved as accreditors by the CPD Committee of the Medical and Dental Board
- Temporary staff who are appointed for a period of up to three months when and as required by the CPD section. Their duty is primarily capturing of the CPD points of the doctors and dentists as they are forwarded to the Board to provide evidence for re-licensure to practise their profession (2001, Personal interview with CPD manager). As from the 1 January 2002, the accreditor will electronically transfer data concerning the attendance of CPD activities to the HPCSA (HPCSA, 2000:4).

It is essential, for purposes of this study, to note that a major administrative problem was experienced with regard to the information technology (IT) programme. During an information-sharing meeting of the researcher and the CPD manager of the HPCSA, on the administration of CPD, at the offices of the HPCSA in 2001 and in another follow-up site visit in 2002, it was emphasised that the selection of the correct IT programme for the retrieval of pertinent information to coordinate the CPD system effectively is critical to the successful administration of the system. It was communicated that the carrying over of CPD points from 2001 to 2002 was problematic and that the IT programme had to be reviewed with additional cost implications. Other than the aforementioned limitations much effort has been put into the successful implementation of CPD.

A. Dissemination of information to the medical and dental professionals

Provision has been made for the distribution of an information brochure on the details of the CPD system to the registered members of the Medical and Dental Board and designated forms to facilitate the administration with regard to:

- Ensuring that the details of the CPD system are explained to the registered members of this Board
- Applying for the approval of CPD activities
- Submitting guidelines on the various categories of CPD activities to be submitted by providers of CPD activities
- A declaration from the CPD provider on the details of the practitioner attending the particular CPD activity and description of the category of CPD activity with its respective CPD point allocation and
- A list of approved CPD accreditors for the CPD activities of the Medical and Dental Board. This list is included in an information brochure entitled ‘Professional Self-Development’.

Although there is wide support for the principle of CPD, concern has been expressed with regard to the high cost of administering CPD and the high

costs of conferences, with subsequent financial implications for the practitioners who feel exploited in many instances (HPCSA, 2001:31). The budg*et al*located to implement CPD includes costs for:

- the salaries of the staff of the CPD section
- technological support to capture and administer the database related to CPD activities
- telephonic and postal correspondence
- travel (often return air tickets) costs for the CPD Committee members of the Medical and Dental Board
- the hiring of a venue and catering facilities (personal interview with CPD manager in 2000).

It should be noted that each of the eight professional Boards implementing CPD has its own budget. However an accurate, itemised costing has not as yet been done. The administrative activities related to the implementing, monitoring and control of CPD is undoubtedly a major cost centre (personal interview with CPD manager in 2000).

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(c) Process

In 1999 CPD was run in cycles of five years, during which time every practitioner was required to accumulate 250 points in order to retain his or her registration. Every practitioner had to accumulate a minimum of 25 points in any one year, while a maximum of 75 points may be accumulated in any year. It was decided that the five-year cycle be stopped at the end of 2003 and replaced by an annual cycle of 50 points. Two of these points would be for ethics; 48 points may be carried over to the following year but the two ethics points may not be carried over. Practitioners are advised annually of the number of CPD points recorded to their credit and of their CPD status. Practitioners can view their CPD status on the HPCSA's website at www.hpcsa.co.za (HPCSA, 2000:4).

It was planned that the initial cycle extend over six years in order to afford the Board, accreditors and providers the opportunity to eliminate any problems

that might arise with the system during the first year. Any practitioner whose name appeared in the register on 1 January 1999, is required to comply before 31 December 2004 with the conditions of CPD, and thereafter during sequential periods of five years. Any person who registers for the first time as a medical practitioner or dentist after 1 January 1999, commences her five-year cycle on 1 January of the following year. Any person whose name is restored to the register of medical practitioners or the register of dentists subsequent to 1 January 2003, after it has been erased from the relevant register for a period exceeding 12 months, is subject to compliance with any condition(s) which the Board may specify prior to the restoration of the name of such practitioner to the relevant register (HPCSA, 2000:5).

B. Categories of educational and developmental activities and allocation of points

The basic premise of the point allocation for activities in the five categories of educational and developmental activities for CPD purposes is that one hour equals one point. However, the eventual responsibility rests with the accreditors to adapt sub-optimal activities downward to an appropriate point allocation per time unit and to recommend to the Board accordingly.

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A maximum of 80% of the points may be accumulated in any one of the specified CPD categories. A minimum of 2 points in professional (medical/dental) ethics is required from all practitioners per year. Practitioners who have obtained more than four points in professional ethics during 1999, 2000 and 2001 may carry forward the excess points for a maximum of four years. Any relevant educational or developmental activity that does not fall into the following listed categories may be submitted to the Board for approval and, if agreed to, will be accredited (HPCSA, 2000:7).

Category 1: Organisational activities

Attendance of formal learning opportunities is credited with one point per hour of attendance. Theses activities include but are not restricted to national and international conferences and congresses, large-group workshops, lectures, seminars, refresher courses and departmental meetings (HPCSA, 2000:7).

Category 2: Small group activities

Participation in small-group learning opportunities is credited with one point per hour where participants are actively involved. These activities include, but are not restricted to small-group workshops, lectures, courses, departmental meetings, teaching ward rounds, journal clubs and small-group discussions. In addition, one point per hour is granted for presenting activities such as those listed under category 3.

Category 3: Individual activities

- ***Self study***

  Only self-study activities accredited by a provider count. These activities include but are not restricted to studying of journals, as well as electronic or computerised material.

- ***Individual learning***

  These activities include but are not restricted to skills training for example, endoscopies and short-term study at university departments.

- ***Research and publication in peer reviewed/ CPD journals***

  The first author is credited with 15 points while co-authors are credited with 5 points per published article (HPCSA, 2000:9).

- ***Teaching and/or training activities of undergraduate students, postgraduate students and/or peers***

  These activities are credited with one point per hour.

- ***Paper/poster presentations/lectures to peers***

  Short papers (shorter than 20 minutes) e.g. congress papers or posters, are credited with 5 points. Co-authors of short papers are credited with 2 points and co-authors of posters with 3 points.

  Long papers (longer than 30 minutes), e.g. invited lectures and keynote addresses, are credited with 10 points. Co-authors of long papers are credited with 3 points (HPCSA, 2000:9).

- ***Relevant additional qualifications (excluding prescribed qualifications obtained by registrars or senior registrars)***

  A completed six-month diploma is credited with 10 points, a completed one-year diploma with 20 points, and a completed two-year diploma with 40 points. A completed Masters or Doctoral degree is credited with 50 points. These points are added to points obtained during the study period, and allocated only on awarding of the qualification and during the year of the award.

- ***Examinations/Evaluations/Assessments***

  These activities are credited with one point per hour and include but are not restricted to undergraduate and postgraduate examinations, evaluations undertaken on behalf of a registering authority – in this case, the Medical and Dental Professional Board – and assessment of thesis or scripts.

- ***Supervision of candidate(s) for higher degrees***

  These activities are credited with 15 points per candidate per year and include being the promoter, mentor or study leader for Masters or Doctoral qualifications HPCSA, 2000:11).

Practitioners are required to submit evidence of their compliance with the mandatory CPD system, to the Board annually, but not later than 31 March of the following year. This evidence comprises a CPD portfolio as set out in a form available from the HPCSA, and certificates issued by providers as proof of attendance of/participation in CPD activities.

On receipt of the CPD portfolios from individual practitioners, the contents will be analysed and the points are captured on the Board's database. Subsequently, practitioners will be advised annually about the number of CPD points recorded to their credit and of their CPD status.

- ***Deferment***

Practitioners may apply for deferment of CPD and the Board will review such applications individually on the basis of reasons acceptable to the Board (HPCSA, 2000:11).

- ***Retirement, illness and non-clinical practice***

Deferment is not granted to practitioners who have retired, practitioners not practising due to ill health, or medical/dental administrators. The Medical and Dental Board is establishing separate registers for these categories (HPCSA, 2000:11).

- ***Practitioners abroad***

Practitioners practising abroad are not granted deferment. However, documentary proof of compliance with CPD requirements in any particular country where such requirements apply will be accepted for CPD purposes in South Africa. In the absence of such proof of compliance with CPD requirements, documentation on activities attended outside South Africa have to be submitted to an accreditors of CPD activities (HPCSA, 2000:11).

- ***Full-time students in Family Medicine, registrars and senior registrars***

The above categories will be exempted for the duration of their training. Compliance will have to be on a pro rata basis for the remainder of the year if the training is completed during a particular year (HPCSA, 2000:12).

- ***Non-compliance***

In the event of a practitioner not complying with the requirements of the CPD system, the board may impose one of the following conditions:

- Requiring the practitioner to follow a remedial programme of CE and training as specified by the Board
- Requiring the practitioner to write an examination as determined by the Board
- Registering the practitioner in a category of registration that will provide for supervision regarded as appropriate by the Board

- Registering the practitioner in a category of registration restricted to non-clinical practice
- Removing the practitioner's name from the relevant register of medical practitioners, dentists or the relevant medical science (HPCSA, 1999:8 reviewed 2000:12).

It is therefore evident that the CPD systems of the eight professional boards are mandatory and that they are based on the sanctions model which, according to (Wallace, 1999:31) tends to be used by the highly visible and well established professions where registration, standards and discipline are explicit. If there is no compliance with the required standards then sanctions of some type will come into play. In the next paragraph, the outcome of the CPD system is discussed.

(d) Outcome

The majority of practitioners participated in CPD activities and obtained the required 50 CPD points during the first official year of CPD (1999). Submissions were received from 83,1% of the medical practitioners and 76,9% of the dentists required to participate in the CPD programme. Of those who participated, 62,6% of the medical practitioners and 56,6% of the dentists accumulated more than the required 50 points (HPCSA, 2001:31).

(e) Summary

Following the success of introducing compulsory CPD for the medical and dental professions in 1999, eight of the 12 Boards of the HPCSA have implemented mandatory CPD that is based on the CPD system of the Medical and Dental Profession's Board. The purpose of the Medical and Dental Board for CPD is to achieve improved patient care. In South Africa, where healthcare is a primary right in term of the Constitution, Act 101 of 1996, it becomes necessary for the South African public to be assured of competent and safe practitioners so that healthcare is indeed accessed. The SANC, in terms of its mandate from the Nursing Act 50 of 1978, has to make visible attempts to

protect the public and thus its purpose for CPD could incorporate elements of competence and safe care to protect the public of South Africa.

The structure and process of the CPD system demands coordinated administrative procedures in offices that are adequately resourced, with well-designed and effective information technology programmes. This approach most definitely escalates costs and has enormous budgetary implications. The SANC does not currently have the resources to emulate this structure and process and has to be realistic about its administrative potential and its pool of resources. Over and above this, the current challenges of the SANC, namely achieveling the overall demands of its provisionally acquired Education and Training Quality Assurer (ETQA) status, calls for a CPD system that is based on the principles (amongst others) of realism, simplicity and affordability.

What lessons can be learned from the system of Continuing Professional Development for the Medical and Dental Professions' Board? Table 3.10 on page 128 highlights the aspects that could be considered for the development of a CPD system for nurses and midwives in South Africa.

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Table 3.10: Aspects of the CPD system of the Medical and Dental Professions' Board for consideration for nurses and midwives in South Africa

Aspects for consideration:

- The compulsory inclusion of ethics annually
- Specification of minimum annual requirements
- A wide variety of CPD activities to increase accessibility
- Provision for an application for deferment of CPD from the Board
- Practitioners practising abroad have to submit documentary proof of compliance with CPD requirements in that particular country
- Non compliance with the requirements of CPD results in the imposition of one of several conditions
- Regular communication and dissemination of information on the merits of implementing mandatory CE.

Having described Continuing Professional Development for the Medical and Dental Professions' Board and highlighted aspects for consideration for the development of a CPD system for nurses and midwives in South Africa, a description of events related to the proposed implementation of CPD for pharmacists follows.

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3.5.2 The South African Pharmacy Council

> "Pharmacy, is a dynamic profession, where the body of knowledge is changing constantly with advances in medicine and pharmaceutical techniques, as well as changes in the needs of the patients. The shift in focus of the pharmacist from a product-orientated to a patient orientated professional, concerned with the pharmaceutical needs and care of the patient has resulted in the need for the development of competencies in areas that may be very different to those covered during her undergraduate training. Pharmacists thus have a professional obligation to remain informed about the profession in scientific, social, political and legal aspects and maintain a level of competence sufficient to provide pharmaceutical services, including pharmaceutical care, effectively and efficiently" (Putter, 2000:5)

Although the South African Pharmacy Council has not as yet implemented a formal and regulated CPD system for pharmacists, publications and articles have disclosed what the pharmacists have in mind with regard to the Continuing Professional Development of pharmacists. The South African Pharmacy Council of is working on what (Wallace, 1999:31) refers to as the 'benefits' model, where CPD is introduced to ensure the continued and enhanced competence of the members of the profession. The emphasis is on the outcome of CPD for practice.

(a) Purpose

"To ensure the Continuing Competence of practising pharmacists in South Africa in the public interest" and "To keep pace with new developments, mastering new approaches to practice, preparing for career changes and maintaining and improving competence" (Putter, 2000:6).

(b) Structure

The South African Pharmacy Council found it necessary to determine from the outset the establishment of a difference between the term Continuing Education and Continuing Professional Development. According to Putter (2000:6), CE includes the attendance of courses, symposia, conferences, and scientific and professional meetings. It may also include participation in distance learning; CE thus refers to planned and organised learning experiences that go beyond the basic undergraduate pharmacy education and provides purposeful learning and individual self-development to enable the pharmacist to keep abreast of significant changes in the pharmacy profession. It is however emphasised that participation does not necessarily translate directly into increased competence, but is one of several factors associated with competence.

Continuing Professional Development, on the other hand, is a process of assuring Continuing Competence and incorporates CE; it is the continuing learning which pharmacists need to undertake towards the maintenance and enhancement of their personal development and professional competence. It

thus emphasises continuing pharmacist competence. In March 2000, the South African Pharmacy Council thus accepted the following four principles as the guiding principles to be taken into consideration in the structuring and implementation of a CPD system:

1. Lifelong competence, which encompasses knowledge, skills and attitude to practise is essential to the public interest
2. All pharmacists have to be able to demonstrate the competencies described in the unit standards for entry level pharmacists
3. The competence of individual pharmacists may be determined by the performance of practice audits, by the random sampling of competence/performance portfolios or by specific assessment of competence
4. A system for re-licensure have to be investigated in which pharmacists could be approved to practise in the various areas of pharmacy, with periodic re-certification based on evidence provided by the pharmacist (Putter, 2000:6).

The South African Pharmacy Council does not have a CPD system as yet but is currently engaged in groundwork for the careful planning of such a system. Discussions have been underway on a self–assessment tool for pharmacists and the maintenance of a portfolio (Personal interview at first site visit to the Pharmacy Council of South Africa in 2001).

(c) Process

In March 2003, at a three-day conference held by the South African Association of Hospital and Institution Pharmacists (SAAHIP), the self-assessment tool for pharmacists was work-shopped as part of the programme The South African Pharmacy Council is currently embarking on a pilot study, using the self-assessment questionnaire in both the public and private sectors where pharmacists practice. This pilot study was approved at a Council meeting that was held on 20 and 21 May 2003 (information obtained on researcher's personal site visit to the South African Pharmacy Council of in May 2003).

This Council has set up a task team that is scheduled to meet in June or July 2003, depending on the availability of the members of the said task team. The latter will come up with a strategy for the proposed CPD system and the necessary budgetary allocation for its implementation. The proposed implementation strategy consists of four steps:

1. The identification and recording of learning needs by individual pharmacists through a suitable self-assessment tool; pharmacists will then identify and list their learning objectives for a specified period.
2. The pharmacist undertakes courses and other learning activities to achieve their own learning objectives. Achievements are recorded in portfolios.
3. Assessment of actual competence and follow-up remedial action as the need arises.
4. The development of the necessary supportive legislative and administrative infrastructure (Masango, Putter & Summers, 2002:1).

(d) Outcome

Maintain a level of competence to provide effective and efficient care (Putter, 2000:5).

What lessons can be learned from the Pharmacists? Table 3.11 on page 132 highlights the aspects that could be considered for the development of a CPD system for nurses and midwives in South Africa.

Table 3.11: Aspects of the proposed CPD system of the South African Pharmacy Council that could be considered for nurses and midwives in the South African context

Aspects for consideration:
❑ CPD is introduced to ensure the continued and enhanced competence of the members of the profession
❑ Development of a self-assessment tool
❑ Embarking on a pilot study, using the self-assessment
❑ Regular communication, publishing of articles on developments around the development of a CPD system and dissemination of information.

Having described events pertaining to the development of a CPD system for pharmacists and highlighting aspects for consideration for the development of a CPD system for nurses and midwives in South Africa, a summary of the CPD systems for all health professions nationally follows.

3.6 Summary of findings with regard to CPD for health professions in South Africa

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Although there is a high level of acceptance, compliance and support for CPD amongst doctors and dentists, there are concerns with regard to the high cost of administering CPD and the high cost of conferences with subsequent financial implications for the practitioners who feel exploited in many instances (HPCSA, 2002:31). A reflection on the CPD system for the medical and dental professions indicates that:

- CPD is mandatory and linked to annual re-licensure.
- A sanctions model is being implemented. In the event of a practitioner not complying with the requirements of the CPD system, the board may impose one of various conditions.
- There is a choice of a wide variety of CPD activities to increase accessibility.

Conversely, pharmacists are engaged in extensive groundwork and the piloting of a self-assessment tool for pharmacists so that a system that is

effective and appropriate is implemented. Careful planning and consultation are being adhered to.

The total number of nurses and midwives in South Africa exceeds other healthcare professionals so the administrative implications will be more arduous and costly if the approach of the Medical and Dental Professions Board is emulated. The challenges in coordinating and ensuring effective monitoring and control mechanisms for all the nurses and midwives on the registers and rolls of the SANC needs thorough planning. The initiative of implementing a pilot study as is the case with the pharmacists would be highly recommended to afford the SANC ample time to consider what would be administratively manageable and affordable in terms of human, material and financial resources.

Having reflected on pertinent aspects of the CPD systems for all healthcare professions in South Africa, Table 3.12 on page 134 provides a overview of the CPD system for healthcare professions (Medical and Dental Professions Board and the South African Pharmacy Council).

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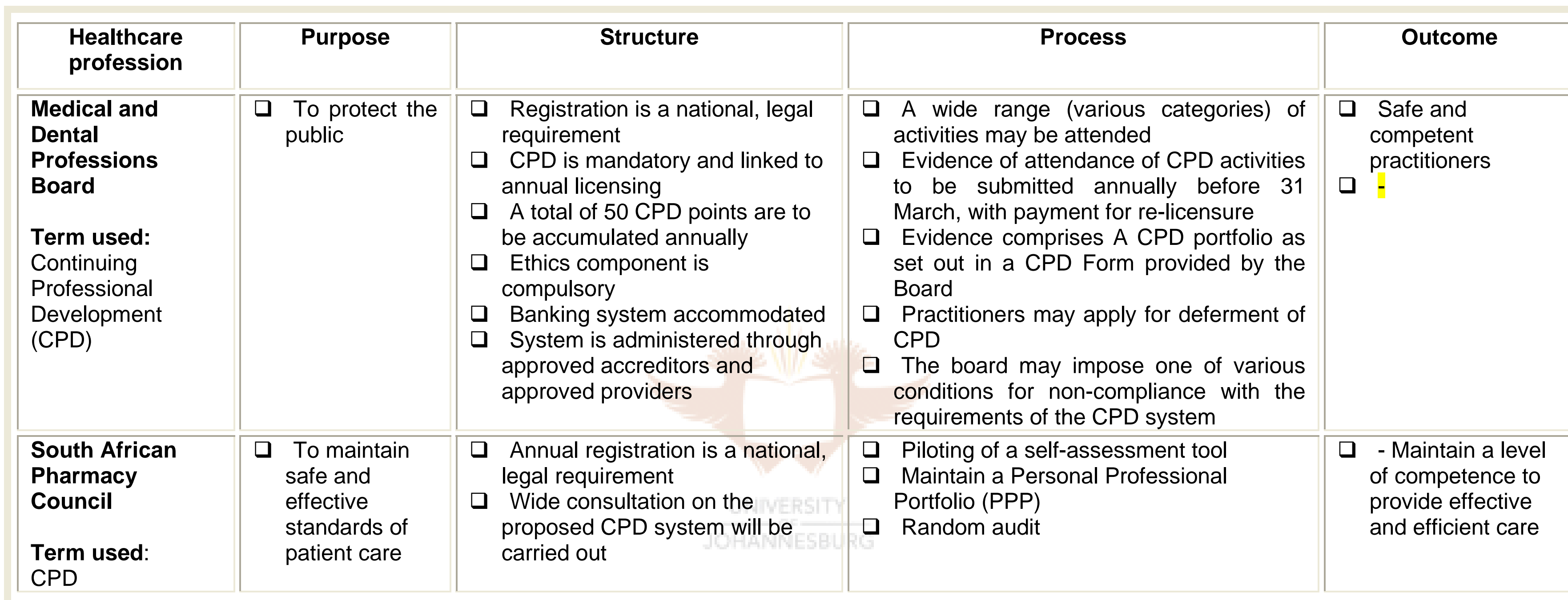
Table 3.12 : A overview of the CPD systems for healthcare professions in South Africa



Healthcare profession	Purpose	Structure	Process	Outcome
Medical and Dental Professions Board **Term used:** Continuing Professional Development (CPD)	❑ To protect the public	❑ Registration is a national, legal requirement ❑ CPD is mandatory and linked to annual licensing ❑ A total of 50 CPD points are to be accumulated annually ❑ Ethics component is compulsory ❑ Banking system accommodated ❑ System is administered through approved accreditors and approved providers	❑ A wide range (various categories) of activities may be attended ❑ Evidence of attendance of CPD activities to be submitted annually before 31 March, with payment for re-licensure ❑ Evidence comprises A CPD portfolio as set out in a CPD Form provided by the Board ❑ Practitioners may apply for deferment of CPD ❑ The board may impose one of various conditions for non-compliance with the requirements of the CPD system	❑ Safe and competent practitioners ❑ -
South African Pharmacy Council **Term used**: CPD	❑ To maintain safe and effective standards of patient care	❑ Annual registration is a national, legal requirement ❑ Wide consultation on the proposed CPD system will be carried out	❑ Piloting of a self-assessment tool ❑ Maintain a Personal Professional Portfolio (PPP) ❑ Random audit	❑ - Maintain a level of competence to provide effective and efficient care

Having completed a description of the CPD systems for all health care professionals in South Africa, it is also essential to describe the dynamic factors that would have to be considered to ensure that the proposed CPD system for nurses and midwives in South Africa is contextually appropriate.

3.7 National dynamic aspects

There are many underlying national dynamics that can influence a CPD system for nurses and midwives in South Africa. The following dynamic aspects are discussed: human rights, national priorities identified by the National Department of Health, management training, dispensing and prescribing medicines and evidence-based nursing and midwifery practice.

3.7.1 Human Rights

In the past decade South Africa has undergone a period of transformation from an autocratic to a democratic state. In the process the country has developed a Constitution, which is hailed as the most liberal and a model of human rights and human freedoms for the rest of the world to emulate. Within the Constitution is enshrined the Bill of Rights (Act 108 of 1996 Ch 2). This Constitution as the law supreme, governs every facet of South African life including the practice of nursing and midwifery.

The conception of the Bill of Rights was necessitated by a history of the violation of human rights. The attempt to address and redress these violations culminated in hearings by the Truth and Reconciliation Commission (TRC). The TRC hearings on the Health Sector Held on 17 and 18 June 1997 heralded the beginning of the health sector's "painful ethical voyage from wrong to right" (Asmal, Asmal & Roberts, 1996:47). This was the first time that health professionals reflected on the ways in which they were complicit in human rights violations during the apartheid era.

An analysis of these TRC health hearings (TRC, 1998) raises a number of challenges to the health professions. The TRC hearings made it clear that the appropriate training of health professionals is essential to the development of

professionals who understand and respect human rights and ethical codes and they therefore recommend that human rights be included in the training programmes of all health professionals. All health professionals should maintain individual competence and this should include ethical and human rights standards (Van Der Merwe, 2000:6).

Support from members of the professions is essential if the health professions are to own a process of establishing human rights as a professional responsibility. Professional accountability becomes a key and non-negotiable objective (Annas & Grodin, 1996:21). Accountability in the context of a human rights framework is the only effective and coherent way to move beyond lip-service to effect systemic transformation and to ensure that health and human rights are integrated into a common paradigm (Mann, Gostin, Gruskin, Brennan, Lazzarini & Fineberg, 1994:6). A CPD system must therefore attempt to minimise or prevent human rights abuses by appropriate coordinated interventions.

3.7.1.1 Professional ethics

Professional ethics is critical to the relationship between the profession and civil society; there is an honouring of an established social contract – a contract that is dependent on ethical practice and respect for human rights. At the societal level, nurses and midwives have largely been given a free hand; in return for this right to self-regulation, society respects them to protect the rights of patients/clients, groups, families and communities. However, this trust can be open to abuse (Baldwin-Ragaven, de Cruchy and London, 1999:10). It is also expected that nurses and midwives ensure that the highest standard of care and conduct are maintained. The following quote expresses this requirement aptly: "What is required is for human rights and professional ethics to be integrated into a single ethic, grounded in human rights principles. This new ethic needs to inform practice and training activities, so that behaving ethically means tangibly supporting human rights" (Baldwin *et al*, 1999:11). A CPD system should therefore also address ethical moral issues. This would most certainly also be in harmony with WHO initiatives.

The World Health Organisation (WHO) reaffirms the protection of human rights in health care and seeks to protect the dignity and integrity of the individual as well as promoting respect for patients. This declaration serves as a right for each country to create its own patient rights policies (WHO 1994). If health is seen as more than just the absence of disease or infirmity but interpreted as the WHO notion of complete well being, then health and human rights should be seen as complementary approaches to maximising human well being. Put simply, if health professionals are in the business of promoting health, then they are also in the business of promoting human rights. Nurses and midwives need to familiarise themselves with patients' rights and charters so that they can firstly achieve their advocacy role and secondly generate improved standards of care.

To date, it has not been a formal requisite for nursing and midwifery programmes to include issues pertaining to human rights. Should an effort be made to comply with the truth and reconcilliation recommendations (Truth & Reconcilliation Commission, 1998), namely, the inclusion of human rights in the training programmes of all health care professions (Van der Merwe, 2000:8), the question would then arise: How will training in human rights be effected to nurses and midwives who are not engaged in formal basic or post-basic education and training programmes? This can be rectified by its inclusion as a component of Continuing Professional Development.

Post registration/enrolment formal nursing and midwifery education and training should address factors affecting human rights practice, such as knowledge, skills, attitudes and ethical research practice. Nurses and midwives should (amongst others) acquire knowledge and understanding of:

- The conceptual framework for human rights
- The core principles of human rights
- Her advocacy role for vulnerable patients/groups in her care
- How to facilitate the adoption of a human rights culture in her working environment

- How to promote the ethical practice of nursing/midwifery which is firmly grounded in a human rights approach
- Codes relating to human rights including the United Declaration of Human

Rights and the South African Constitution's Bill of Rights (Baldwin-Ragaven *et al*, 2001:67).

This purposeful conscientisation of nurses and midwives through including human rights into the ethics component of Continuing Professional Development, could result in the development of a culture of human rights awareness, empowered to take action against abuses whenever and wherever they occurred. There needs to be a moral commitment to respect for human rights by all health care professionals. It is precisely this imperative that inspired the development of the *Batho Pele* Principles and the Patients' Rights Charter.

3.7.1.2 The Patients' Rights Charter

The Department of Health developed the Patients' Rights Charter and the *Batho Pele* Principles (See section 3.7.1.3 below), in an endeavour to promote the culture of a caring ethos, to strive for excellence in customer service and to ensure the realisation of the right to access of health care services.

"Patients have a right to:

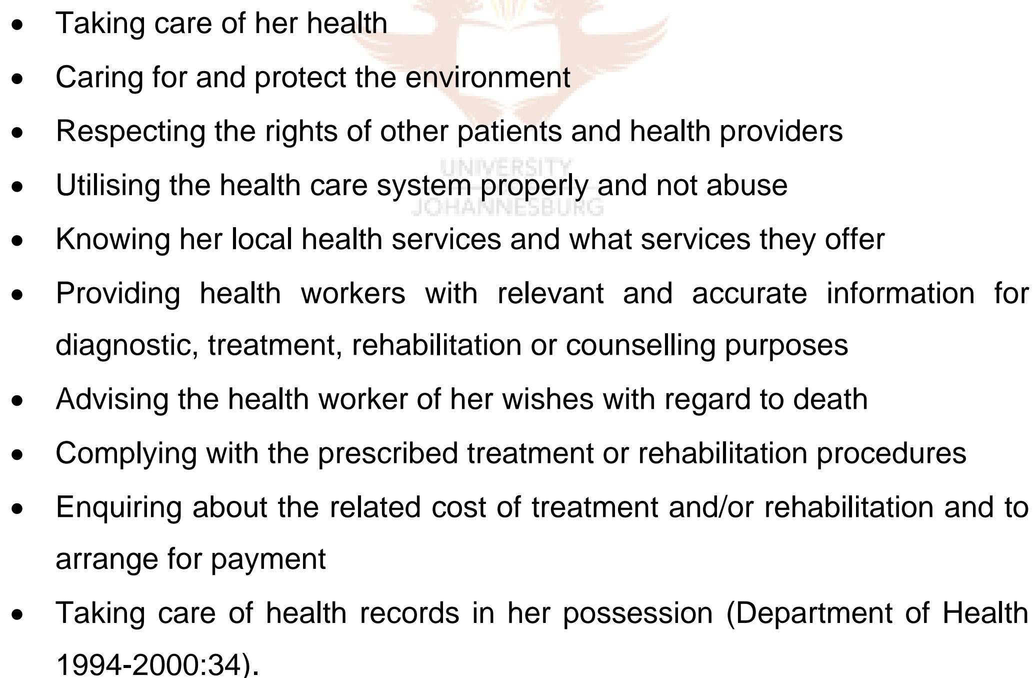
- A healthy and safe environment which includes adequate water supply, sanitation and waste disposal and protection from pollution, ecological degradation and infection;
- Participate in decision-making with respect to both health policy development and in matters affecting one's health
- Access to health care, including
  - -receiving timely emergency care
  - -treatment and rehabilitation
  - -provision for special needs
  - -counselling
  - -palliative care

-health workers who are courteous, empathetic and tolerant

-Provision of health information in a language understood by the patient

- Knowledge of one’s health insurance/medical aid scheme
- Choice of health service provider or health facility for treatment
- Be treated by a named health care provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- Referral for a second opinion
- Continuity of care
- Complain about health services.” (Department of Health, 1994-2000:34)

Nurses and midwives should have a thorough understanding of the Patients’ Rights Charter especially with regard to what their responsibilities entail *and* what the patients’ responsibilities comprise. A patient’s responsibilities comprise:



- Taking care of her health
- Caring for and protect the environment
- Respecting the rights of other patients and health providers
- Utilising the health care system properly and not abuse
- Knowing her local health services and what services they offer
- Providing health workers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes
- Advising the health worker of her wishes with regard to death
- Complying with the prescribed treatment or rehabilitation procedures
- Enquiring about the related cost of treatment and/or rehabilitation and to arrange for payment
- Taking care of health records in her possession (Department of Health 1994-2000:34).

3.7.1.3 The Batho Pele White Paper

In addition to the Patients' Rights Charter, the White Paper on Transforming Public Service Delivery published on 24 November 1995, seeks to introduce a fresh approach to service delivery:

> "... an approach which puts pressure on systems, procedures, attitudes and behaviour within the public service and re-orientates them in the customer's favour, an approach which puts the people first. This does not mean introducing more rules and centralised processes or micro-managing service delivery processes. Rather it involves creating a framework for the delivery of public services which treats citizens more like customers and enables citizens to hold public servants to account for the service they receive."

The approach is encapsulated in the name, which has been adopted by this initiative – *Batho Pele* (a Sesotho adage meaning 'People First'). The *Batho Pele* initiative applies equally to both internal and external customers. National and provincial departments have many internal customers such as staff within their own organisations, as well as other departments and institutions for whom they provide a service. Since nursing/midwifery is directly a people's profession these *Batho Pele* principles should be a respected backdrop for the ethics component of the proposed CPD system for nurses and midwives in South Africa.

The scope of the *Batho Pele* White Paper is directly applicable to those parts of the public sector, both national and provincial, which are regulated by the Public Service Act, 1994. This White Paper explicitly states the requirements that are mandatory for national and provincial public service departments. Amongst these are: The performance of staff that deals with customers must be regularly monitored, and performance that falls below the specified standards should not be tolerated.

Service delivery and customer care must be included in all future training programmes, and additional training should be given to those who deal directly with the public, whether face-to-face, in writing or on the telephone. This should not require the injection of large amounts of additional

resources: it is more a case of reorienting existing training programmes to focus on service delivery. All managers have a duty to ensure that the values and behavioural norms of their organisations are in line with the letter and spirit of the principles of *Batho Pele*. An understanding and application of the principles is vital for nurses and midwives who are practising their profession in South Africa.

The Eight Principles of *Batho Pele* are:

1. **Consultations**: citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered;
2. **Service Standards:** citizens should be told about what level and quality of public services they will receive so that they are aware of what to expect;
3. **Access:** all citizens should have equal access to the services to which they are entitled;
4. **Courtesy:** citizens should be treated with courtesy and consideration;
5. **Information:** citizens should be given full, accurate information about the public services they are entitled to receive;
6. **Openness and transparency:** citizens should be told how national and provincial departments are run, how much they cost and who is in charge;
7. **Redress**: if the promised standard of services is not delivered, citizens should receive an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response;
8. **Value for money:** public services should be provided economically and efficiently in order to give citizens the best possible value for money.

(Government Gazette no. 18340, notice 1459 of 1997:15)

In terms of an implementation strategy the *Batho Pele* White Paper proposes the following eight steps:

1. Identify the customer
2. Establish the customer's needs and priorities
3. Establish the current service baseline

4. Identify the 'gap improvement'
5. Set the service standard
6. Gear up for delivery
7. Announce service standards
8. Monitor delivery against standards and publish results.

These steps reflect the expectations of the public in their interactions with the nurses and midwives, just as in the case of the public service generally. The Department of Public Service and Administration (DPSA), who is responsible for the Public Service transformation policy and, within that, for improving service delivery, will provide leadership and expertise continuously to guide and support national and provincial departments' implementation programmes, and to assist in capacity building. In conjunction with others, such as the South African Management Development Institute and the Joint Universities Public Management Education Trust, the DPSA project team will ensure that key line and staff officials within departments are assisted to develop expertise and share good practice. The DPSA will evaluate the overall effectiveness of the *Batho Pele* initiative and submit regular reports to Parliament.

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In addition, the White Paper mandates that national and provincial departments publish their service standards in a Statement of Public Service Commitment. "The aim is to make a clear commitment to the Service Standards that citizens can expect, and to explain to citizens how the organisation will fulfil each of the *Batho Pele* principles" (Government Gazette No 18340 of 1 October 1997:28).

Batho Pele has the potential to bring about a major change in the way that public services are delivered. It marks the start of a continuous process of development, which will lead in time to public services that the public has a right to expect and that public servants are proud to provide. "*Batho Pele* must become the watch word of the new South African public service" (Government Gazette No. 18340 of 1 October 1997:30).

The National Department of Health, as a government department, is therefore under a statutory obligation to provide high standards of service in keeping with the *Batho Pele* Principles. Consequently, the National Department of Health has launched certain prioritised initiatives. Nurses and midwives, as the majority health care professionals, should have a CPD system that will incorporate all the national and provincial programmes and priorities.

3.7.2 National priorities identified by the Department of Health (DOH)

In 1994 the African National Congress published the Reconstruction and Development Programme (RDP). This is an integrated, coherent, socio-economic policy framework. The RDP proposed the restructuring of the health system so that it is based on the district health system, which is the vehicle for the delivery of primary health care. "This emphasises community participation and empowerment, intersectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitative services" (Reconstruction & Development Plan, 1994:45). This restructuring and development should not be confined to the health care providers in the public sector only, but include those in the private sector. The challenge to the health care providers in the private sector whose main business is a curative approach, is to fulfil their social responsibility by engaging in community outreach programmes and participating in campaigns in the form of private/public partnerships, to address the national/provincial programmes and priorities.

There is a need for training and re-orientation of all existing health workers in the primary health care approach. Nurses and midwives who are employed in the clinics provide a largely disease-oriented medical service. The training of primary health care nurses lacks a coherent strategy, as there is no consensus on the content and the duration of primary health care programmes. National/provincial programmes and priority initiatives that nurses and midwives need to acquire competencies in include the following:

- An expanded programme of immunisation
- Violence against women and child abuse

- Sexual assault training
- A reduction in the spread of and management of HIV/AIDS and STIs; including the syndromic management approach of STIs
- Youth-friendly reproductive health services
- Appropriate training of health care workers
- Comprehensive management of tuberculosis including the Directly Observed Treatment Strategy approach that is advocated by World Health Organisation
- Comprehensive management of carcinoma of the cervix, hypertension and diabetes
- Comprehensive measures to reduce substance abuse
- Integrated Management of Childhood Illnesses; a World Health Organisation strategy to reduce morbidity and mortality from the five diseases that are responsible for 70% of childhood mortality in the developing world namely, diarrhoea, acute respiratory infections, malnutrition, measles and malaria
- Given the high incidence of HIV/AIDS in South Africa, intervention strategies to reduce the incidence of this disease
- Maternal deaths notification, including five major causes of deaths:
  - Complications of hypertensive conditions in pregnancy (23.2%)
  - AIDS (14.5%)
  - Obstetric haemorrhage (13.3%)
  - Pregnancy related sepsis (11.9%)
  - Pre-existing medical conditions, mainly cardiac disease (10.4%) (Department of Health, 1994-2000:8)
- A thorough knowledge and understanding of the partogram is a critical requisite for all midwives so that it is used effectively in all clinical settings (Department of Health Report, 1998:3; Department of Health Report, 2002:11)
- National Drug policy published by the Department of Health with an essential drug list and standards treatment guidelines.

Nurses and Midwives will have to acquire expertise through Continuing Professional Development, to support the successful implementation of the national drug policy and to promote the concepts of the essential drug list and all the other national/provincial priority programmes and initiatives. A CPD system that accommodates the national programmes, priorities and initiatives of the Department of Health and the specific area of practice of the nurse and midwife will undoubtedly be contextualising the CPD system for nurses and midwives in South Africa and making it relevant in terms of addressing the health needs of South Africa.

The successful implementation of national/provincial programmes and priorities will not occur in the absence of strengthened and effective management structures.

3.7.3 Management training

The strengthening of health service management is internationally accepted as being one of the most critical factors in bridging the gap that exists between policy and implementation. It is also seen as an important priority in the South African National Health Plan, where management is one of the principal areas highlighted. A strong plea is further made to strengthen the capacity of institutions to support human resource planning and management. The orientation of training programmes has to shift from the past 'blueprint' and normative models to a participative, flexible and process-oriented model which allows facilitators to support teams to analyse their own problems and develop relevant solutions within the real life context of the workplace (Schaay, Heywood & Lehmann, 1998:93).

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Two levels of management skills were recommended in a study conducted by Human and Strachan (1996:15) to assess the self-perceived training needs of senior managers in the nine provinces of South Africa. The authors concluded that in the current context of transformation, there is a need to train managers both in "…generic management skills as well as transformational management skills understanding health policy, being able to manage the

complexity and change in the health sector, being able to set up new structures, having a bias for action and confidence".

A common theme that runs through the numerous workshops and reports focusing on health management training at national and provincial levels, is the need to develop a cadre of managers who are able to manage through innovation and action – as opposed to administration – and who are able to manage within the context of rapid and sometimes turbulent change (Mapplebeck, 1995:26).

Enrolling personnel on management training programmes should be seen as a dual investment, both in terms of strengthening effective management practice within the health service and in terms of the opportunity it creates to support the career enhancement of individuals in the health service. Unfortunately, the latter is currently given much consideration, consequently individuals are often sent on a variety of courses, which might have little to do with the role or direction they ultimately hope to pursue in the medium or long term. It would thus be important to explore and map out with individual personnel both their immediate training needs and their long-term career vision, so that the training they receive is congruent with their career objectives (Schaay, *et al*, 1998:101).

> "A common principle within the literature, is that training across traditional sector boundaries should be encouraged, a competency based approach to management training should be pursued, and that the training should encourage a reflective and self-directed approach to learning. In addition the particular skills by health workers to manage a transforming health system – at every level within the public health service – should serve to guide the development of the content of the evolving health management programmes in South Africa" (Schaay, *et al*, 1998:16).

The recommendations emanating from the South African Health Review (1998), are based upon the results of years of documented discussions, workshops and policy documents and are as follows:

- A nation-wide management training needs assessment should be developed to define the competencies required at each level and to identify the existing gaps.
- Provinces need to develop and fund coherent and realistic management training strategies or plans to fill the identified training needs.
- A plan should be developed to initiate a process of accreditation, which will encourage sharing of best practices and the development of quality learning materials, approaches to delivery and assessment.
- A comprehensive database should be established that captures the number of personnel who have undergone training, a record of the content, structure and cost of the programmes across the nine provinces.
- Collaborative ventures between health departments and training institutions should be encouraged.
- Mechanisms to provide for continued support for trainees in their workplace through processes of mentoring and apprenticeship should be put in place.
- A sample of current management programmes should be evaluated. Lessons from innovative and ideal models need to be identified and widely communicated to inform the training practices in other projects (Schaay, *et al*, 1998:102).

Continuing Professional Development, in the component of area of practice, would make provision for management training. The above recommendations should inform providers of CPD programmes as to what the specific needs and the desired outcomes pertaining to management training are.

Another critical dynamic factor that impinges on safe health care delivery is the dispensing and prescribing of medicines. The question then arises: Are nurses and midwives adequately trained to dispense and prescribe medicines?

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3.7.4 Dispensing and prescribing of medicines

In terms of Act 50 of 1978, as amended, Section 38A nurses are allowed to dispense, prescribe and handle medicines only under certain conditions. The most important condition is that a medical practitioner is not available at the time. Section 38A only makes provision for registered nurses in the services of the Department of Welfare and pensions, a provincial administration, a local authority or any health service that is designated by the Director-General to perform a health service function. This means that registered nurses working in health care facilities who are not designated by the Director-General and all registered midwives are excluded from the provisions of Section 38A. This results in numerous illegal practices, especially in the rural areas where there is a scarcity of doctors and pharmacists.

At present there is one pharmacist per 4 499 people in South Africa. The norm for industrialised countries, as proposed by the World Health Organisation, is one per 2 300 people. When considering equity in distribution or utilisation, South Africa can be said to have an overall shortage of pharmacists. Table 3.13 illustrates this shortage.

Table 3.13: Pharmacists: population ratios per province
(South African Health Review, 1998:107) 1996 population figures

Province	Number of pharmacists	Pharmacists: Population ratio
Eastern Cape	829	1: 7 075
Free State	467	1: 5 289
Gauteng	4 127	1: 1 738
KwaZulu-Natal	1 478	1: 5 191
Mpumulanga	373	1: 7 094
Northern Cape	108	1: 6 907
Northern Province	251	1: 16 446
North West	444	1: 6 854
Western Cape	1 638	1: 2 514
Total	9 715	1: 3 897

(Source: Interim South African Pharmacy Council)

It was further found that pharmacists are severely maldistributed among the provinces. The majority of pharmacists are concentrated in Gauteng while the Northern Province only has one pharmacist per 16,446 people. There is also a maldistribution of pharmacists between the private and public sectors – only 26% of pharmacists are employed in the public sector, which serves approximately 80% of the population (Putter & Hatting, 1998:1). This shortage burdens nurses and midwives who are the providers of health care in these remote areas. There is an acknowledged need to extend the prescribing and dispensing role to nurses and midwives on condition that the SANC regulates it. This entails amongst others:

- Education and training programmes approved by the Pharmacy Council
- Initial training, continued updating and accrediting of prescribers
- Regulating the practice of nurses and midwives
- Putting mechanisms in place for continued monitoring and support of generalists and specialists functions within the profession
- The development of protocols for diagnosing and prescribing for certain conditions.

Gray (1999:4) emphatically states that nurses can and should prescribe medicines and that appropriate Continuing Education would improve service delivery.

Continuing Professional Development, by incorporating area of practice, has a major role to play in contributing towards the protection of the public against malpractice by incompetent nurses and midwives and in terms of successfully implementing the national drug policy.

All these national priority programmes and initiatives with their consequent impact on service delivery prompted the need for the first national summit on nursing.

3.7.5 The first National Summit on Nursing (23-27 August 1999)

The National Summit on Nursing grew out of concerns regarding the current state of nursing education and training as well as service delivery within the country. Although considerable transformation has occurred since 1994, significant change is still needed within the nursing and midwifery professions to achieve the national objective of equitable and high quality primary health care services as set out in the ANC Health Plan and the White Paper for transformation of the health system in South Africa (1997).

This summit achieved wide stakeholder representation with 178 delegates in attendance. Provincial delegations from both the public and the private sector included human resource directors, nursing service managers, representatives from nursing education institutions, district and hospital managers, as well as clinic nurses. Other stakeholders included employee organisations representing nurses, South African Student Nurses' Organisation, professional organisations, the hospital Association of South Africa, as well as community partnerships and community organisations. The main objectives were to:

- Review nursing education and training
- Explore nursing practice within a multidisciplinary approach
- Promote a caring and compassionate ethos at all levels of health care
- Strengthen partnerships with all relevant stakeholders
- Promote participatory research
- Institute a forum for professional development
- Develop outcomes for implementation in 2000 (Gumbi, Manganye, Ntsimane, Maqaqa, Ramadi, Baron, Strasser & Kaye-Petersen, 1999:4).

The format of the summit included presentations by a variety of speakers as well as time for plenary discussions and small group work (commissions). The final two days focused on the development of resolutions. The report was written by the steering committee (researcher was one of the committee members) that presented it to the minister of health in November 1999.

Dr Tshabalala-Msimang, the Minister of Health, also outlined the following highlights of the presentations that have a direct bearing on Continuing Professional Development for nurses and midwives in South Africa:

- Waging a campaign against inappropriate practices and promoting *Batho Pele*
- Promoting the primary health care approach
- Agreeing on the definition of a primary health care nurse
- Identifying the competencies this cadre should have
- Co-ordinating the content and the duration of this training
- Reviewing of the scope of practice of nurses and midwives so that it facilitates health care service delivery
- Placing a programme in place for the massive training and re-orientation of nurses and midwives so that they in turn are empowered to develop the nation (Tshabalala-Msimang, 1999:35)

The Minister of Health also emphasised that nurses and midwives are in the forefront of the delivery of quality health care services and that nurses and midwives are relied upon to provide the first level of care. In her address she said: “You know that it is not always necessary for clients to be seen by doctors and that nurses can attend to the majority of cases themselves, before referring the complicated cases to the doctors. Therefore we value your contribution very much” (Tshabalala-Msimang, 1999:37).

Dr Ntsaluba, the Director-General of the National Department of Health, in his opening address at the summit on nursing, also reflected in the following statement that a strong sense of trust was vested in nurses and midwives: “I have great faith that indeed the nursing profession can live up to the expectations that we have of you…” (Ntsaluba, 1999:27). These quotations further challenge nurses and midwives to update their knowledge, skills and attitudes so that they do not compromise on the quality of the service delivery expected of them.

Community-based education was also identified as a much-needed strategy to complement the effective implementation of a primary health care approach and as a means to bridge the gap between the basic and post basic curricula and the realities of health care practices in the community. According to Boelen (1995) Community-based education is an acknowledgement of the health profession's obligation to society and can therefore be fitted into the model of social accountability (Boelen, 1995 In: Mazaleni, 1999:59). The *White Paper* for the Transformation of the Health System in South Africa (1997) categorically states that:

> "It is essential to obtain the active participation and involvement of all sectors of South African society in health and health-related activities. All sections of the community, all members of households and families and all individuals should be actively involved, in order to achieve the health consciousness and commitment necessary for the attainment of goals set at the various levels. The people of South Africa have to realise that, without their active participation and involvement, little progress can be made in approving their health status. Health teams and workers at all levels should develop a caring ethos and commit themselves to the improvement of the health status of their communities. They should not only be responsible for the patients who attend their health facilities, but also have a sense of responsibility towards the majority of the population in their catchment areas. Emphasis should be placed on reaching the poor, the underserved, and the aged, women and children, who are amongst the most vulnerable" (Notice 667 of 1997:5).

In response to this *White Paper* the SANC, in December 1999 sent out a circular 18/99, to all nursing education institutions and other relevant stakeholders, requesting that community based education and problem based learning be incorporated in all basic and post basic nursing education and training programmes where and as appropriate. This circular also requested that national priority programmes be incorporated in all basic and post basic education and training programmes.

How will all this be accomplished for nurses and midwives that are not engaged in formal education and training programmes? What mechanisms will have to be put in place to implement all these transformative processes? It

is evident that a CPD system has to be developed and implemented. However, the content of such Continuing Professional Development has to incorporate the identified limitations in relation to competencies, so that nurses and midwives are capacitated to fast track service delivery. There is also a need to ensure that CPD includes the aspects that impact on effective service delivery within the context of South Africa.

Over and above these transformative developments, professional benchmarking with regard to building the knowledge base of the nursing and midwifery professions should be included and applied to all formal and non-formal education and training for nurses and midwives. Evidence-based practice should be included in CPD of all health care professions.

3.7.6 Evidence-based nursing and midwifery practice

Nursing and midwifery research have experienced remarkable growth and are providing nurses and midwives with an increasingly sound base of knowledge from which to practise. Nurses and midwives who incorporate research evidence into their clinical decisions are being professionally accountable to their patients/clients and are also helping nursing and midwifery to achieve professional identity.

Nurses and midwives are being asked more than ever before to document their role in the delivery of health care. Consumers are increasingly recognising health care as a right rather than a privilege and, with spiralling costs, health care professionals are being questioned about how their services contribute to the total delivery of health care. This increasing interest in examining health care practices makes it essential for nurses and midwives to evaluate the efficacy of their practices and to modify or abandon those practices that either have no effect or adversely affect the health of patients/clients (Polit and Hungler, 1999:4).

Midwives have a clear responsibility that the care they offer to women and their babies are based on the best available research evidence. It is important

to recognise how, in the past, some interventions which were not based on evidence did more harm to than good. These include routine inductions, routine episiotomies, restricting the mother's position at birth, taking babies away from their mothers on postnatal wards, and giving breast-fed babies top-up feeds with formula milk. It is both challenging and uncomfortable to question these and many other interventions, which were once part of every day practice, and the detrimental effects that they have had on women and their babies.

Many questions about practice still remain unanswered. In addition, factors such as technological advances, changes in the way maternity services are organised, women's expectations of their childbirth experience and of what the service should offer, mean that there are still many issues, questions and challenges to be addressed. Because of these factors, midwives have to continuously develop their knowledge on a continual basis so that women and their babies can be assured of safe and quality midwifery care.

Striving to render optimum care entails reflecting on particular practices, reviewing the literature, attending workshops, seminars, symposia and peri-natal meetings or actually conducting a research study. Then midwives have to identify whether there is a need to change practice, implement that change and continue to improve and develop their knowledge and clinical care. Evidence-based practice is at the centre of high quality midwifery care. There is an ethical imperative to deliver care that is based on the best available information, to minimise medico-legal risks (Proctor, Renfrew *et al* 2000:3).

The current emphasis on evidenced-based health care requires nurses and midwives to base their clinical practice to the greatest extent possible on research-based findings rather than on tradition, authority, intuition or personal experience (Polit & Beck, 2004:13). Nurses and midwives need to become engaged in a variety of research-related activities as a way of enriching their professional lives and making a purposeful contribution to the body of knowledge of nursing and midwifery. These research activities include the following:

- Participating in a journal club in the practice setting, which involve regular meetings to discuss and critique research articles
- Attending professional conferences that present research findings
- Evaluating completed research for its possible utilisation in the practice setting
- Assisting in the collection of research information
- Reviewing proposed methods for research information with respect to their feasibility in a clinical setting
- Participating on an institutional Ethics Committee to review the ethical aspects of proposed research before it is undertaken
- Incorporating research findings into nursing and midwifery practice or education (Polit and Hungler, 1999:4).

The above research activities are incorporated in CPD activities in the area of practice of the nurses and midwife.

3.7.7 Summary

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It thus becomes evident that the various socio-political factors and national dynamic aspects have to be considered in the development of a CPD system for nurses and midwives in South Africa. The in-depth discussion of these pertinent aspects were regarded as critical to the development of a CPD system for nurses and midwives; a system that is contextually acceptable and cognisant of discussions, developments and priorities in the South African healthcare arena.

3.8 Concluding statements

The theoretical framework provides information on the purpose, structure, process, outcome and a summary of the aspects of each of the CPD systems for nurses and midwives in selected countries internationally that could be applied within the South African context and of CPD systems for healthcare professionals nationally. The theoretical framework will be used to describe the Draft CPD system and the Final CPD system in respect of the purpose, structure, process, outcome and summary. The Final CPD system will also

include the context, role players and underlying dynamics. The discussion on the national dynamic aspects that influence a CPD system for nurses and midwives in South Africa will also inform the development of the Draft CPD system and the Final CPD system for this study.

Chapter 3 provided a description of the knowledge frameworks of how CPD is implemented for nurses and midwives in selected countries internationally, for health professions nationally and a discussion on the national dynamic aspects that should be considered for the proposed CPD system for nurses and midwives in South Africa. In Chapter 4 the Draft CPD system for nurses and midwives in South Africa will be described.

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CHAPTER 4

A DESCRIPTION OF THE DRAFT CONTINUING PROFESSIONAL DEVELOPMENT SYSTEM FOR NURSES AND MIDWIVES IN SOUTH AFRICA

4.1 Introduction

A description of the theoretical framework on how Continuing Professional Development for nurses and midwives is implemented internationally, and for health professionals nationally, was provided in Chapter three. The previous chapter also described the national dynamic factors within a South African context that influence the development of the Draft CPD system and the Final CPD system for nurses and midwives in South Africa. The Draft CPD system that the researcher has developed with the SANC since August 2000, is described according to the format used in Chapter 4, namely purpose; structure; process; outcome; and summary.

4.2 Overview of the Draft CPD system

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The Draft CPD system is based on the CPD system implemented by the Medical and Dental Board of the HPCSA in 1999. Figure 4.1 visually represents the Draft CPD system for nurses and midwives in South Africa.

Figure 4.1. A visual presentation of the Draft CPD system

The SANC will monitor and control the Draft CPD system with the assistance of approved accreditors and providers. According to the system all nurses and midwives on the registers and rolls of the SANC have to accumulate a total of 15 CPD points per annum, where the duration of one hour for a CPD learning activity equals one CPD point. The CPD system will be administered by the SANC who will, however, delegate the responsibility of accrediting CPD activities to Accreditors approved by the SANC. Providers of CPD activities will also be approved by the SANC. The approved accreditors will recommend to the SANC the approval of and point allocation for CPD activities, offered to nurses and midwives by the providers.

Each nurse and midwife keeps evidence of CPD activities in her CPD portfolio. Annual entry of CPD activities is made onto the SANC's CPD statement and forwarded to the SANC before the 30 March or as determined by the SANC. A process of deferment is accommodated when a nurse or midwife, due to illness or other life circumstances, is unable to meet the CPD requirement of 15 points. A positive evaluation of the annual CPD statements for compliance determines whether the registration/enrolment of the nurse and midwife is renewed for that specific year. Non-submission of annual CPD statements without an application to the SANC for a deferment results in non-renewal of the registration of those particular nurses and midwives.

The SANC will conduct an annual audit to determine compliance with the Draft CPD system by means of a 5% stratified random sample of the total number of nurses and midwives on its registers and rolls. Findings of non-compliance are referred to the Preliminary Investigation Committee of the SANC. This committee then determines whether the case of non-compliance warrants a formal hearing by the Professional Conduct Committee of the SANC.

4.3 Description of the Draft CPD system

The Draft CPD system is described below, according to purpose, structure, process, outcome and summary.

(a) Purpose

The primary purpose for a Draft CPD system (See Annexure F), for nurses and midwives in South Africa, is to protect the public through promoting continued learning for safe care to all (SANC, 2000:1).

(b) Structure

The Draft CPD system was based on the CPD system of the HPCSA and was administered by the SANC who appointed accreditors. These accreditors would be responsible for accrediting and reviewing CPD activities of providers, according to specific criteria and guidelines. Accreditor status was granted to applicants who met the requirements specified by the SANC (See Annexure F). The SANC ensured that the responsibilities delegated were carried out in a fair and equitable manner and retained the right to withdraw any delegated authority from accreditors, should the circumstances so require.

A proposal for the human resources required to administer the Draft CPD system at the offices of the SANC was presented to the Education Committee of the SANC on 11 October 2000, and to the full Council (SANC) at a meeting held on 8 May 2001. These included:

- One CPD manager (at the level of a senior administrative officer) responsible amongst others for co-coordinating the handling of applications for the approval of accreditors and confirming recommended activities and CPD point allocation
- One administrative officer deputising for the manager
- Two senior typists.

The administrative officer and the typists were responsible for creating and keeping up to date the database of accreditors, providers, approved activities and credit points allocated thereto; processing the information received from the providers; transferring and recording information on the database specific to each registered/enrolled nurse and midwife, while the CPD manager supervised the entire process.

An itemised budget covering costs for the human resources, equipment, furniture and stationery was drafted. The proposed budget reached a total of R1 207 784 (See Annexure G, SANC WD14/2000, unpublished). The senior manager for information management at the offices of the SANC compiled a detailed proposal with regard to the resources and the information technology input, to provide the necessary electronic infrastructure (See Annexure H).

Stakeholders of the SANC were invited to send two delegates each to represent them at the National Workshop of the Education Committee in September 2001 where wider consultation on CPD occurred. The approved stakeholders of the SANC included:

- The Department of Health
- South African Qualifications Authority (SAQA)
- The Health and Welfare SETA (HWSETA).
- The Council for Higher Education
- The heads of the departments of nursing in the 18 universities in SA The heads of the 42 nursing colleges in SA
- The heads of the nursing departments in the 10 Technicons in SA
- The various professional associations
- The three private sector groups, namely Afrox Healthcare, Medi-clinic and Netcare
- Organised labour groups – 16 listed
- Special interest groups – 36 listed (See Annexure I).

In addition to the identified stakeholders, other role players are the population for which the CPD system will be implemented, namely all the nurses and midwives of South Africa who are registered/enrolled with the SANC. The question then arises: How many nurses and midwives are on the registers and rolls of the SANC? Table 4.1. Illustrates the distribution of the nursing and midwifery population in the nine provinces of South Africa on 31 December 2003.

Table 4.1: Distribution of the registered/enrolled nurses and midwives in the nine provinces of South Africa (SANC, 2003)

Province	Nurses and midwives on the registers and rolls of the SANC as at 2003/12/31			
	R/N	E/N	E NA /	Total in each province
Eastern Cape	11 678	3 318	5 150	**20 146**
Free State	7 216	1 288	2 981	**11 485**
Gauteng	26 871	7 567	13 760	**48 198**
Kwa-Zulu Natal	18 343	9 769	8 442	**36 554**
Limpopo	7 006	2 948	3 125	**13 079**
Mpumulanga	4 420	1 873	1 502	**7 795**
Northern Cape	1 856	567	912	**3 335**
North West	6 330	2 059	3 793	**12 182**
Western Cape	12 995	4 186	7 766	**24 947**
Total number of nurses and midwives (various categories) in South Africa	**96 715**	**33 575**	**47 431**	**177 721**

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These statistics for registered nurses, enrolled nurses and enrolled nursing auxiliaries, indicate the number of CPD statements that will be received by the administrative personnel of the SANC on an annual basis for processing and capturing of CPD data. These statistics would also assist with the monitoring of submissions of CPD statements from the nine provinces of South Africa, to determine the nurses' and midwives' compliance with the CPD system.

(c) The process

The process firstly deals with a systematic, step-by-step description of the development of the Draft CPD system by the Education Committee of the SANC, together with the researcher. Secondly, the Draft CPD system will be described in detail..

4.3.1 The development of the Draft CPD system

Step 1

The first formal discussion on CPD occurred on 9 June 2000, at a workshop of the Education Committee (EDCO) of the SANC where their projects for the business plan for the financial year 1 September 2000 to 31 August 2001 were discussed. The Education Committee of the SANC included the development of a CPD system for nurses and midwives in South Africa in its business plan. The researcher's first presentation was in August 2000 and was structured so as to commence deliberations around pertinent questions that needed to be considered for developing a CPD system for nurses and midwives within a South African context. The following questions were posed to the Education Committee:

- Is there a justified need for a CPD system for nurses and midwives who are licensed to practise in South Africa?
- Would all the following categories, namely Nursing Auxiliaries; Enrolled Nurses and Midwives; and Registered Nurses and Midwives be included?
- Would the implementation be staggered for various categories?
- What would the content entail in relation to theory, skills and attitude?
- How will it be implemented to ensure that it is based on the principles of validity, simplicity, realism, practicability, affordability and attainability?
- Would it be based on a three-year or a five-year cycle?
- What would be put in place for nurses and midwives who have not been practising for five to10years?
- When and how will consultation with the nurses and midwives occur?
- How will CPD points be allocated? Would it be the same for each category?
- Will exemptions be granted?
- Will CPD be regulated? (SANC Working Document 10/2000, unpublished).

Step 2

Discussions followed the presentation of these questions. The Education Committee of the SANC requested information on existing CPD systems for nurses and midwives internationally, and for health professionals nationally. This information was used as a basis for developing the Draft CPD system for nurses and midwives in South Africa. The researcher then conducted a descriptive, exploratory literature search and other data-gathering methods to meet the request of Education Committee. A report was compiled to reflect the findings of the researcher (SANC Working Document 14/2000, unpublished). This working document was presented to EDCO at a meeting held in April 2001. The main areas covered included:

- A description of the international findings on CPD for nurses and midwives in Australia; Canada: College of Ontario; the United Kingdom; the United States of America: California; and Africa: Kenya.
- The national findings on CPD for healthcare professionals with special emphasis on the CPD system for the Medical and Dental Board of the Health Professions Council of South Africa as their CPD system had commenced on in January, 1999
- Information and technology
- Proposed resources – staffing and equipment requirements
- Proposed budgetary requirements (SANC Working Document 14/2000, unpublished).

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A discussion also followed at the Education Committee on the South African context of health service provision and the prevailing socio-political milieu. The fact that nurses and midwives are often referred to as the 'backbone' of service delivery led to a consensus that it is imperative that they be continually updated and developed in terms of all the requirements for adequate and acceptable healthcare service delivery in South Africa. It was also noted that there are legal and socio-political factors that would impact strongly on the purpose, structure, process and outcomes of the Draft CPD system for nurses and midwives in South Africa. Hence dynamic factors, such as human rights

and national programmes and priorities of the Department of Health, are included and discussed in the Draft CPD system.

Step 3

The IT requirements and proposed human resources were presented to the Education Committee and the drafted CPD document was only presented to the SANC in May 2001. It was resolved that the following changes be made to the draft CPD document and that it must also be presented to the Laws and Practice Standards Committee for discussion and input. The researcher coordinated the documentation of these developments.

Step 4

The amendments as proposed by the SANC were effected and the amended first draft CPD document was presented in July 2001 to the Adhoc Laws and Practice Standards Committee (A working committee of the SANC's Laws and Practice Standards Committee). It was resolved that a joint workshop be held by these two committees so that they could discuss amongst other items, the first draft of the CPD document that would be presented to all the relevant stakeholders of the SANC. The SANC ratified the amended draft CPD document in July 2001, and the content thereof is contained in Annexure F.

Step 5

This CPD document, with the word 'DRAFT' imprinted across its front cover page (See Annexure F), was presented at the national conference of the Education Committee on 12 and 13 September 2001. Copies of the document were distributed to all the delegates. An overwhelmingly positive response was received and this was evidenced in a report that was presented to the SANC in November 2001 (SANC, 2001 unpublished). The written evaluations of the delegates who attended this conference formed the basis of the final report. Correspondence in response to the national workshop was also received from some of the representatives of the SANC's stakeholder group. An example of such correspondence is attached as Annexure J.

Step 6

The Draft CPD document was sent out to the Human Resource Directorates of the nine provinces for further consultation, collaboration and comment. The comments/inputs from Human Resource Directorates of the nine provinces was forwarded to the Department of Health. A consolidated report of the inputs was compiled (See Annexure K) and presented to the SANC. The report indicated that the contents of the Draft CPD document was accepted and it was emphasised that special consideration be made to accommodate nurses and midwives in remote rural areas. A cautionary note not to repeat the mistakes made by the Medical and Dental Board of the HPCSA was also reflected.

Step 7

Additional written feedback was requested from South African Quality Assurance Authority (SAQA), Health and Welfare Seta (HWSETA) and the Council for Higher Education (CHE). The following inputs were received and presented to the Education Committee of the SANC on 3 and 4 October 2001:

- The director of SAQA expressed his concern about the use of the term credits (CPD credits), and further commented that credits would only apply if unit standards are used for CPD programmes and credits appropriately allocated (See Annexure L).
- The Health and Welfare Seta responded telephonically to the request of the researcher and enquired about the criteria for the approval of CPD activities. It was satisfied when it was indicated where and what was listed as requirements in the draft CPD document, to qualify for the approval of CPD activities.
- No comments were received from the Council for Higher Education.

Step 8

The Education Committee of the SANC, in its report dated 3 and 4 October 2001, then recommended that the following adjustments be made to the 'Draft CPD Document':

- The term ‘credits’ must be replaced with points throughout the document, to avoid confusion with the credits that were allocated to approved formal education programmes
- Under the activities for ‘Category 3’ Promoter/mentor/study leader for masters/Doctoral, 15 points must be removed
- The ‘Banking System’ must be added for nurses and midwives practising abroad (See Annexure F).

The above recommendations were ratified by the SANC (Council Minutes November 2001, unpublished). The SANC also resolved that a detailed budget be presented in July 2002 for the implementation of CPD in 2003, as recommended by the Education Committee (Education Committee Report, 3 and 4 October 2001, unpublished).

On 28 February 2002 the researcher resigned from the SANC. Further developments with regard to CPD ceased until April 2003 when the SANC resolved that a task team draft a newsletter that was presented to the SANC in May 2003 (See Annexure M). This newsletter was not sent out to the nurses and midwives.

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Step 9

Consultation processes with the profession comprised various presentations at planned conferences/meetings/workshops to which the researcher was invited to present the Draft CPD system for nurses and midwives tin South Africa (See Table 4.2). Plenary sessions were accommodated and queries pertaining to the Draft CPD system were clarified. In all instances there were positive responses and a general agreement to the urgent need for the implementation of a CPD system for nurses and midwives in South Africa. Clarification was sought around the terminology of accreditor, provider and the various categories of CPD activities. Table 4.2 provides an overview of the sample realisation on CPD as part of the wider consultation process with the profession at large from November 2000 to May 2003.

Table 4.2: Sample realisation: consultation on the Draft CPD system for nurses and midwives in South Africa.

Date	Event	Province and Target Group
28 November to 1 December 2000	International Midwifery Conference Heads, Hearts and Hands of Midwives in the New Millennium	Northern Province Midwives from the nine provinces
18 July 2001	Staff Development Programme	Gauteng Community health nurses
31 October 2001	Conference: Practical Solutions for Peri-natal Problems	Gauteng, Northern Province, Mpumulanga midwives
29 November 2002	TECHNEDSA (Technicon Nursing Education Departments, South Africa)	Representatives (lecturers) of the various Technicons in the nine provinces of the RSA
5 to 7 December 2001	International Midwifery Congress: 'Midwives Bringing Light to the Nation'	Midwives from the nine provinces of South Africa 1 500 delegates
17 to 18 September 2001	National Workshop of the Education Committee of the South African Nursing Council	All stake holders of the SANC (All nine provinces represented (See Annexure I)
March 2002	FUNDISA (Forum for the nursing departments of the universities in the nine provinces of South Africa).	Representatives from the Nursing Department in the universities of the nine provinces of the RSA
19 to 20 June 2002	2nd International Health Conference: Reshaping The Nursing Landscape (University of the Witwatersrand. Department of Nursing Education)	All health care professionals (national and international representatives)
21 June 2002	Presentation and workshop	Western Cape nurses and midwives in the Private sector
August 2002	Presentation at ECSACON Conference in Dar es Salaam, Tanzania	Nurses and midwives of the 14 countries that form the East, Central and Southern Africa College of Nursing (ECSACON)
October 2002	Nurse Educators/Administrators forum (Public and private sector)	Nurse educators and managers in public and private sector
May/June 2003	Nurses and midwives in the private sector	Nurses and midwives in the private sector

4.3.2 The Draft CPD system

The Draft CPD system is based on the point system, similar to that of the HPCSA (See section 3.5.1). Each nurse and midwife who is registered or enrolled with the SANC is required to obtain 15 CPD points annually. Evidence thereof must be entered on an Annual CPD Achievement Form (See Annexure Q) that is issued annually by the SANC with the annual reminders for submission of the annual licensing fees. This statement is completed and submitted to the SANC annually on or before 30 March or as determined by the SANC. Each nurse and midwife that appears on the register/roll of the SANC has to meet the requirement of 15 CPD points annually.

The first year for implementation decided on was 2003. This has subsequently been changed to the implementation of a pilot study by the SANC during the year 2004 to allow the Council time to consider the administrative logistics and the technicalities for the effective running of the CPD system. The distribution of the points is illustrated in table 4.3.

Table 4.3: The distribution of CPD Points
(One CPD point equals one hour)

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Specified area	**Number of CPD Points**
Ethics (emphasis on human rights)	3
Area of practice	7
National/Provincial programmes and priorities	5
Total points to accumulate annually	15

Each nurse and midwife should plan to achieve 3 points for Ethics with an emphasis on human rights, 7 points for her specific area of practice and 5 points for national/provincial programmes and priorities. The total number of points to be accumulated annually is 15. A record has to be kept of each learning experience, in the form of a CPD portfolio. The Continuing Professional Development portfolio serves as evidence for each learning activity that the nurse and midwife participated in. Certificates of attendance should be filed in the CPD portfolio.

Various CPD activities have been accommodated according categories 1, 2 and 3 (See Annexure F) so that nurses and midwives who practise their professions in a rural setting are not prejudiced by the Draft CPD system. A description is provided of the documented evidence that is required for each category of CPD activity.

Category 1: A certificate from the provider.

Category 2: A certificate describing the activity under the following headings:

- Type of activity
- Content addressed
- Expert(s) involved e.g. critical care nurse specialist
- Date and time
- Signed by chair/leader of activity

Category 3: Self study

- Keep a record in the same way as for *Category 2*, but with only the details of the individual nurse and midwife
- Individual learning: As for self-study signing
- Research and publication: A copy of the article/publication
- Qualification: Copy of certificate
- Evaluation: Appointment letter

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On licensing annually every nurse completes the 'CPD Statement' (See Annexure F), signs it and submits it to the SANC. The data is captured and analysed by the CPD officers of the SANC.

The SANC will conduct an annual audit to monitor compliance with the CPD system. The CPD Officer of the SANC draws a stratified random sample of 5% of nurses and midwives, and these practitioners are requested to submit their CPD portfolios. The content of the portfolio is checked against the CPD Statement that was submitted to the SANC. If the evidence in the portfolio does not support the statement, the matter is referred to the preliminary Investigation Committee of the SANC. This committee then determines

whether the case warrants a formal hearing by the Professional Conduct Committee of the SANC.

The CPD system will be administered by the SANC. The SANC will however delegate the responsibility of accrediting CPD activities to Accreditors approved by the SANC. Accreditors have to meet the SANC's requirements to obtain approval status (See Annexure F) at a nominal fee that will be determined by the SANC from time to time. Providers of CPD activities will be approved against criteria determined by the SANC (See Annexure F). Providers will submit their CPD activities to an approved accreditor for approval of the activity and the number of points allocated for the specific activity. All nurses and midwives practising their profession in South Africa are expected to keep a personal professional portfolio wherein an accurate record will be kept of all their CPD activities. Copies of certificates of attendance for conferences, workshops, etc., will also be filed in the CPD portfolio.

All the nurses and midwives on the registers and rolls of the SANC will receive CPD statements together with their annual registration reminders from the SANC. The CPD statements are completed and returned to the SANC. An audit will be conducted annually to monitor compliance with the requirements of the CPD system. This audit will comprise a random stratified sample of 5% of the total number of nurses and midwives on the registers and rolls of the SANC. Non-compliance with the Draft CPD system results in the matter being forwarded to the Preliminary Investigation Committee of the Professional Conduct Committee of the SANC. Provision has however been made for the application for a deferment (See Annexure F).

Nurses and midwives who have not been on the register/roll for five or more years are required to complete a return-to-practice programme comprising 40 CPD points. The distribution of these points is illustrated in Table 4.4.

Table 4.4: Distribution of points for the return-to-practice programme

Content	Number of points
Ethics (emphasis on human rights)	8
Area of Practice	25
National/Provincial Programmes and Priorities	7
Total number of points	**40**

The definitions of the concepts used in the Draft CPD system are also included in the Draft CPD document (See Annexure F).

Having drafted the CPD system, at a meeting held on April 2003, the Education Committee of the SANC delegated a task team to draft a newsletter informing the profession at large firstly about the implementation of the Draft CPD system, and secondly about the SANC's intention to conduct a pilot study on the Draft CPD system. The researcher was included in this task team, which met in May 2003 to draft a newsletter (See Annexure M) that was presented to the SANC at a meeting in June 2003. The SANC resolved that the task team, with the assistance of the registrar (CEO), amend the drafted newsletter by including the definitions of the various concepts used in accordance with the Draft CPD document (See Annexure F).

This amended newsletter would then be enclosed with the 2003 annual reminders for the payment of licensing fees (for 2004) that are sent out annually in the month of July to each nurse and midwife who appears on the register and rolls of the SANC. The newsletter was not amended, as the task team did not meet. The term of office of the first democratically elected SANC ended on 30 June 2003 and the newly elected SANC came into office on 1 July 2003. The newly elected SANC focused on the induction of the new SANC members and this was followed by a strategic workshop in December 2003. The Draft CPD system was put on hold since May 2003 and the nurses and midwives are awaiting the SANC's decision with regard to Continuing Professional Development.

(d) Outcome

The outcome of the Draft CPD system is the promotion of continued learning for safe care to all.

(e) Summary

The Draft CPD system is based on the CPD system implemented by the Medical and Dental Board of the HPCSA since 1999. The SANC, in terms of its mandate from Nursing Act 50 of 1978, as amended, is expected to make visible attempts to protect the public of South Africa and monitoring and controlling CPD could contribute to this achievement. However the Draft CPD system demands coordinated administrative procedures in offices that are well resourced, with efficient and effective information technology programmes. The SANC does not currently have the resources (human, financial and information system) to monitor and control such a costly system as that of the HPCSA. Moreover the HPCSA has also experienced problems with its information system with regard to CPD.

In a media statement, dated 4 June 2004, the HPCSA acknowledged the shortcomings of its current CPD system in the following statements:

> "Council wishes to apologise most sincerely to its practitioners for the administrative and IT shortcomings of the current system ... The programme needs to establish whether we are improving the knowledge and skills of our practitioners through the existing system or whether we are placing more emphasis on the accumulation of points. By not evaluating the knowledge gained or skills acquired from certain activities we cannot measure whether we achieve the overall objective of Continuing Professional Development. The reconfigured CPD system will address this shortcoming" (HPCSA, 2004:1).

In the same press release, the HPCSA stated that a carefully thought through theCPD system – with lessons learnt from other such systems used elsewhere – is the recommended route to inform the process of a new CPD system.

In a more recent press release dated, 3 October 2004, the HPCSA stated: “In view of the difficulties encountered with the current CPD system, Council commissioned a rigorous review of the current CPD system in order to align it with competencies and outcomes rather than emphasising on the accumulation of points” (Press statement, Padayachee, 2004).

The Draft CPD system has been on hold since April 2003. The newly elected and appointed SANC has been through a period of induction, followed by a strategic workshop in December 2004. There has been no further development with regard to the Draft CPD system for nurses and midwives in South Africa.

4.4 Conclusion

The SANC needs to take an informed decision on implementing a CPD system for nurses and midwives in South Africa. The Draft CPD system is based on the CPD system of the Medical and Dental Board of the HPCSA. The HPCSA has acknowledged that this CPD system has since 2002 presented with various administrative and information technology shortcomings and “that the CPD committee will work through CPD systems used elsewhere in finally making recommendations in terms of what the new system should look like” (HPCSA, 2004).

In Chapter 4 the Draft CPD system was described. A description of the Final CPD system for nurses and midwives in South Africa, for this study. Follows in Chapter 5.

CHAPTER 5

A FINAL CONTINUING PROFESSIONAL DEVELOPMENT SYSTEM FOR NURSES AND MIDWIVES IN SOUTH AFRICA

5.1 Introduction

In Chapter 2 the Draft CPD system for nurses and midwives in South Africa was described. In this chapter the Final CPD system for nurses and midwives in South Africa is described under the following sub-headings:

5.2 Overview

5.3 Assumptions

5.4 A description of the Final CPD system for nurses and midwives in South Africa, according to purpose; context; definition of concepts; the principal role players and a process description of each of their roles; outcomes; and summary

5.5 Conclusion

5.2 Overview

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The Final CPD system for nurses and midwives is based on the theoretical framework in Chapter 3 of this study, that is, the professional, ethical and legal framework within a South African context, the systems theory, lessons learned from descriptions on CPD systems of the selected countries internationally with a table of recommendations in each instance for consideration for nurses and midwives in South Africa (See Tables 3.4, 3.5, 3.6, 3.7, 3.8, and recommendations from the CPD systems of the healthcare professionals in South Africa (See Table 3.10, 3.11) and the national dynamic factors in South Africa that influence a CPD system for nurses and midwives in South Africa. Finally, the Draft CPD system also informed the process of development of the Final CPD system for nurses and midwives in South Africa.

The description of the Final CPD system firstly commences with the professional, ethical and legal framework that requires compliance to influence the standard of nursing and midwifery care that is ministered to the consumers. The professional, ethical and legal framework for purposes of this study includes the following:

A. **Constitution of South Africa,** Act 101 of 1996

B. National Health Plan, policies and Priority Programmes of the Department of Health

C. **Multiprofessional Health Team Legal Framework** with special reference to:
   - The Health Professions Act 56 of 1974, as amended
   - Pharmacy Act 53 of 1974, as amended
   - Occupational Health and Safety Act 85 of 1993

D. **Nursing and Midwifery Legal Framework,** namely
   - The act of the nursing and midwifery profession, Nursing Act 50 of 1978, as amended
   - The Nursing Bill, Government Gazette No 25554 of 10 October 2003
   - The Scope of Practice for nurses and midwives, Government Notice R2598 of 30 November 1984, as amended
   - The regulation pertaining to the acts, omissions and accountability of nurses and midwives, Government Notice R387 of 15 February 1985, as amended

E. **Education Legal Framework**
   - The SAQA Act 58 of 1995, as amended
   - Higher Education Act 101 of 1997, as amended
   - The Further Education and Training Act 98 of 1998

F. **Labour Legal Framework:**
   - The Skills Development Act 97 of 1998
   - The Skills Levies Act 9 of 1999

Secondly, the Final CPD system is based on the systems theory as the components that encompass this system are inter-related. A continuous flow of information, materials and energy flow in, through, and out of the system as

the **input, throughput and output.** Figure 5.1 visually represents of the Final CPD system with key concepts strategically placed within enlarged, shaded arrow tips demonstrating the flow of the components of the CPD system as input, throughput and output.

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Figure 5.1. A visual presentation of the Final CPD system

5.2.1 Key concepts of the final CPD system

Figure 5.1 on the previous page clearly describes each of the key concepts in the visual presentation of the Final CPD system. The purpose for implementing the CPD system is to have a cadre of nurses and midwives who are committed towards striving for Continuing Competence to render quality nursing and midwifery care (output).

5.2.1.1 Input

The green shaded area represents the input of the CPD system. The three principal role players, (Nurse and Midwife, Employer and the SANC) are located here, as each one of them has to provide input that is critical to the success and the sustainability of the Final CPD system. The consumers are centrally placed as they are ultimately affected by the quality of healthcare that is provided.

5.2.1.2 Ongoing partnership, cooperation and open communication

The red double tipped arrows arranged in a circle demonstrate the ongoing (continuing) partnership, cooperation and open communication among the three principal role players. It is important to note that the red double-tipped arrow between the nurse and midwife and SANC is thick and dark red in colour, depicting the intensity of the accountability between these two principal role players. The double-tipped arrow between the nurse and midwife and the employer is dark red but not as thick as the previously described one. The double-tipped arrow between the SANC and the employer has a much lighter amber shade and is very much thinner; its presence however is the researcher's purposeful attempt to initiate collaboration and a joint commitment to the Final CPD system for its successful implementation. The centre point of service delivery for the three principal role players is the consumers who have a right to quality health care. Consumers also make their input with regard to the service delivery that they are receiving from each of the three principal role players. The input then flows into and through the throughput.

5.2.1.3 Throughput

The throughput comprises the process, which more specifically are the roles and responsibilities that each of the three principal role players adheres to. The nurse and midwife is located uppermost to depict the degree of responsibility for Continuing Professional Development that is the responsibility of the nurse and midwife. The flow of the input into and through the process of the throughput, with the adherence to the dynamic factors, result in the output, that is the CPD system for nurses and midwives striving towards Continuing Competence.

5.2.1.4 Role of the nurse and midwife

The nurse and midwife's role is that of reflective practice, continual self- and peer assessments, developing an annual learning plan and maintaining regularly updated evidence of how the outcomes of the said annual learning plan have been achieved. The monitoring of the progress and achievement of the outcomes of the annual learning plan is also incorporated in the Joint Performance Management (JPM) system, and more specifically during the four monthly performance reviews. The completed annual learning plan is filed in the CPD portfolio of evidence.

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5.2.1.5 Role of the SANC

The SANC's roles are facilitation, collaboration, monitoring, control and feedback. The SANC maintains commitment to fulfilling its mandate of protecting the consumers. In an earnest approach to protecting the public, the SANC regulates the nursing and midwifery professions by monitoring education and practice standards.

5.2.1.6 Role of the employer

The employer plays a key role in creating a working environment that is conducive to and supportive of the national skills development strategy, in ensuring the compilation of a workplace skills plan that is coordinated by an appointed skills development facilitator. The development of skills is aligned to

and coordinated within the joint performance management system (JPM) at the workplace setting. The employer's commitment to addressing the standard of nursing and midwifery care to meet the expectations of the consumer is also essential. The employer is accountable to the nurse and midwife for providing a safe work environment.

5.2.1.7 Dynamic factors

The successful implementation of the CPD system by the principal role players is also affected by dynamic factors such as commitment, accountability, honesty and compliance. The nurse and midwife maintains commitment to quality nursing and midwifery practice. In addition the nurse and midwife is accountable, amongst others to the SANC and also to the employer and vice versa. The value of honesty as a golden thread linking the components of the Final CPD system into an integrated whole and the compliance of all the role players is emphasised. Adherence to these dynamic factors is viewed as a critical success factor for the successful and effective functioning of the Final CPD system for nurses and midwives in South Africa.

It thus becomes apparent that the effective implementation of the Final CPD system for nurses and midwives in South Africa is dependent on each of the three principal role players honouring and adhering to the aforementioned dynamic factors. In the case of the entrepreneur, the nurse and midwife (who is also the employer) and the SANC share a joint accountability.

5.3 Assumptions

The Final CPD system is based on the following assumptions:

A. The nurse and midwife has a duty to practise her profession competently, that is, have the required knowledge, practise the appropriate skills, display a professional attitude based on sound ethical and moral principles. According to R387 of 15 February 1985, as amended, chapter 2, No 18 (1) states that "…except in the case of an emergency a nurse may not perform an act (a) which does not pertain to his registered profession; (b) for which he has inadequate

training or experience". According to these regulations the registered nurse and midwife has professional authorisation to perform her nursing and midwifery activities as an independent practitioner. This means that she is liable and accountable for all her acts and omissions within a given situation and the consequences thereof (Muller, 20002:64).

B. The nurse and midwife has a moral commitment to respect human rights as is stated in the Constitution Act 101 of 1996, Chapter 2, Bill of Rights and affirm that the promotion and protection of human rights is crucial to the promotion of holistic health care.

C. The nurse and midwife affirms the need for continually developing their competency levels because: "Professional competencies directly impact on the quality of health care being rendered and on the amount of trust patients and their families place on health professionals" *(Department of Health*, 2001:46).

D. As a profession accountable to the public, the nurse and midwife affirms the need to demonstrate her value of nursing and midwifery care in terms of improved outcomes linked to her daily professional activities (Ditmeyer, Koepsell, Braunn, Davis & Lush, 1998:11).

E. The SANC has a legal responsibility to verify the Continuing Competence of the nurse and midwife to safeguard the South African public.

F. The employer is responsible for the provision of an environment that enables the nurse and midwife to provide a quality service within the limits of reasonableness. The employer may also be held liable (vicariously) for negligence of the nurse and midwife as a result of workplace environmental variables over which it exercises control (Muller, 2002:55).

G. The consumer has a right to access health care (RSA, 1996).

H. A CPD system is a structured, well planned and organised flow of a series of components **(input – throughput – output)** with role players that will effectively influence each other to achieve a desired output of continuing updating and mastering nursing and midwifery competencies (adapted from Du Toit, 1995:41). An exponent of modern

systems theories, Ackoff, 1981, defines a system as "A set of interdependent parts having a common purpose in which the behaviour of each element of a system has an effect on the behaviour as a whole (Ackoff, 1981 In: Department of Health, 2001:5).

I. CPD is the maintenance of and enhancement of competence of professionals throughout their career, according to a plan that is aligned to the needs of the professional, the employer, the profession and society (Madden & Mitchell, 1993 In: Wallace, 1999:28).

J. Competence is the knowledge, skills, behavioural attributes and values required to perform a job to a desired standard (Saunders, 2002:37).

5.4 Description of the Final CPD system for nurses and midwives in South Africa

The Final CPD system for nurses and midwives in South Africa is described according to purpose; context; definition of concepts; structure and process description of the principal role players; outcomes; and summary.

5.4.1 Purpose

The purpose is the goal or the intent of the CPD system. The overall purpose of the Final CPD system is to have a cadre of nurses and midwives that strive for Continuing Competence. Over and above this overall purpose there are also other objectives for a Final CPD system for nurses and midwives in South Africa, namely:

- To facilitate the fulfilment of the SANC's legal requirement to protect the public of South Africa
- To strive for the promotion of quality nursing and midwifery care
- To promote the credibility of the SANC with regard to aligning its practices with national and international trends of regulatory bodies in coordinating, administering and controlling the implementation of CPD so that it is seen to be issuing licenses to practise to nurses and midwives that are committed to lifelong learning (Whittaker, Carson & Smolenski, 2000:2).

5.4.2 Context

A description of the context of the CPD system with special reference to the professional, ethical and legal framework follows. Figure 5.2 illustrates the component of the visual presentation that refers specifically to the professional, ethical and legal framework and the need for compliance and commitment to the Constitution, nursing and midwifery regulations, education acts, labour acts, multiprofessional acts and national health policies and priorities. A detailed discussion of figure 5.2 follows on page 186.

Figure 5.2. Context of the CPD system for nurses and midwives in South Africa.

5.4.2.1 Professional, ethical and legal framework of the final CPD system

The Final CPD system functions within a professional, ethical and legal framework that expects compliance of the principal role players to influence the standard of nursing and midwifery care to the consumers. This framework, for purposes of this study, includes:

A. The Constitution of the Republic of South Africa, Act 101 of 1996

Chapter 2, No 27 states that: " …everyone has the right to have access to health care services, including reproductive health" (RSA, 1996). To ensure effective access for all patients to health care as provided for in the Constitution of the Republic of South Africa, **the National Health Plan, Policies and priorities** have adopted significant transformative changes in policy documents such as the Patients' Rights Charter. This Charter provides a common standard for achieving the above right, so that both patients and health care providers have a clear understanding of the standards of service patients should receive (Department of Health, 1994-2000:33).

In addition to the Patients' Rights Charter, the policy of the Department of Health, in seeking to transform the public service delivery, based on the *Batho Pele* White Paper (RSA, 1997c:12), attempts to introduce a fresh approach to service delivery: "…an approach which puts pressure on systems, procedures, attitudes and behaviours within the public service and reorients them in the customer's favour, an approach which puts people first, …it enables citizens to hold public servants to account for the service they receive". These consumer charters have raised expectations and by so doing have placed new pressures on professionals to improve their standards of nursing and midwifery care.

The priority programmes of the Department of Health include, amongst others, areas such as HIV/AIDS, Tuberculosis, Malaria, Maternal and Child Health.

B. The multiprofessional legal framework

This framework influences the CPD system in that the nurse and midwife carries out her professional practice within a multiprofessional team and should take cognisance of the legislation that regulates the medical and pharmacy professions, namely, the **Health Professions Act 56 of 1974**, as amended and the **Pharmacy Act 53 of 1974**, as amended. In most healthcare situations there is a joint as well as a reciprocal responsibility and a reciprocal loyalty that exists in the multiprofessional team so as to safeguard the patient, family, group and community (Searle & Pera, 1995:227).

C. The Occupational Health and Safety Act 85 of 1993

This Act makes a variety of demands on the employer to provide and maintain a working environment that is safe and without risk to the health of his employees. This Act also expects of the employer to provide training and supervision, as may be necessary to ensure, the health and safety of his employees.

D. The Nursing Act 50 of 1978

This Act governs the nursing and midwifery professions. In terms of this Act the registered nurse and midwife/*accoucheur* is an independent practitioner, which means that she is accountable for all her acts and omissions. In terms of Chapter 2, Section 16 (1) of this Act: "No person shall be entitled to practise within the Republic the profession of a registered nurse, a midwife, an enrolled nurse or a nursing auxiliary unless he is in terms of this Act registered or enrolled, as the case may be, as a nurse, a midwife, a nursing auxiliary…" (RSA, 1978:9). It is a criminal offence to practise the profession of nursing and midwifery if one is not registered/enrolled as a nurse and midwife with the South African Nursing Council (SANC).

Over and above being registered/enrolled, practice of a profession requires knowledge of its scope of practice and the rules or conditions under which a person may practise that particular profession. In nursing and midwifery, the scope of practice for nurses and midwives and the rules setting out the acts and omissions are defined by two sets of regulations stipulated under section

45 (1) (q) of the Nursing Act 50 of 1978. These regulations are the Scope of Practice of the nurse and midwife; Government Notice R2598 of 30 November 1984, as amended; and Government Notice R387 of 15 February 1985, as amended.

E. Government Notice R2598 of 30 November 1984, as amended

This Notice relates to the scope of practice of registered nurses, midwives and enrolled nurses and midwives (See Annexure C); it outlines the acts (that nurses and midwives should adhere to) and procedures that they should perform competently. Practice of a profession requires knowledge of its scope of practice and the rules or conditions under which a professional person may practise.

F. Government Notice R387 of 15 February 1985 as amended, Chapter 2, No 3

This Notice authorises "…nurses and midwives to carry out acts in respect of diagnosing, treatment, care, prescribing, collaborating, referral, co-coordinating and patient advocacy as the scope of his profession admits".

Chapter 2, No 18 (1) of this regulation states that: "…except in the case of an emergency a nurse may not perform an act – (a) which does not pertain to his registered profession; (b) for which he has inadequate training or experience".

According to these regulations, the registered nurse and midwife has professional authorisation to perform her nursing and midwifery activities as an independent practitioner (See Annexure D). This means that she is accountable for all her acts and omissions within a given situation and responsible for the consequences thereof (Muller, 2002:64).

G. Higher Education Act 101 of 1997, as amended and the Further Education and Training Act 98 of 1998

Through these Acts the Department of Education has also effected changes to provide optimal opportunities for learning, the creation of knowledge and the pursuance of excellence by promoting the full realisation of the potential of every learner and employee through tolerance of ideas and appreciation of diversity.

South Africa, like many countries all over the world is looking for a better way of educating its people and organising its education and training systems so that they might gain the edge in an increasingly competitive economic global environment. The rapid technological advances have put education systems under extreme pressure as they try to adapt and incorporate these changes in an effort to produce more effective, creative and adaptable people. Success, or even survival, in such a world demands that South Africa has a national education and training system that provides quality learning, is responsive to the ever-changing influences of the external environment and promotes the development of a nation that is committed to life-long learning (SAQA, 2001:3) These, and other political pressures resulted in the establishment of the National Qualifications Framework.

H. The National Qualifications Framework (NQF) (See Annexure N)

This is a set of principles and guidelines by which, records of learner achievements are registered, to enable national recognition of acquired skills and knowledge, thereby ensuring an integrated system that encourages lifelong learning. Qualifications and standards registered on the NQF are described in terms of learning outcomes that the qualified learner is expected to have demonstrated. Hence there is the commitment to a system of education and training that is organised around the notion of learning outcomes.

When learners know that there are clear learning pathways which provide access to, and mobility and progression within education, training and career paths, they are more inclined to improve their skills and knowledge, as such improvements improve their employment opportunities (SAQA, 2001:3). For the purpose of this study it is necessary to enumerate the following objectives of the NQF:

- “To create an integrated national framework for learning achievements;
- Facilitate access to, and mobility and progression within education, training and career paths;
- Enhance the quality of education and training;

- Accelerate the redress of past unfair discrimination in education, training and employment opportunities;
- Contribute to the full personal potential and the social and economic development of the nation at large" (SAQA, 2001:5).

The objectives of the NQF are being addressed through the establishment of the South African Qualifications Authority (SAQA) that was put in place by the **SAQA Act 58 of 1995, as amended.** The functions of SAQA are essentially twofold:

- To oversee the development of the NQF by formulating and publishing policies and criteria for registration of bodies responsible for establishing education and training standards or qualifications and for the accreditation of bodies responsible for monitoring and auditing achievements in terms of such standards and qualifications.
- To oversee the implementation of the NQF, by ensuring the registration, accreditation and assignment of functions of the bodies referred to above, as well as the registration of national standards and qualifications on the NQF (SAQA, 2001:11).

One such body is an Education and Training Quality Assurer (ETQA). The primary focus area of an ETQA is to assure quality of the services made available by providers through the processes of accreditation, monitoring and auditing. The SANC was granted conditional approval as a ETQA in 2001. Over and above the changes realised in the educational field, the Department of Labour also effected significant changes.

I. Skills Development Act 97 of 1998 and the Skills Levies Act 9 of 1999

The Department of Labour, through these Acts, also makes transformative demands. This department has established 25 Sector Education and Training Authorities (SETAs) to realise the goals of the Skills Development Act 97 of 1988 and the Skills Levy Act 9 of 1999. One of these SETAs is the Health and Welfare Sector Education and Training Authority (HWSETA) which endeavours to: "create an integrated approach to the development and

provision of appropriately skilled health and welfare workers to render quality services comparable to world-class standards" (HWSETA, 2001:10). While there are numerous potential education and training providers for the HWSETA, it is imperative that a coordinated strategy for the provision of Continuing Professional Development for nurses and midwives be provided through a CPD system.

The contribution of the employer to this coordinated strategy underpins the creation of an environment conducive to the rendering of quality nursing and midwifery care. The employer makes a significant contribution to the standard of nursing and midwifery care that is rendered by its employees. The employer enables the nurse and midwife to provide a quality health service within the limits of reasonableness. The employer remains responsible for the provision of a safe environment and may be held liable (vicariously) for the negligence of the nurse and midwife as a result of environmental variables over which the employer exercises control (Muller, 2002:55).

It thus becomes evident that compliance with the professional, ethical and legal framework (National Health Plan, policies and priority programmes, the Constitution, nursing and midwifery, education and labour, multiprofessional), coupled to commitment of all the role players, is critical to the successful implementation of the Final CPD system for nurses and midwives in South Africa. The main concepts in the Final CPD system are defined below.

5.4.3 Definition of main concepts

Context

Context describes the external and the internal nature of the nursing and midwifery practice for which Continuing Professional Development is required. In this study the context refers to the professional, ethical and legal framework for nursing and midwifery practice and for Continuing Professional Development.

Principal role players

The principal role players refer to the nurse and midwife, SANC and the employer who relate in an interactive way manner to fulfil their roles and responsibilities with regard to the Continuing Professional Development of nurses and midwives.

Process

Process refers to the roles and responsibilities that are executed by the principal role players, based on the system's approach with reference to input, throughput and output.

Dynamics

According to *The Concise Oxford Dictionary* (2001:447) dynamics is characterised by constant change, i.e. "forces which stimulate developments or changes within a system or process". In the context of this Final CPD system the dynamics are commitment, accountability, honesty and compliance.

Purpose

The purpose is the goal or intent of the Final CPD system.

The principal role players and the process description that is followed by each of the role players are discussed below.

5.4.4 Structure and process description of the principal role players

The revolution in skills development that South Africa needs will not be achieved if it becomes the responsibility of the government only. The Skills Development Act 97 of 1998 encourages partnerships between government, employers, employees, education and training providers and communities. The Act also states that it is the needs of the employers, the economy and the communities that have to decide on which skills are needed, so that priorities for skills development can be set. These partnerships necessitate the identification and description of the contribution of each of the role players in the achievement of the national skills development strategy and for the

purposes of this study, the CPD system for nurses and midwives in South Africa.

The principal role players in the Final CPD system are the nurses and midwives; the SANC; and the employer.

5.4.4.1 Nurses and midwives

Nurses and midwives are empowered by the nursing and midwifery legal framework to practise their professions in various healthcare settings. The parameters of such professional practice are competence; authority; facilitation; advocacy; nursing and/or midwifery diagnosis; planning, implementing, and evaluating nursing and midwifery care; and accurate and complete record keeping of all interventions (Searle & Pera, 1995:192). Nurses and midwives are responsible for key activities perceived as essential for the delivery of knowledgeable, competent and legally and ethically based nursing and midwifery care to a patient, family, group and community.

Within the parameters of nursing and midwifery practice, nurses and midwives share instrumental and expressive roles with the doctor and other allied health professionals. Professional practice by a nurse and midwife is based on her knowledge, understanding acceptance of the instrumental and expressive roles, responsibility and accountability (Searle & Pera, 1995:194). The nurse and midwife's instrumental role varies according to the availability of the other members of the multiprofessional health team. The nurse and midwife has a duty to exercise wise judgements concerning her ability, that is to what extent her competencies will meet the patient's needs, depending on the urgency of the situation, availability of doctors, for she is held accountable for all her acts and omissions (Searle & Pera, 1995:219).

The nurse and midwife are the associate and co-worker in the provision of health care within a multiprofessional health team. To fulfil these responsibilities and their instrumental and expressive roles, nurses and midwives are required to engage in appropriate Continuing Professional

Development. The nurse and midwife has the following roles and responsibilities within the Final CPD system:

- Conducting a self-assessment, peer assessment and reflective practice
- Compiling an annual learning plan and individual development plan
- Compiling and maintaining a CPD Portfolio of Evidence
- Completing the CPD Achievement of Outcomes Form of the SANC annually.

Figure 5.3 depicts a visual presentation of the roles and responsibilities of nurses and midwives.

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Figure 5.3 The roles and responsibilities of the nurse and midwife

The visual presentation demonstrates that nurses and midwives play a pivotal role in the efficient and effective running of a CPD system. They should therefore be encouraged to be committed to lifelong learning and fostering a culture of learning within the nursing and midwifery professions. In this role they have to ensure that the following matters enjoy priority:

A. Reflective practice, self-assessment and peer assessment

The nurse and midwife is accountable for her own Continuing Professional Development as determined by a self-assessment of her own learning needs and a peer assessment. The nurse and midwife also develops the skill of self-awareness, as it is the foundation upon which reflective practice is built.

Reid (1993) defines reflective practice as: “a process of viewing an experience of practice in order to describe, analyse and evaluate and in so inform learning from practice”(Reid.1993:305). Reflective practice enables nurses and midwives to take responsibility for identifying and responding to their individual needs and to develop greater independence in initiating, planning, conducting and communicating their learning needs. Nurses and midwives also realise that honest reflection requires courage, self-confidence and a certain degree of maturity (Burns & Bulman, 2000:32). Reflective practice encourages nurses and midwives to identify their learning needs, assess their own level of competence, examine their accountability and articulate their concerns before accepting new responsibilities. Numerous differing definitions of reflective practice contain some characteristics common to all, particularly that reflective practice should :

- Be based in practice
- Be capable of developing new knowledge
- Be consciousness raising
- Help turn experience into learning
- Raise self-awareness
- Liberate individuals from conventional and traditional ways of thinking
- Be creative (Burns & Bulman, 2000:32).

Bond *et al* (1985) suggests that reflection is a key concept in exploring two areas central to a person's development. Firstly, the 'learning on the job' experience which characterises much of adult learning, and secondly, the need to develop awareness and growing understanding of one's own learning processes (Bond *et al* 1985 In: Hancock, 1998:37) There is consensus that reflective practice can enhance personal and professional learning (Atkins and Murphy, 1993:1188) and also that it empowers and assists nurses and midwives in the development of their professional knowledge (Jarvis, 1992:174). Reflective practice learning can be promoted through the use of written accounts such as the annual learning plan for the Final CPD system. Redfern, 1995) recommended the process of writing because:

- Thoughts can be transferred onto paper for examination and analysis in an objective way
- The process of constructing words and sentences in one's head before being committed to paper enables thoughts and recollection of events to be given a certain degree of structure
- It provides a permanent record of professional practice which can be used to gain further insights
- The act of maintaining a written record such as the annual learning plan for the Final CPD system helps the nurse and the midwife to develop a disciplined approach to their Continuing Professional Development (Redfern, 1995).

"Reflective writing is a valued tool for generating nursing knowledge among experienced nurses. It is becoming widely accepted in both professional and lay publications as a mechanism for coping with critical incidents." (Craft, 2005:53)

B. Annual learning plan

The nurse and midwife compiles an annual learning plan based on her self- and peer assessment and also on the reflective practice exercise. This learning plan includes outcomes that are specific, measurable, action oriented, realistic and linked to time frames. The learning plan is structured according to the identified aspects for CPD, namely ethics and professional

practice with an emphasis on human rights at an applied level; area of practice; and national and provincial priorities and programmes.

Table 5.1 describes the steps for developing an annual learning plan for registered and enrolled nurses and midwives who have successfully completed a basic nursing and/or midwifery education and training programme.

Table 5.1: The steps for developing an annual learning plan for registered and enrolled nurses and midwives who have successfully completed a basic nursing and/or midwifery education and training programme

Step 1: Self assessment

The nurse and midwife reflects on recent critical incidents that occurred during the course of her nursing and midwifery care and in so doing conducts a self-assessment by critically analysing the aforementioned incidents against the employer's standards. These standards serve as a yardstick. In the absence of such standards the nurse and midwife uses the appropriate SANC entry standards for a RN, RM, EN; ENA; alternatively an example of standards for registered nurses (Muller, 1992 reviewed 1999) against which to measure performance, are attached as Annexure O.

Learning opportunities such as knowledge gaps, lack of psychomotor skills, attitudinal barriers, unprofessional conduct, violation of the nursing and midwifery regulations and violation of human rights (related to the critical incidents) are identified. This critical analysis should also accommodate the ethical component: the right, wrong or ought to be done (Burns and Bulman, 2000:41).

Action:

- ❑ Undertake a detailed examination by making honest judgements about a minimum of 3 areas of her strengths in her specific area of practice
- ❑ Identify 3 areas for concern that require development
- ❑ Record the findings

Step 2: Peer assessment

Identify a peer that is familiar with the nurse and midwife's roles. The nurse and midwife may also consider other feedback sources such as line managers, students, patients/clients; diverse sources of feedback increase learning opportunities.

Action:

- ❑ Follow the same course of action as described in step one

Step 3: Combine sources of feedback

Combine all the sources of feedback. Prioritise development areas. Formulate outcomes for each of the identified limitations in her specific area of practice. The outcomes specify achievements that are to be accomplished on the completion of the learning plan. Describe the learning activity that she plans to do for each of the identified areas for concern. Describe measures for monitoring the attainment of the specified outcomes

Specify a realistic time frame to attain the outcomes of the learning activity

The nurse and midwife transcribes this into her annual learning plan.

Action:

- ❑ Prioritise development areas
- ❑ Formulate outcomes for each learning activity
- ❑ Describe the learning activity for each area of development
- ❑ Transcribe into annual learning plan.

Step 4: Evaluate the progress of the annual learning plan

The nurse and midwife evaluates and assesses her progress against the employer's standards; if unavailable against the SANC's entry to the profession standards. Record the attainment of the outcomes for each learning activity.

Action:

- ❑ Evaluate and assess progress
- ❑ Record the attainment of the outcomes

Step 5: File completed learning plan into portfolio of evidence

File the completed learning plan and all other certificates of attendance (workshops, seminars and conferences) into her CPD portfolio of evidence.

Action:

- ❑ File all relevant documentation as evidence of compliance with the Final CPD system.

C. Reminders for the appropriate location of CPD activities

The level of the CPD activities and the assessment thereof should be based on the location of the highest qualification on the NQF Framework (See Annexure N) to determine the levels for the various categories of nurses and midwives in South Africa, i.e. levels 4, 5, 6, 7, 8).

This annual learning plan is presented and discussed with her line manager (employer) and the standards to be attained are agreed upon during the three/four monthly performance reviews of the Joint Performance Management System. The time interval is determined by the learning needs of the individual nurse and midwife. The annual learning plan is applied to the workplace activities of the nurse and midwife. The entrepreneur applies her annual learning plan to her specific area of practice. Emphasis on peer group assessments provides a valuable source of feedback for the entrepreneur: "Evaluation of one's performance by peers is a hallmark of professionalism and a method by which the profession is held accountable to society. Nurses and midwives must be willing to have their practice reviewed and evaluated by their peers" (Whittaker, Carson & Smolenski, 2000:6).

The nurse and midwife monitors her progress on a monthly basis and the line manager monitors the attainment of the outcomes of the written learning plan on a four-monthly basis, or more or less frequently, depending on the individual's learning needs. The findings and progress made during the financial year of the organisation where the nurse and midwife is employed are consolidated during the final performance appraisal for that specific year. In the case of the entrepreneur, the onus rests on her to honestly reflect on her private practice and to ensure that mechanisms are put in place to meet her learning needs as is documented in her learning plan. This honest reflection calls for an emphasis on ethics.

Ethics refers to the study of human behaviour in respect of what is considered to be right or wrong in terms of moral judgement (Tschudin, 1993:75). In South Africa, the nursing and midwifery professions expect all their members to practise their professions in an ethical manner and thus the following concepts were entrenched in the ethical code:

- The need for truthfulness and honesty
- Reliability
- Responsibility and accountability
- Respect for the dignity of others
- Adherence to the ethical legal framework (Tschudin, 1993:75).

Over and above ethics and the area of practice, the learning plan accommodates the identification of strengths and concerns with regard to the national priorities as identified by the Department of Health. Every nurse and midwife who practises her profession in South Africa, whether in the public or private sector, should have a sound knowledge of the national priority programmes. In the private sector this knowledge can be applied as part of the organisations' social responsibility and as a community out reach programme. A record of the annual learning plan is filed in the portfolio of evidence.

D. CPD portfolio of evidence

Seldin (1991) proposes that the portfolio of evidence is a representation of hard evidence and specific data about one's learning. Murray (1994) extends Seldin's (1991) definition by indicating that a portfolio is a collection of documents that represents the best of one's discipline and provides one with the occasion to reflect on her discipline with intensity, the intended outcome being to describe the full range of one's abilities over a period of time (Seldin, 1991 & Murray, 1994 In: Stockhausen, 1997:4). Boud (1992) believes a framework, such as a portfolio, "... elicits evidence of achievement and provides an opportunity for learners to make judgements on how successful they have been in meeting their goals" (Boud, 1992:185). It is thus evident that portfolios engage learners in "... a continual process of self-reflection, goal setting and attempts to change" (Gerrish, 1993:172).

The nurse and midwife, who need to engage in such an continuing developmental process, compile her CPD portfolio of evidence. Such compilation includes her annual learning plan. The specific format for the CPD portfolio of evidence is not standardised however nurses and midwives are expected to adhere to the minimum guidelines provided by the SANC for the compilation of the CPD portfolio of evidence as provided in Annexure P.

Over and above these minimum guidelines, the nurse and midwife is encouraged to compile her CPD portfolio of evidence according to the

individual's preference and ensure that it is a true reflection of her professional development.

The CPD portfolio is kept updated and readily available for reference should the nurse and midwife be requested to complete the CPD Audit Form to verify that the CPD Achievement Form is indeed a true reflection of the record of learning in her CPD portfolio of evidence. A period of six weeks is permitted from the date of postage of the SANC's letter of notification of inclusion in the 5% stratified random sample and CPD Audit Form requesting information from the nurse and midwife's CPD portfolio of evidence, to the date of its arrival at the offices of the SANC.

E. The CPD Achievement Form

The nurse and midwife submits a completed CPD Achievement Form (See Annexure Q) annually to the SANC with the annual registration/enrolment fee, within the time frame determined by the SANC. The CPD Achievement Form of the SANC provides a summary of the Continuing Professional Development that the nurse and midwife attained for a particular year. The contents of the CPD portfolio of evidence of the nurse and midwife should verify what is reflected on the CPD Achievement Form that is submitted to the SANC. Table 5.3 below outlines the structure, process and outcomes standards that the nurse and midwife adheres to, so as to demonstrate compliance with the CPD system and the applicable legislation.

Table 5.2: Structure, process and outcome standards for registered and enrolled nurses and midwives

Structure standards

- ❑ There is evidence that each nurse and midwife has an updated file with:
  - Relevant legislation affecting her practice
  - SANC policies, procedures and regulations pertaining to the CPD system
  - Minimum guidelines with regard to the compilation of the CPD portfolio of evidence.

Process standards

- ❑ There is evidence of the involvement of nurses and midwives in the identification of their training needs for the workplace skills plan
- ❑ There is a training programme on Joint Performance Management for all nurses and midwives
- ❑ There is training provided for self- and peer assessment, reflective practice and the compilation of a CPD portfolio of evidence
- ❑ There is evidence of self- and peer assessment, reflective practice, annual learning plan with entries of progress made and an individual development plan in the nurse and midwife's CPD portfolio of evidence
- ❑ There is evidence of support for under-performance.

Outcome standards

- ❑ There is compliance with the Joint Performance Management System at the workplace of the nurse and midwife
- ❑ There is evidence of compliance with the requirements of the CPD system, namely, CPD Achievement Forms completed annually and forwarded to the SANC as determined by the SANC
- ❑ Completion and submission of the CPD audit form to the SANC when requested as part of the SANC's 5% stratified, random sample, for verifying what is reflected on the CPD Achievement Form.

Table 5.2 described the structure, process and outcomes standards. Figure 5.4 on page 204 represents the process description of the roles and responsibilities of all nurses and midwives.

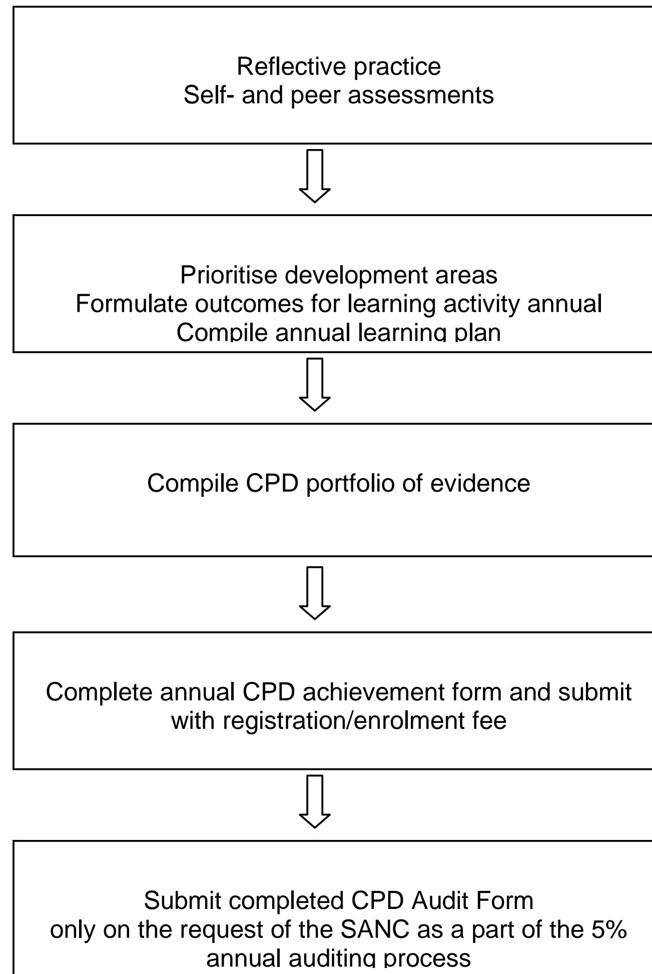

Figure 5.4: A process description of the roles and responsibilities of all the nurses and midwives

Nurses and midwives who are practising their profession follow this process description. On the other hand, nurses and midwives who have not been practising their profession for one or more years are expected to register for a return-to-practice programme so as to update their competencies. A description of this programme follows.

F. Return-to-practice programme

A Return-to-practice programme refers to a refresher course that is successfully completed by the nurse and midwife who has not been practising her profession for one or more years. Evidence of the successful completion

of such a programme, completion of the SANC's restoration form and the payment of a fee determined by the SANC, assures re-registration/enrolment.

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(i) Process description of the return-to-practice programme

The nurse and midwife completes a refresher course or a return-to-practice programme to update her nursing and midwifery competencies (knowledge, skills, attitudes and values). This programme's credit value at 120 notional hours is 12 credits (ten notional hours = one credit). Education and training of such a programme occurs at a nursing education institution that has been accredited by the SANC as a provider for nursing and midwifery education and training.

Table 5. 3: The return-to-practice programme

Content	Duration
Ethics and Professional Practice The emphasis is on Human Rights at an applied level	A minimum of 20 notional hours – 2 credits
Area of practice	A minimum of 80 notional hours for theory and practice – 8 credits
National/provincial priorities and programmes	A minimum of 20 notional hours – 2 credits

The nursing education institution (NEI) attended by the nurse and midwife must be **approved by the SANC for conducting education and training in the particular area of practice or discipline.** For example, in the case of Critical Care Nursing (ICU), the NEI has to be approved by the SANC to offer a one-year diploma for an additional qualification (Government Notice R212 of 19 February 1993) or a short course in Critical Care Nursing. National/provincial priorities and programmes include, amongst other conditions, HIV/AIDS, Tuberculosis, Malaria and Maternal and Child Health Care.

The return-to-practice programme culminates in a formal assessment, which evaluates identified competencies. The candidate and the SANC are informed of the results of the assessment. A report is presented to the SANC by the head of the NEI, on the successful completion of the return-to-practice programme by the nurse and midwife, who wishes to be restored to the register/roll of the SANC. Payment of a fee as determined by the SANC and the completion of a restoration to the register/roll form, is also a requisite.

Having described the roles of nurses and midwives with regard to the implementation of the CPD system for nurses and midwives in South Africa, it is important to note the roles of the SANC.

The roles and responsibilities of the SANC are illustrated in Figure 5.5 on page 207.

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Figure 5.5: The roles and responsibilities of the SANC

5.4.4.2 *The role of the SANC*

The SANC has the following roles and responsibilities within a CPD system:

A. Facilitation
B. Collaboration
C. Monitoring and control
D. Feedback.

A. Facilitation

The SANC, as the regulating body for the nursing and midwifery professions takes the lead in playing a facilitative role with regard to the planning and implementing of CPD training workshops so that the profession develops a common understanding of what the CPD system entails in terms of the regulation for CPD, CPD policy and procedures of the SANC. The following logistics with the accompanying documents should also be thoroughly explained at the planned workshops:

- Compilation of outcomes-based learning plans
- Compilation of a portfolio of evidence
- Completion of the SANC's CPD achievement form
- Completion of the SANC's audit form if and when included in the 5% stratified random sampling process of the auditing committee of the SANC
- Consequences of non-compliance with the CPD system.

Notification of the CPD workshops should be timeously planned to ensure the attendance of the majority of representatives of the SANC's stakeholders. Workshops should make provision for sufficient time for plenary sessions so that queries of the attendees are adequately addressed.

B. Collaboration

Although collaboration is identified as a role of the SANC only, this is indeed not so. The SANC, in its capacity as the regulating authority for nurses and midwives, leads the profession by precept and example and initiates the much-needed collaborative approach. The South African Interim Nursing

Council and the first democratically elected SANC adopted the transformative principles of democracy, inclusivity and transparency, and in so doing invited partnerships and collaborative processes for the introduction of new regulations, policies and directives. The current SANC also adopts these principles. Prior to 1996, the SANC functioned as a prescriptive authority and this was not in the spirit of participative and collaborative management. In compliance with the new spirit of consultation, inclusivity and collaboration, the SANC, as one of the three principal role players, shares the responsibility of collaboration with the other two principal role players, as well as with the other role players (See section 5.4.4.5). This cooperative approach is a much-needed prerequisite to optimise effective and coordinated functioning of the proposed CPD system for nurses and midwives in South Africa.

The importance of achieving a cultural change to support and deliver the CPD agenda through working collaboratively to develop common solutions and shared approaches is emphasised (http://www.dh.gov.uk/PublicationsAndStatistics/Pubications/PublicationsPolicyAndGuidancepublications :6). This entails, amongst the SANC's other duties, sending the annual newsletter to all nurses and midwives to inform them about developments at the SANC. A description of the Final CPD system is included in such newsletters, so that nurses and midwives are informed about developments pertaining to CPD and the proposed date for its implementation.

Table 5.4 depicts the strategies to demonstrate the application of the SANC's roles and responsibilities with regard to collaboration.

Table 5.4: Strategies to demonstrate the application of the SANC's collaborative roles and responsibilities

- Annual updating of the contact persons and mailing addresses of the approved SANC stakeholders list (See Annexure I).
- Timeous scheduling and dissemination of agendas for consultative forums with the stakeholders.
- Inviting agenda items within a specific time frame from the role players for discussion at scheduled consultative forums.
- Timeous mailing of discussion documents on the first drafts of new policy documents and regulations pertaining to the proposed CPD system.
- Determining realistic dates for written inputs/feedback on new processes such as the proposed CPD system.
- Ascertaining the collation and assimilation of all inputs from the stakeholders on discussion documents, for presentation at a meeting of the SANC.
- Allowing an open attendance of SANC meetings especially with regard to the discussions related to new processes such as the CPD system.
- Permitting reasonable discussion on for example, the CPD system within a stipulated time frame and inviting active participation from those in attendance of the SANC meeting.
- Disseminating information brochures on the structure, process and outcome standards of proposed CPD system and including a copy of and explanation on the CPD Achievement Form, minimum guidelines for the CPD portfolio of evidence and CPD Audit Form (See Annexure Q, P and R respectively).
- Provision is made for road shows and workshops to present the CPD system and other essential developments at the SANC. Plenary sessions are accommodated and suggestions for improvement are invited and recorded.
- Capturing of highlights, the aforementioned suggestions and the consensus reached around areas of concern at the aforementioned workshops, into a consolidated report for presentation to the SANC for final decision making.
- Acceptance of invitations to present the proposed CPD system at workshops and conferences of professional societies, organised labour and other special interest groups.

In addition to these strategies the SANC may further alert the profession at large through radio slots on local radio stations. Publications on the CPD system may also be included on the SANC's website, in professional and organised labour journals and other appropriate publications to further fulfil the SANC's role of sharing information and inviting comments and suggestions.

The SANC also ensures that a well-informed and trained CPD officer with her working team members deals effectively with telephonic or electronic enquiries pertaining to the Final CPD system.

Collaboration is essential for the SANC as part of its commitment to operating on democratic principles. It is also suggested that those who seek professional development and enrichment of their practice need to look towards a greater understanding of team working and collaboration in care. Those professionals who underpin their practice with a philosophy encapsulating collaboration are more likely to achieve professional enhancement than those who continue to work in the old uni-disciplinary team environment, maintaining demarcation lines and roles, and offering limited and limiting responses to multidimensional health needs (Fatchett, 1998:8).

C. Monitoring and control

Monitoring refers to the role of the SANC in ensuring overall observance of the implementation of the Final CPD system. This is an continuing monitoring process.

Control implies the evaluation of compliance with the CPD system. It therefore also includes ascertaining whether the CPD Achievement Forms of nurses and midwives are authentic and whether they verify the contents of the CPD portfolio of evidence. This role is accomplished by the annual audit conducted by the Audit Committee of the SANC (See Annexure R).

The SANC is obliged to me*et al*l the legal mandates with regard to the licensing of nurses and midwives for practice. One of its legal mandates is to work directly with licensees in assuming competence for practice in the interest of public protection. Licensing requirements have to define what is necessary for members of a profession to renew their registration/enrolment with the SANC so as to contribute to quality nursing and midwifery practice. The regulating of CPD firstly through the Nursing Bill, Government Gazette No 25554 for the nursing and midwifery professions and subsequently through

regulations specifically for Continuing Professional Development for all the role players to view it in the serious light that it warrants.

In addition, the following standards provide guidelines for the SANC to fulfil its role of monitoring and control of the Final CPD system. Table 5.5 outlines the structure, process and outcome standards necessary for the SANC to fulfil its role of monitoring and controlling the Final CPD system for nurses and midwives in South Africa.

Table 5.5: Structure, process and outcomes standards for the monitoring and controlling of the CPD system by the SANC

Structure standards:

- ❑ Legislation for the regulation of CPD
- ❑ A formal system in operation according to determined resources (human, equipment and budget)
- ❑ An appropriate information management system in place.

Process standards

- ❑ An induction procedure for the orientation of the CPD officer and her working team members to the CPD system
- ❑ A manual with clearly defined policies, roles and procedures for the CPD system
- ❑ Evidence of regular collaboration with all the role players
- ❑ An auditing committee to monitor annual compliance with the CPD system
- ❑ A training programme for the developmental needs of the CPD officer and her working team members
- ❑ A customer feedback system in place.

Outcome standards

- ❑ Fulfilment of the SANC's legal obligation of protecting the public
- ❑ Evidence-based CPD and practice
- ❑ Alignment to national and international benchmarking of regulatory bodies implementing a mandatory CPD system that is linked to annual re-licensure.

Having outlined the structure, process and outcome standards that the SANC should adhere to so as to fulfil its responsibilities of monitoring and controlling the CPD system, a systematic sequence of events SANC's role of the process description is illustrated in figure 5.6 on page 213.

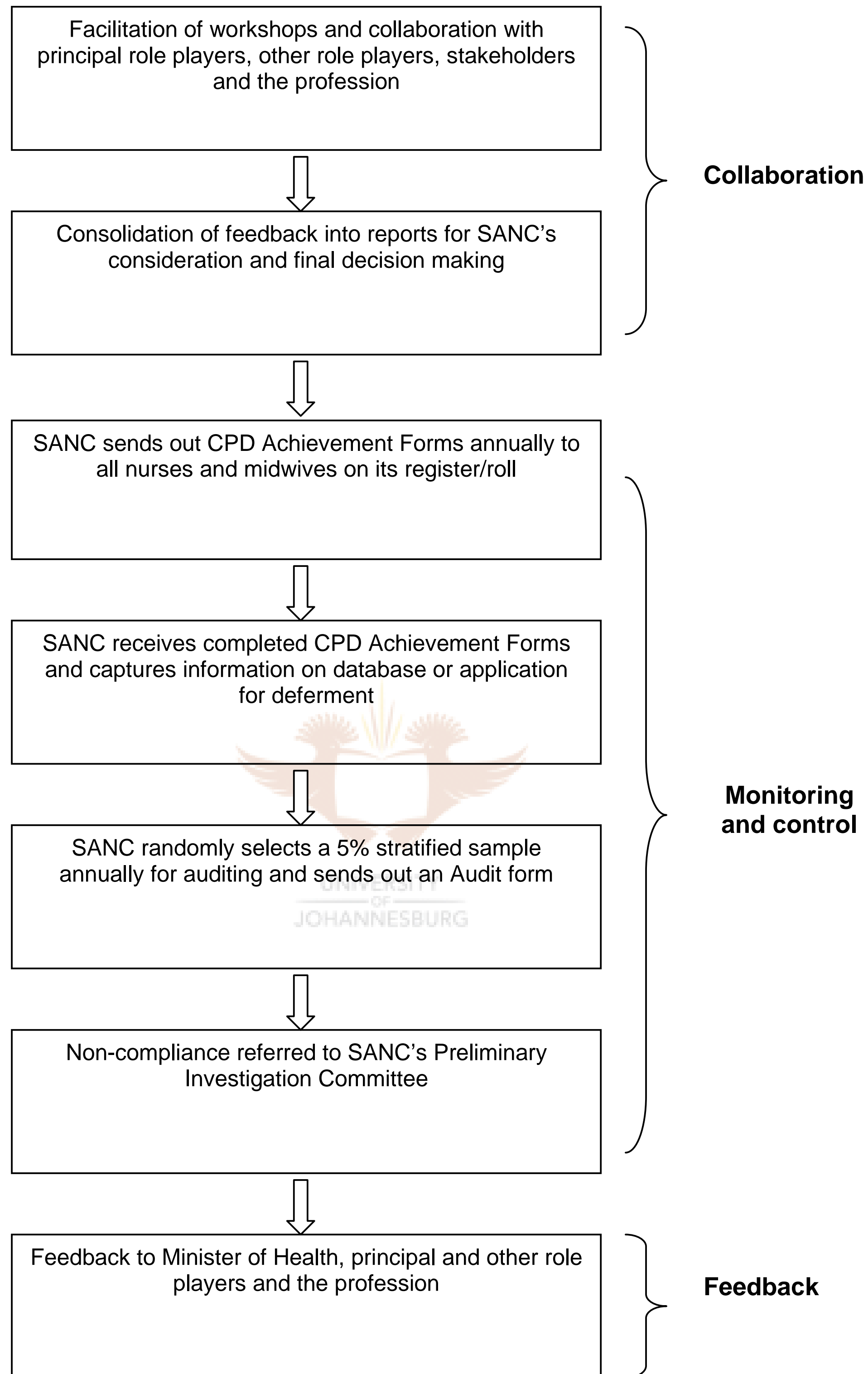

Figure 5.6: A process description of the roles and responsibilities of the SANC

Annually during the month of July, the SANC sends out reminder cards for the payment of the annual licensing fee to each nurse and midwife that is registered/enrolled with the SANC. The envelope for **the annual reminder registration card also includes the CPD Achievement Form of the SANC** that is completed by each nurse and midwife and returned to the offices of the SANC, within the time frame that is stipulated by the SANC. Nurses and midwives who, due to circumstances of life, are unable to meet their minimum CPD requirements (ethics, area of practice and national/provincial priorities) submit a letter of **application for deferment** to the SANC.

On applying for re-licensure annually, every nurse completes the CPD Achievement Form (See Annexure Q), signs the declaration appearing on this form and submits it to the SANC. The data is captured and analysed by the CPD officer and her working team members indicating compliance or non-compliance of the nurse and midwife. Nurses and midwives only receive correspondence from the CPD officer when the result is non-compliance.

Nurses and midwives are **not required to send their CPD portfolios of evidence or any part there of (CPD attendance certificates) to the SANC**. The only other follow-up correspondence is if they are **randomly selected** for the annual auditing process and requested by the Audit Committee of the SANC to **complete a CPD Audit Form** to verify the contents of the CPD Achievement Form. A period of six weeks is permitted from the date that the SANC sends out the Audit Form until it is returned to the office of the SANC. Nurses and midwives are reminded that this six-week period is for accommodating the postage system only as the CPD portfolios of evidence are updated regularly and ready for easy referencing to complete the CPD Audit Form of the SANC.

The SANC conducts an annual audit to monitor compliance with the CPD system. The CPD Officer of the SANC draws a 5% stratified random sample of nurses and midwives, and these practitioners are requested to complete the Audit Form with information from their CPD portfolios of evidence. The completed Audit Form (See Annexure R), on arriving at the SANC is checked

against the annual CPD Achievement Form of the particular nurse and midwife that was submitted to the SANC with her annual re-licensing fee. If the completed Audit Form demonstrates non-compliance with the minimum CPD requirements and the information obtained from the CPD portfolio does not support the information on the CPD Achievement Form of the SANC, the matter is referred to the Committee for Preliminary Investigation of the SANC and, on its findings and recommendation, to the Professional Conduct Committee of the SANC. It is important to note that the procedures of the Professional Conduct Committee make provision for an appeals procedure.

An outline of the role of the CPD officer and her team members is to:

- Receive the CPD Achievement Forms and evaluate them for compliance.
- Capture the information electronically on the SANC's database for nurses and midwives and in each instance indicate compliance or non-compliance with the Final CPD system.
- Allow the clerks who work with the processing of renewal of registrations/enrolments to readily retrieve this information electronically and determine whether to renew the registration/enrolment or not.
- Make an entry of compliance/non-compliance with the CPD system, onto the database, for the individual nurse and midwife.
- Submit a list of all the nurses and midwives who have not complied with the Final CPD system to the Preliminary Investigation Committee of the SANC.
- Submit all the applications for deferment to the CPD Committee of the SANC who, in turn, submit a consolidated report of their recommendations to a meeting of the Council for ratification.
- Send out written responses to the nurses and midwives informing them whether the SANC approved their application for deferment or not and the conditions that apply to the said application.
- Attend to telephonic and electronic enquiries on the Final CPD system.

The CPD officer and the clerks that process registrations on a daily basis agree on a system that will function coordinately and effectively between their

sections. Over and above this, the CPD Officer and her working team members also assess the CPD Achievement Forms against the completed CPD Audit Forms from the 5% stratified, randomly selected sample of nurses and midwives. The findings are consolidated in a report that is presented in a meeting of the Council.

The CPD Officer also prepares a consolidated CPD report at the end of each year and submits it to the CPD Committee of the SANC. This report is then submitted to the full Council for approval, as it will ultimately provide feedback to the Minister of Health, all nurses and midwives on the register/roll of the SANC, employers (HR division) and to the other role players.

D. Feedback

Feedback is a process whereby information about the CPD system is made available to relevant persons either as a monitoring mechanism or as a control measure to reflect on its effectiveness. Feedback on the CPD system is provided as follows:

- A *consolidated annual report* is sent to the Minster of Health. This report contains a detailed account on the developments at the SANC and the progress of such developments. A report on the CPD system as one of the developments is also included in this annual report. The progress of the CPD system remains an annual item in this report so that the Minister of Health is informed about the compliance/non-compliance of nurses and midwives.
- A report on the CPD system is included in the SANC's annual newsletter sent to the nurses and midwives, and SANC's stakeholders. This report also remains an annual item in this newsletter.
- Compliant nurses and midwives receive an annual receipt as evidence of an updated licence to practise her profession. Individual nurses and midwives and those selected for the 5% stratified random sampling only receive a written notification from the CPD officer when the:

- CPD Achievement Forms have not been received within the time frame that is determined by the SANC, or
- CPD Achievement Forms of the individual nurse and midwife demonstrate non-compliance with the CPD system.
- CPD Audit Form does not verify the information that appears on the CPD Achievement Form (if selected in the 5% stratified, random sample of the SANC for auditing).
- Nurse and midwife has been referred for non-compliance to the Committee for Preliminary Investigation of the SANC.
- CPD officer responds to an application for deferment.

Having described the roles and responsibilities of the SANC, the roles and responsibilities of the third principal role player, the employer, follows.

5.4.4.3 Role of the employer

It is the employer's role and responsibility within a CPD system to provide the following:

A. A National skills development strategy
B. A Skills development facilitator
C. A Workplace skills plan
D. A Joint performance management
E. An Annual training report.

Figure 5.7 on page 221 visually represents of the roles and the responsibilities of the employer.

Figure 5.7. The roles and the responsibilities of the employer

A description of the employer's contribution to the national skills development strategy follows.

A. The National Skills Development Strategy

The **National Skills Development Strategy**, launched by the government in April, 2001, is an endeavour of the National Department of Labour, through its 25 Sector, Education and Training Authorities (SETAs) (and for the purpose of this study, the Health and Welfare Sector Education Authority (HWSETA)) to create an integrated approach to the development and provision of appropriately skilled health and welfare workers to render quality services comparable to world-class standards (Department of Labour, 2002:7).

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Employers have to comply with the National Skills Development Strategy and its accompanying legislation. Employers should however also look beyond mere compliance with legislation and embed a national commitment to facilitating skills development of employees as a national goal. Facilitating skills development is about equipping people to perform quality jobs in which they can take pride. The Skills Development Act 97 of 1998 and the Skills Levy Act 9 of 1999 are designed to increase investment in training with the aim of improving employee skills and thereby making businesses more productive, effective and efficient. This will encourage economical growth so that South Africa can compete with world markets (Department of Labour, 2002:11).

Since 1 April 2001, employers have had to pay a skills development levy of 1% from the total amount that the employer pays in remuneration (salaries or wages) each month, to a SETA in the area of primary focus and for the purpose of this study, the HWSETA. This levy is paid by the seventh day of each month. These levies are used as the main source of finance to implement the National Skills Strategy. Eighty percent of the skills levies paid in by the employers go to the HWSETA. The new levy/grant system is designed to provide incentives for employers to give training the attention that

it deserves. For the purpose of this study, the employers of nurses and midwives register with the HWSETA (Department of Labour, 2002:2).

The employer is also responrequiredsible to appoint a skills development facilitator.

B. Skills development facilitator

A skills development facilitator is a practitioner who is appointed by the employer to:

- Identify skills gaps
- Develop a workplace skills plan
- Play a major role in implementing the skills plan
- Initiate and maintain effective quality management systems within the planned training process
- Compile an annual training report for the employer, based on an evaluation of training practices.

Furthermore, the employer should provide a workplace skills plan.

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C. Workplace skills plan

A workplace skills plan is a statement of the skills that would enable the organisation to achieve its strategic objectives. It describes the training that is delivered, the learning that will be achieved and who the intended beneficiaries of training are. Organised labour has a shared responsibility with the employer to ensure that processes are firstly adhered to in keeping with the labour legislation (Skills Development Act 97 of 1998 and Skills Levy Act 9 of 1999) and secondly fairly planned, especially in terms of the skills development plan. Furthermore, such processes have to reflect employment equity needs.

In the case of nurses and midwives this training and learning takes the form of Continuing Professional Development where competencies are acquired, maintained or updated. Attention is drawn to the fact that competencies are

more than just skills and also include knowledge, attitudes, behavioural attributes and values.

Employers also ensure that workplace training addresses the recommendations of the HWSETA. At a workshop on 23 January 2001 the following objectives and recommendations were identified:

(i) Developing a culture of caring

- Promote the development of ethics training and ensure its inclusion in all education and training within the sector
- Ensure the incorporation of a caring ethos

(ii) Promoting outcomes-based education

- Extend CPD and/or further training to all levels of employees in the sector
- Ensure that present training infrastructures transform their product to outcomes-based criteria so that workplace training is relevant
- Ensure that all training is linked to NQF and SAQA requirements
- ensure that workplace training uses registered providers

(iii) Addressing the threat of HIV/AIDS

- Focus training programmes on the removal of the stigma of a positive status as well as the practical issues
- Include a core module on HIV/AIDS in all learnerships and skills programmes developed and/or approved by the HWSETA
- Impart in training the specific skills required at community level to slow down the spread of HIV/AIDS

(iv) Improving management skills to

- Ensure that all aspects of management education and training are a high priority
- Include occupational health and safety as a core module

(v) Redressing rural/urban initiatives

- Use incentives such as discretionary grants to encourage employers to develop learnerships programmes with a particular focus on rural areas

(vi) Employment equity

- Reflect employment equity needs in workplace skills plans
- Identify and prioritise the previously disadvantaged for learnerships needs
- Created career paths through the implementation of workplace skills plans

(vii) Deliver service excellence. Training must be comparable with world standards in:

- Ensuring linkages with local and international training providers
- Developing international links for exchange programmes and the use of foreign donor aid for skills development
- Adopting and incorporating best practice models wherever possible within a South African context
- Developing training for new professions that are being integrated into the health and social system.

Education and training will need to be decentralised to encourage wide-spread participation" (HWSETA, 2001:2).

It is important that employers, skills development facilitators, organised labour bear in mind that CPD training programmes should not be planned in isolation. They should take cognisance of national developments such as the recommendations of the HWSETA so that employers receive incentives that are invested into future CPD needs. Over and above complying with the National Skills Development Strategy, employers have to ensure that an effective Joint Performance Management System is in place.

D. Joint Performance Management System

A **Joint Performance Management System (JPM)** is an ongoing process. The employer (line manager) and the nurse and midwife shares the responsibility of managing and monitoring her own progress in those competencies required to perform her daily duties, to determine whether the goals of the organisation and the developmental needs of the nurse and midwife are met. The employer (line manager) and the individual nurse and

midwife jointly agree on duties and standards for the financial year of the organisation.

An induction programme is run for new employees so that they attain a thorough understanding of the organisations' Joint Performance Management System. The line-manager, who represents the employer, is supportive of the nurse and midwife achieving the outcomes of her annual learning plan. Individual development plans with regard to career pathing are also mutually agreed upon and developed jointly by the line-manager and the nurse and midwife (employee).

During the four monthly performance reviews the progress of the nurse and midwife (employee) is monitored and documented in the Joint Performance Management form of the organisation and in the CPD portfolio of evidence of the nurse and midwife. The training needs of the employee are documented and training undergone with its application to the area of practice in the workplace is also documented. An accurate account is kept of self- and peer assessments, follow-up training and the outcomes thereof, in the annual learning plan of the nurse and midwife.

E. The Annual Training Report

This is a report that provides an accurate account of the training that was implemented for a particular financial year and also includes details of any variance between training that was actually implemented as compared to that which is reflected in the workplace skills plan approved by the HWSETA.

The Skills Development Facilitator compiles an Annual Training Report that is submitted to the HWSETA by 30 March each year (HWSETA's financial year is from 1 April to 31 March of the following year). Compliance, as in training implemented according to the approved workplace skills plan, results in the following: the employer is reimbursed with 15% of its 1% levy for the plan and 45% of its 1% levy for the Annual Training Report (Department of Labour, 2002:11).

Table 5.6 outlines the structure, process and outcomes standards that employers adhere to, so as to demonstrate compliance with the National Skills Development Strategy and its accompanying legislation.

Table 5.6: The structure, process and outcome standards for employers

Structure standards

- A work environment conducive to the facilitation of skills development
- An appointed workplace skills facilitator
- Evidence of a training needs analysis
- Evidence of a workplace skills plan that is approved by the HWSETA
- Evidence of a record keeping system to capture data related to the implementation of the approved workplace skills plan
- An established Joint Performance Management (JPM) system with a minimum of four monthly performance reviews.

Process standards

- Implementation of the approved workplace skills plan with follow up assessments so that employees may be accredited
- Compliance with the payment of the skills levy
- An induction programme for the orientation of new employees to the JPM system of the organisation
- Continuing training for line managers and employees with clearly defined roles and responsibilities pertaining to the JPM system
- Evidence of three monthly reviews of performance and monitoring of fulfilling agreed upon standards and measurable outcomes as indicated in each employee's annual learning plan
- A mutually agreed upon individual development plan for each employee.

Outcome standards

- Evidence of improvement in employee's workplace performance
- A financial reimbursement from the HWSETA for re-investment in training and development of employees
- Evidence of increased consumer satisfaction.

Having described the structure, process and outcomes standards for the employer, a process description on the systematic sequence of events with regard to the role of the employer is illustrated in Figure 5.8

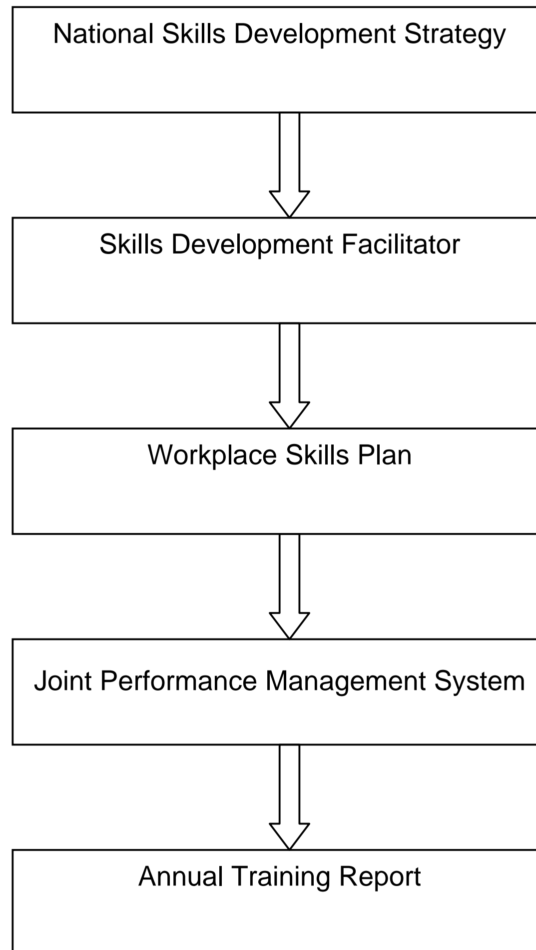

Figure 5.8: A process description of the roles and responsibilities of the employer

Having described the roles and responsibilities of the employer, the focus turns to the contribution of dynamics to the Final CPD system.

5.4.4.4 Dynamic factors critical to the CPD system

The success of a CPD system is dependent, amongst other things, on dynamic personality and character factors such as integrity, honesty, commitment to the daily tasks and practices, and dedication to the broader

nursing and midwifery profession. With regard to these dynamic factors, it is essential to bear in mind that commitment to, compliance with, and the inter-accountability of each of the three principal role players of the CPD system is an imperative to achieve the success of the system. It is only with the adherence to commitment, accountability, honesty and compliance that the CPD system would influence the health care that consumers are receiving and thus the consumers are only reflected in the visual presentation at this stage of the description of the CPD system. A visual presentation of the dynamic factors are depicted in Figure 5.9.

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Figure 5.9 A visual presentation of the dynamic factors.

With the illustrated role of the dynamics of all components of the Final CPD system I mind, it must be emphasised that nurses and midwives make and keep commitments to Continuing Professional Development by making truthful entries in their CPD Portfolios of evidence. This establishes an inner integrity and an ability that empowers them to muster courage and strength of character, to accept accountability for and compliance with their own professional development and growth, which is the essence of effectiveness. A brief explanation of each of the concepts (commitment, accountability, inter-accountability and compliance) affecting the dynamics around CPD follows.

A. Commitment

Commitment pertains to being dedicated to a cause, and in this study, to CPD. The successful running of the Final CPD system for nurses and midwives in South Africa is sustained by dedication from the principal role players and the other role players.

Commitment implies affirmation of the social contract, the unwritten contract that the nurse and midwife conclude with society when she becomes registered/enrolled. Trust is the key to the contractual relationship between the nurse and midwife and society. This implies trust in the competence of the nurse and midwife, in her professional ability and morality, integrity, fidelity and awareness of her role and functions within the legal and ethical parameters of her practice.

Being a member of the nursing and midwifery professions also demands commitment to the particular profession, its ideals and mission. The mission of the nursing and midwifery professions to protect the rights of the patients to knowledgeable, competent, legal and ethically based care. Every member of the profession who is concerned about the nature and quality of patient care needs to participate in the growth of the profession’s knowledge (Searle & Pera, 1995:114).

B. Accountability

Accountability entails that the nurse and midwife is answerable for her own acts and omissions. Being accountable means that the nurse and midwife is expected to justify her actions, decisions and omissions with regard to her daily practice of nursing and/or midwifery. Accountability also implies that there is personal and individual liability for the consequences of every act and/or omission of the nurse and midwife. Inter-accountability is the joint or shared accountability among the principal role players, namely, the SANC, nurse and midwife and the employer. In the case of the entrepreneur, who is self-employed, the inter-accountability is between her and the SANC.

C. Honesty

Honesty means free of deceit, truthful and sincere, fairly earned (The Concise Oxford Dictionary, 2002:554). This pertains especially to the nurse and midwife when she engages in reflective practice, self- and peer evaluation, compilation and evaluation of annual learning plans and maintaining a CPD portfolio of evidence. Verkerk, Lindemann, Maeckelberghe, Feenstra, Hartoungh, and De Bree (2004:31) expand by saying:

> "To adapt to the new environment, a good professional must not only exhibit the technical proficiency that allows her to do things right – she must also do the right thing. She needs to be aware of her own professional norms and values; to be able to express them to her colleagues, her patients, and their families; and to work together with these other actors to provide ethically responsible care. In short, if professionals are to do the right thing, they must develop a refined capacity for moral reflection."

D. Compliance

Compliance pertains to obeying rules and for the purpose of this study, for nurses and midwives, it means meeting the CPD requirements in accordance with the SANC's policy and CPD regulations. When such regulations are promulgated for the SANC it means effectively monitoring and controlling the implementation of the CPD system and putting regulations and policies in place to effect this. For the employer it means complying with the specifications of applicable legislation such as the Skills Development Act 97

of 1998, and Skills Levies Act 9 of 1999. Compliance also entails the active participation and collaboration of the principal and other role players.

Having reviewed the contribution of dynamics to the Final CPD system, it is essential at this stage to direct attention to **the consumers,** who as mentioned previously have been deliberately omitted from figures 5.3, 5.5 and 5.7. The **consumer** refers to the recipient of health care as either a patient, group, family, community and the public at large. Consumers expect the principal role players to have the attributes of commitment, accountability, honesty and compliance with the professional, ethical and legal framework (Figure 5.2). The consumer also expects quality nursing and midwifery care. According to the Constitution, Act 101 of 1996, Chapter 2: "… everyone has the right to have access to health care services, including reproductive health" (RSA, 1996). Over and above the Constitution of South Africa, the consumer charters of the Department of Health (Patients' Rights Charter and the *Batho Pele* White Paper) have raised the expectations of the consumers.

There should be mechanisms in place to encourage ongoing input and participation from consumers regarding the healthcare they receive from nurses and midwives. Furthermore, consumer's views and preferences should carry a higher value (Fatchett, 1998:7).

The description of the Final CPD system would fall short if reference is not made to other role players who although not reflected on the visual presentation (Figure 5.1), make a significant contribution to the process of Continuing Professional Development.

5.4.4.5 Other role players

Other role players that contribute to the CPD system are the professional organisations and organised labour, and the consumers of healthcare.

A. Professional organisations and organised labour

The roles of professional organisations and organised labour are multifaceted and with regard to CPD include, amongst others:

- Providing guidance and support to their members with regard to reflective practice, self- and peer evaluation and the development of annual learning plans and CPD portfolios of evidence
- Ensuring that training and professional development is distributed equitably and fairly at the workplace to all levels of nurses and midwives and participating in the development of workplace skills plans
- Contributing to the development of on-line learning programmes to increase the accessibility of distance learning
- Lobbying and negotiating for increasing the accessibility of CPD for nurses and midwives in all healthcare settings and with special reference to nurses and midwives that are employed in remote rural areas
- Arranging workshops and conferences according to the current needs of the profession and the socio-political dynamics of the country so that members are kept informed and abreast of advances in the profession and also with regard to the socio-political dynamics affecting healthcare
- Making provision for a credible professional journal that is distributed regularly to its members and also running workshops to empower members to develop writing skills thus enabling their active participation in publications for the said journal and others
- Administering and controlling bursary schemes so that eligible applicants are assisted financially to engage in relevant CPD activities.

B. Consumers of healthcare

Consumers of healthcare are considered important role players as they receive healthcare. Therefore they have the right to expect updated, professional care.

Having delineated the significant contributions of other role players, it is evident that the Final CPD system requires the joint efforts of the principal role

players, consumers and other role players for the realisation of the continuous energy flow firstly into the input, then the throughput to the output.

5.4.5 Outcome

This research study envisages increased consumer satisfaction through compliance with and commitment to the effective implementation of the Final CPD system by the three principal role players as well as the other role players.

5.4.6 Summary

The Final CPD system adheres to the principals of validity, simplicity, realism, practicability, affordability, and attainability.

5.5 Conclusion

Whilst the transformed National Health Plan, policies and priority programmes make increasing demands for effective healthcare delivery, nurses and midwives, like all other healthcare professionals, are required to provide evidence of the value of their contribution in terms of purposefully participating in Continuing Professional Development. This entails lifelong learning through ongoing upgrading of knowledge, skills and attitudes because the achievement of a mere qualification is insufficient to carry them indefinitely through a career as healthcare professionals. Continuing Professional Development for nurses and midwives in South Africa should be formalised and regulated in such a way that it is compatible with other national healthcare professions and international benchmarks.

In Chapter 5 the Final CPD system for nurses and midwives in South Africa was described in detail. Chapter 6 will critically reflect on the Final CPD system for nurses and midwives in South Africa.

CHAPTER 6

A CRITICAL REFLECTION ON THE CPD SYSTEM FOR NURSES AND MIDWIVES IN SOUTH AFRICA

6.1 Introduction

Critical reflection contributes to understanding how well the Final CPD system relates to the practice of nursing and midwifery. Various critical questions are asked about the functional value of the Final CPD system. The system is examined with respect to each of the questions and the responses are screened to determine which could be used to refine and add value to the system. The purpose for conducting a critical reflection on the Final CPD system is related to the research objective, which sets out to validate and to refine the Final CPD system for nurses and midwives in South Africa.

The Final CPD system was evaluated according to the following five criteria adapted from Chin & Kramer (1995:125):

1. Clarity of CPD system
2. Simplicity of the CPD system
3. The applicability of the CPD system (applicability to nursing and midwifery)
4. The accessibility of the CPD system
5. The importance of the CPD system.

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6.2 Selection of validators/appraisers

A group of validators (n=31) evaluated the Final CPD system for nurses and midwives in South Africa. The sample was purposively selected from the principal role players; other role players; academic experts; and senior managers of human resource departments of healthcare institutions in both the private and public sectors. The rationale for this selection coincides with the principal role players (See section 5.4) and other role players.

The group of validators representing the principal role players comprised:

- Academic experts in research and model evaluation
- Elected members of the SANC
- Senior managers from the public and private sectors
- Nurses and midwives practising both in urban and rural healthcare settings
- Professional associations and organised labour.

The distribution of the representative sample of validators was as follows:

- Six academic experts that comprised registered nurses and midwives; two of which are elected members of the second democratically elected SANC
- Three senior managers from the public sector, registered as nurses and midwives and holding the positions of director, deputy director and assistant director at a provincial head office
- Six senior managers, two from each of the three private sector companies in South Africa. One of these senior managers is an elected member of the SANC
- Ten nurses and midwives, five from urban healthcare settings and five from rural healthcare settings. One of the poorer provinces, namely, the Eastern Cape, with remote rural healthcare settings, was purposively selected for rural representivity
- This particular sample grouping included various categories of nurses and midwives in South Africa, distributed as follows:
  - two registered nurses
  - two registered midwives
  - two enrolled nurses
  - two enrolled nursing auxiliaries
  - two enrolled nursing assistants
- One registered nurse and one registered midwife practising abroad and maintaining their registration with the SANC
- Two registered nurses midwives internationally based in non governmental organisations.

6.3 Process of disseminating the Final CPD system to the validators

Copies of the following documents were forwarded to the validators, three of which were transmitted electronically and 28 delivered by hand (See Annexure 5.1):

- A covering letter
- A copy of the document with the proposed CPD system
- Guidelines for conducting the critical reflection and
- The critical reflection tool.

Validators were allowed sufficient time to peruse the document in order for them to complete the critical reflection tool. The researcher thereafter set up meetings with the respective validators to discuss their written feedback on the Final CPD system. As the researcher engaged in discussions that were centred on the questions, the focus was on clarifying processes within the CPD system to increase its suitability for the South African context. The ideas the researcher developed from the critical reflection contributed to the researcher's critical insights and directs the refinement of the Final CPD system. The written feedback of the validators will be discussed under the five criteria according to Chinn & Kramer (1995:125).

6.4 Discussion of the feedback of the validators/appraisers

The feedback of the validators was critically reviewed and is described below by means of paraphrasing and direct quotations.

6.4.1 Clarity of the CPD system

In terms of this criterion the feedback received is presented below:

Feedback – Clarity of the CPD system

The visual presentation conceptualises the Final CPD system clearly and brings complex issues together into a cohesive whole (n=20). The tripartite partnerships within the Final CPD system provide a dynamic interaction to sustain it (n=5). The role of each of the principal role players and the structure, process and outcome standards are clearly described (n=25). The flow diagrams illustrating the process description for each of the principal role players is clear (n=27). While the Final CPD system is clearly expressed in most respects, the author needs to expand on the meaning of a learning activity (n=5), for example, a validator suggested that specific reference be made to a learning activity of an extended duration such as the ICU course versus an activity of one-hour duration.
Two validators stated that the visual presentation is too busy and one validator stated that it does not demonstrate the systems approach.
One validator stated that the introduction should be clearer by including some aspects of the overview in 5.3 into the introduction. Structural and semantic clarity is maintained throughout (n=9). The lack of a separate list of definitions of the concepts detracts from the clarity of the Final CPD system (n=6). One validator requested that more definitions of competence should be explored and that competence should be defined in the context of specific criteria that can be accounted for during practice.
One validator expressed concern around the SANC's role: "The description of the Final CPD system is clear but it appears as though the role of the SANC is subdued. As a professional body, it would seem that for the first 5 – 10 years of the implementation of the Final CPD system, the SANC should be playing a stronger facilitative role. The sequence of the SANC's role would be: ❑ facilitation ❑ collaboration ❑ monitoring and evaluation ❑ feedback It is the SANC that identified the need for CPD, therefore it should have a greater thrust in ensuring its implementation".
The Final CPD system is illustrated well and looks good and simple on paper, however, there is a need to translate the roles and responsibilities of the role players and to describe them at a more applied level (n=8).
Two respondents expressed their concern about the level of competence as follows: "The nurse must be competent as a generalist and then in the particular specialist field. Differentiate between clinical competence and professional competence".
Some clarity was sought on the levels of learning that would qualify for recognition as CPD learning activities (n=5).
There was also concern (n=3) that the consequence of not complying with the Final CPD system is not clear. The document does not indicate whether this system will be implemented for all categories of nurses and midwives (n=5).

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One validator also queried as to what 'values or points' would be used. I quote: "How are you going to suggest the points or values for the three identified areas (Ethics, clinical and national/provincial programmes) for CPD? How would the nurse and midwife be able to attain these points i.e. what activities will be required for CPD?"

One validator expressed the following concerns:
"Need to document the fact that individual nurses will cover the costs of the 'return-to-practice programme' or could motivate for sponsorship from the future employer. Costs for 'return-to-practice programme' should not deter nurses and midwives from actively participating in such a programme. What about nurses and midwives who have been out of practice for less than five years?"

There was concern by a validator that the explanation of the context of CPD was not clear:
"I would recommend that reference be made to the role of labour organisations in the skills development and skills planning processes. Although labour is not a principal role player, labour has a shared responsibility with the employer to ensure that processes are adhered to according to the legislation, executed fairly and according to the plan, e.g. labour has to be part of the development of skills development plans – if not the relevant SETA will not accept the plan if labour participation has not been proven".

One validator remarked on the reference made to the employer's role in ensuring safety and vicarious liability:
"... you may want to consider including the Occupational Health and Safety Act as one of the pieces of labour legislation that should be mentioned. Part of ensuring a healthy and safe environment is for the employer to ensure that nurses and midwives are adequately trained to perform their duties and updated regularly".

Another validator expressed her concern about the fact that the information provided makes it appear that:
"CPD activities will be accredited by the HWSETA. I do not believe that is where the responsibility for accreditation lies. I would suggest that you add a statement here around the SANC's ETQA role for nursing and midwifery education and training programmes".

One validator alluded to an incorrect technical application of the employer's role and the skills development strategy:
"The National Skills Strategy refers to the national strategy that will be overseen by the Department of Labour. The HWSETA only represents a sector within the broader skills strategy and therefore develops a sector skills plan that has to feed into the national skills strategy".

Some controversial feedback by a particular validator reflected on the following concerns:
"The way it is set out is clear but I do not believe the principle of the employer and the SANC having a joint accountability or that even a relationship with one another is correct (sic). I suggest that a solution could be found if the nurses and midwives were located uppermost in the visual presentation and the employer and the SANC on either side of the lower aspects of the triangle, with the double arrows of inter-accountability positioned between the nurse and midwife and the SANC and another double pointed arrow between the nurse and midwife and the employer; this would rightly indicate where the joint accountability lies".

A question arose as to how competence will be proven. It was argued that this System does not indicate how competence will ultimately be demonstrated (n=5). One of the five validators stated further: "... that if the competency issue is resolved then it is reasonable not to accredit providers but to put the onus on the nurse and midwife to seek good input and then to prove her competence".
One validator stated that there should be a link between the SANC's monitoring and control role and its Quality Management System (QMS) as an Education and Training Quality Assurance Body (ETQA).
It was also recommended by a validator that CPD certificates of attendance be attached to the SANC's annual CPD statement that is submitted to renew the nurse and midwife's registration. The same validator further suggested that the workplace skills facilitator of a particular institution should sign off all the annual CPD statements that are submitted to the SANC from the nurses and midwives employed at that institution.
One validator expressed her concern at the proposal of implementing the Final CPD system manually within an era of e-base learning and that electronic submissions through smart cards should be introduced. It was further argued that: "Even a nurse and midwife in the most remote rural area possesses a ATM card and can use a smart card, this will enhance accessibility".

One of the challenges facing a CPD system for nurses and midwives in South Africa is the divergent healthcare settings in which they practise their professions. There are both first and third world settings Bearing this important challenge in mind, the researcher found it essential to purposefully reflect on the following quotes from rural participants separately:

Quotes from rural participants:

"The Final CPD system is clearly explained. In the rural context the onus lies with the nurse and midwife to engage in reflective practice and self- and peer assessment. Training must be put in place so that there is a common understanding of reflective practice, self- and peer assessment and the drawing up of learning plans with outcomes".
"The Final CPD system is clearly put forward if only we could all work together to make it work".
"The way it is explained in writing is clear and understandable".

Quotes from some participants (n=2) maintaining registration with the SANC and practising abroad:

> "The outline is very clear and internationally compatible. It does not clearly define how it will be applied to nurses and midwives practising abroad – There is no guarantee that employers abroad will have any commitment to signing off the SANC's annual CPD statement. If overseas employers refuse involvement then the CPD declaration has to accept collaboration between the nurse and the SANC only".

6.4.1.1 Concluding statements: clarity of the CPD system

- There was general acceptance and agreement on the clarity of the Final CPD system.
- The tripartite partnerships within the system provide a dynamic interaction to sustain the Final CPD system.
- The researcher should translate the roles and responsibilities of the role players and describe them at an applied level.
- The lack of a separate list of definitions of the concepts detracts from the clarity of the Final CPD system.
- Clarity was sought on the levels of learning that would qualify for recognition as CPD learning activities for the various categories of nurses and midwives.
- The Final CPD system does not indicate how competence will ultimately be demonstrated.
- Training should be put in place so that there is a common understanding of reflective practice, self- and peer assessments, the compilation of outcomes-based annual learning plans and the compilation of CPD portfolios.

Having discussed the feedback on the clarity of the Final CPD system, a discussion on the feedback with regard to the simplicity of the Final CPD system follows.

6.4.2 Simplicity of the Final CPD system

In terms of this criterion the feedback is as follows:

It was generally felt that the Final CPD system was simple to understand and that the relationships among the principal role players were clearly defined (n=20). The following quote from a respondent expresses similar views of other respondents: "It is simple enough to understand and the visual presentation supports it adequately. Each principal role player has clearly defined roles that are simple to achieve. Relationships between the various role players are expressed simply and clearly. Concepts are minimal and thus enhance the simplicity of the Final CPD system".
Another respondent expressed her views as follows: "Focus on the tripartite relationship and the accountability of the employer, is excellent as it is presented in this document, however, the employer's participation in the skills process is merely incentivised and by no means compelling, thereby impacting too unfairly on the professional".
A recommendation was made that legislation should make this more binding for the three principal role players (n=3).
There was concern that although the Final CPD system looks simple on paper it must not result in a complicated paper driven exercise.
One respondent stated that there is no correlation between JPM and CPD and that skills development does not necessarily guarantee competence.
Four respondents questioned whether the SANC would cope with the work entailed in conducting a 5% auditing sample of approximately 173, 000 nurses and midwives. It was seen to entail an overwhelming workload and there was doubt as to whether the SANC could afford to implement such a CPD system. The following quote from a validator expresses the concerns around the SANC: "What capacity will the SANC require to perform the evaluations of the 5% of 173,000 nurses and midwives? How will the process of evaluation of portfolios of evidence impact on the licensing of the nurse and midwife? Will it be completed soon enough to ensure that the nurse and midwife do not end up with an unlicensed period? The SANC will have a responsibility to ensure that the Final CPD system does not result in a disruption of services!"
There were further queries on the SANC's staffing complement to perform the identified duties (n=6). These validators also expressed their concerns around staffing issues. Comments from these validators include: "How many staff members are estimated to be necessary to perform these functions? What will the cost be and where will the funding be coming from? Will nurses and midwives have to pay an additional fee for the evaluation of the Portfolio of Evidence and then also pay a licensing fee?" "Will the SANC's cope with monitoring the Final CPD system timeously without the occurrence of a backlog. The SANC will have to do a huge amount of work to improve on its service delivery..."

Validators (n=3) emphasised that the SANC should only implement the Final CPD system after their database is electronic and updated. One of the three validators cautioned that: "The SANC's entire database and backup system should be electronic before the Final CPD system is implemented as I fear that there will yet be another backlog that will not be corrected".
One validator enquired about the level of worker that shall be involved in the auditing process and in the ratifying of compliance with the Final CPD system.
The process for managing CPD queries was also questioned by a validator: "Would the SANC have a separate helpdesk for CPD? Would processes be put in place to effectively handle electronic queries around CPD as the current call centre is already inundated with calls? These must have reply times so that nurses and midwives are ensured of quick responses".
One validator stated that the SANC's annual newsletter to the nurses and midwives should include an analysis and interpretation of the SANC's findings on the implementation, monitoring and control of the Final CPD system.
Nurses and midwives and the public at large should have access to the SANC's annual report that is sent to the Minister of Health.
Validators (n=5) alluded to the fact that other professionals attend CPD activities but do not necessarily change their behaviour or learn anything.
In terms of the following quotations, concerns, validators (n=2) queried the implementation of three monthly performance reviews and the implementation of joint performance management for agency staff and entrepreneurs: "Three-monthly joint performance reviews are not feasible unless for neophytes or in the case of poor performers. And what about entrepreneurs/private nursing and midwifery practitioners that are not engaged in joint performance management activities? Who will sign off the SANC's form for annual achievement of CPD outcomes for nurses and midwives employed by agencies? "The determination of the time frame for performance reviews should not be prescribed but decided upon by the employer as three monthly performance reviews are not feasible for all employees. The needs of individual employees vary".
One validator expressed her dissatisfaction about the SANC sending out one annual newsletter to all nurses and midwives: "This should happen much more often to achieve higher levels of awareness, visibility and communication as things happen or evolve".
One validator found it necessary to align the return-to-practice programme to the current credit system as is required by SAQA as follows: "Ethics and Professional Practice, 20 notional hours = 2 credits; Area of Practice, 80 notional hours = 8 credits; national/provincial priorities and programmes, 20 notional hours = 2 credits. Total of 120 notional hours = 12 credits".

Quotes from rural participants:

"The Final CPD system as explained is very useful in the sense that it aims to have a cadre of nurses and midwives that strive for continual competence! Rural areas have very few doctors and the availability of nurses and midwives striving for Continuing Competence is most welcome".
"It is very simple, each role is clearly defined and how it is connected to the other that is the relationship among the principal role players".
"It is simple enough as we all work together as a team, but needs to be implemented.

6.4.2.1 Concluding statements: simplicity of the CPD system

- There was a general agreement that the Final CPD system was simple to understand.
- The fact that there are not too many concepts, enhance the simplicity of the Final CPD system.
- Each principal role player has clearly defined roles and responsibilities.
- Legislation is necessary to make the roles and responsibilities of the three principal role players, namely, the nurse and midwife, the employer and the SANC, more binding.
- There is doubt as to whether the workload of auditing a 5% sample of 173,000 nurses and midwives registered with the SANC, would be managed with the existing staff situation at the SANC.
- There is also concern about the SANC's financial capacity to implement the Final CPD system.
- The SANC should have an updated electronic database of:
  - nurses and midwives on its register and rolls
  - its accredited providers (nursing education institutions with their approved clinical facilities
- Although other professionals attend CPD activities, there are no observable differences in their knowledge nor skills.

6.4.3 Applicability of the Final CPD system

In response to the request to comment on the applicability of the Final CPD system, all the validators remarked that the Final CPD system applies to

nurses and midwives in general and that it is not confined to specific areas of practice.

Feedback on applicabilty

They stated that the scope of the Final CPD system is all encompassing (n=31) and that the purpose of the Final CPD system applies to all nursing and midwifery practice areas (n=28). It was also felt that the Final CPD system would work particularly well in the urban public sector and in the private sector but that there would be challenges in the rural environment where 'employer' resources are limited (n=10).
One validator aptly quoted the current state of affairs as being: "Identification of high-risk areas in clinical practice such as nurses and midwives in private practice (entrepreneurs), will require other processes such as indication on the register that they are in private practice. Midwives are regarded as a high-risk group and are identifiable on the registers as midwives, but we do not know how many of them practise as midwives".
One validator considered the call for 5% auditing: "The review and call for 5% sample of portfolios is acceptable under the current climate in which the CPD process is still not being accessed smoothly…however once mechanisms are fully in place as proposed, then a more accountable method needs to be considered for establishing compliance. This would certainly be the case for midwives when one considers the 'Saving Mothers, Saving Babies Report' and its findings".
Another validator was concerned about how one differentiates between the generalist and the specialist nurse and midwife. She further stated: "What about various levels of complexity such as diplomas versus master's degrees? What about updated information versus going through the notions? Differentiate between clinical competence and professional competence".
There was a suggestion that the nature of the CPD learning activities be aligned to the NQF level of the highest qualification attained by the nurse and midwife (n=3). The need to align CPD learning activities to outcomes based education was also recommended (n=4).
The development of a culture of life-long learning during basic education and training was emphasised by two validators.
One validator felt that: "The Final CPD system will be a core factor in improving the quality of healthcare delivery in South Africa. Effective monitoring systems will need to be put in place in order to ensure its effectiveness".
One validator expressed a serious concern against the weighting of the Final CPD system: "I believe from what I have read that there is a gap of what will be seen as CPD, what I mean is the standard against which it will be weighted. For instance, if I have read 5 articles in an accredited journal, how will that weigh against attending a 1-day workshop on the same topic? You need to include against what will CPD be measured. There must be a standard that states clearly what would count towards CPD i.e. reading 5 articles = ? points – Attending a workshop = ? points. It is not clear at all what the quality assurance of the standards of the Final CPD system will be".

The same validator argued further that: "I am concerned at the conservative method of a portfolio. We are living in a new millennium and it should be a smart card based record system. Each employer/entrepreneur must ensure that an electronic recording system is in place for CPD points".

Quotes from rural participants:

"In its applicability to nursing and midwifery, the Final CPD system is generally acceptable. The overall purpose explained in 5.5 on page 12 of the guidelines you provided convinces me so".
"It can be applied to nursing staff and midwifery".
"It can be applicable if all the bodies are working together. More people from the lower levels should go to the courses".
"The System can be applied to all levels of nursing practice mostly midwives really need CPD".

6.4.3.1 Concluding statements: applicability of the Final CPD system

- There was a general agreement that the Final CPD system applies to nurses and midwives in general and that its scope is all encompassing.
- The development of a culture of life-long learning should be established during basic education and training programmes.
- There should be a differentiation in the CPD learning activities of the generalist and those of the specialist nurse and midwife.
- There should be a linkage between the CPD learning activities and the nurse and midwife's highest qualification level, in terms of the National Qualifications Framework (NQF). CPD learning activities should be outcomes based.
- Follow-up assessments should be in place.
- The review and call for 5% of portfolios is acceptable until the Final CPD system is well established and then a more accountable method of monitoring compliance with the Final CPD system should be developed.

6.4.4 Accessibility of the CPD system

Feedback on accessibility

The Final CPD system is accessible to all nurses and midwives. The visual presentation with its relevant explanations makes the System 'user friendly' (n=18). The inclusion of the employer and the SANC in the System makes it more accessible to nurses and midwives in South Africa. However, there was concern as to how the public sector would put systems in place to provide the necessary training (n=6). The basis of this concern centred on the resources available and the logistical capacity of the public sector especially in the rural healthcare settings.
Some responses from validators in urban settings, on the accessibility of the Final CPD system, are given hereunder: "In order for this tripartite relationship to support an effective and accessible CPD system, the issue of accountability of the employer needs to be regulated. The SANC could consider a strategy that extends legislative obligations for the employer as the strategic provider of the service and its direct impact on the quality of care to the patients".
"Accessibility cannot be evaluated based on the information provided. The obligation of the employer to develop skills in the work place may not be sufficient to provide the nurse and midwife with sufficient points for re-licensing. Obviously the cost involved to obtain the required CPD points will have a big impact on the accessibility of the Final CPD system. Although the minimum guidelines document alludes to some of the issues that will provide for CPD points, a clear description of how easily (or not) the nurse and midwife will be able to accumulate CPD points has not been provided in Chapter 5, for example, if a nurse writes an article or delivers a paper at a conference, it may require significant time to prepare the paper/article, but may not cost much in terms of money. The options available will determine/contribute to the accessibility of the System".
"The Final CPD system could be more robust. It appears to be superficial. Employers do not follow through the Workplace Skills Plan and Annual Training Report. There must be more emphasis on the role of the professional in terms of the Final CPD system".
"Annual licensing may be unrealistic".
"Democratic means of collaborating with organised labour in marketing CPD should be considered".
"Maybe if peer evaluation is brought in as indicted, it will conserve the accessibility aspects which are good while solving the competency/compliance to criteria debate".

Quotes from rural participants:

"In rural context following traditional attendance of CPD activities does not work ... the reasons being:

1. Rural facilities are understaffed and struggle to attract staff. 2. The absence of resources has compelled nurses in rural settings to return to business as usual when they return from trainings. 3. Rural nurses are improvising and do not implement best practising models. 4. Management and monitoring of the nurse and midwife's progress with regard to his or her daily duties is difficult even in the urban areas where the staff shortage is lesser".
"At present, CPD is not well entrenched among nurses and midwives, and in some cases with employers. I would recommend that awareness campaigns and workshops be conducted countrywide. Perhaps employers also need to be evaluated in terms of how well they promote the implementation of CPD within the workplace. Many nurses and midwives cannot be released from their responsibilities because of a shortage of staff in the clinical settings. In the E C we have been hard hit by the mass exodus of nurses and midwives to foreign countries. The rural nature of our province makes it difficult to travel to centres where workshops are being conducted. Cost is another factor that limits access to CPD opportunities".
"The way it is put here it is clear and everyone can use it. But with the shortage of staff I just wander if it is introduced it can be used".
"It can be introduced if done the right way".
"With the shortage of staff it is not accessible for everybody to attend these courses".
"It could be accessible. But with the shortage of staff it is not".

6.4.4.1 Concluding statements: accessibility of the CPD system

There appears to be distinct differences between the responses of urban validators and that of rural validators in respect of:

- Urban settings require a more robust CPD system whilst rural validators felt that a lack of resources militate against a robust application of the CPD system.
- Urban validators argue for more employment commitment and compliance whilst rural validators point out that understaffing problems would make more employer involvement difficult.
- Rural validators expressed their doubt as to the value and application of training interventions.

There was however agreement that self- and peer assessment as indicated in the Final CPD system would solve the accessibility aspect and that training needs would be more focused and clearly identified.

6.4.5 Importance of the Final CPD system for nurses and midwives in South Africa

There was an overall consensus that there is a definite need for a CPD system as it has the potential to influence the practice of the nursing and midwifery professions and nursing education and research. The comments of the validators included the following:

With the pace of new technology and new knowledge development in healthcare, CPD is an essential way of keeping professionals abreast of developments. The quality of healthcare is dependent on professionals with updated knowledge and skills (n=28). The Final CPD system makes provision for a feasible and practical way to achieve this, however, the main problem identified (n=5) was in assessing competence in the clinical skills as this appeared to be the main area of concern.
One validator expressed the following concern: "The seriousness/critical necessity for a CPD system is not adequately motivated".
Three validators noted that the implementation of a CPD system for nurses and midwives in South Africa is of paramount importance to maintain the status of the South African nursing and midwifery professions in the international arena. It was further stated that this CPD system is of critical importance to all aspects of nursing and midwifery and has great potential to influence the quality of care and delivery thereof.
In response to the issue of whether the Final CPD system would be favourably received by the nurses and midwives in South Africa, a validator expressed her view as follows: "Not so to my knowledge, where CPD has been mentioned it was seen by some as an additional burden in terms of time and cost; a money making racket. There is the group that believes that a CPD system is long overdue and that it has the potential to make a difference to the quality of nursing and midwifery care provided to our communities".
The need for training to be outcomes based and competence driven as being key to performance was identified (n=5). One of the five validators expressed her concern that qualifications must be seen as the beginning of professional education and functional in practice and not as an end in itself.
Two validators appealed that it must be more than merely a paper-driven exercise.
It was stated that the Final CPD system has a high degree of importance, particularly to achieve its purpose. Its influence on practice is very clear, however its influence on research and education needs to be articulated (n=3). This indicates the need for ongoing research and refinement based on lessons learned from the implementation of the CPD system over a period of time.
The general capacity of nurses and midwives will determine whether it will be favourably received (n=4). Logistics and other factors in the actual implementation of CPD are other considerations that will influence the

reception of the Final CPD system (n=6).

The following quotes from various validators express their views on the importance of the Final CPD system:

"The Final CPD system will enable a more accurate assessment of nursing and midwifery demographics in terms of practising versus non-practising nurses and midwives in South Africa and areas/disciplines being practised versus prediction of future training needs. There is concern that nurses and midwives in South Africa maintain registration and thus a license to practise in many disciplines where they have not practised for many years. The SANC needs to address this as a matter of urgency".

"In support of South Africa's biggest growth market, tourism, nurses and midwives have an obligation to ensure individual competence in support of the tourism industry".

"Professional associations must play a more active role in the Final CPD system especially with regard to the continuing professional growth and development of its membership".

"Providers of nursing and Midwifery education and training will play an active role in laying the foundation of CPD in South Africa, in terms of the current outcomes-based methodology, ongoing outcomes-based follow-up assessments linked to CPD so that credits may be retained for evidence of learning achieved. This could then serve as evidence for Recognition of Prior Learning".

"The System is important to achieve and enforce a culture of life-long learning with the aim to provide nursing and midwifery services of high standard and quality. It goes without saying that all role players should acknowledge that quality care of a high standard is not dependent on education and training alone – the nursing and midwifery workforce should be provided with the required infrastructure support, sufficient working equipment and sufficient stock to provide a safe service (for both the patient and the staff) for which the employer also carries the vicarious liability".

One validator, after a follow-up discussion on her critical reflection and a discussion on existing CPD systems for nurses and midwives internationally, expressed her opinion in writing on the Final CPD system:

"In summary this subject has been thoroughly researched and taking into consideration the circumstances in our country, I believe that if any system is feasible in South Africa then this is it!".

Quotes from rural participants:

"It is very important for South African nurses and midwives to undergo a CPD system. There are some nurses and midwives who do not read medical and nursing journals. The CPD system will assist in ensuring that all staff will strive for continual competence".

"The CPD system is of crucial importance to nurses and midwives in South Africa. They are the cadres of health professionals who are the backbone of healthcare in SA. It therefore makes it imperative for employers to structure their work so that there are opportunities for them to reflect on their practice and where appropriate to expose them to facilities where they can update their clinical skills. In service training programmes could and should play a key role in incorporating the CPD systems as a means of building quality in healthcare

delivery".

"It is important because it is going to upgrade us and improve our standards in quality care".
"Very important. It will upgrade our knowledge; give us confidence in the quality of care that we give our clients. The only thing that is needed is the working together of the role players to implement the CPD system like the doctors do".
"It is very important for us as nurses to render quality nursing care to patients".
"It is important for nurses and midwives as it would allow us to render a better service to the clients".

6.4.5.1 Concluding statements: importance of the Final CPD system

- There was an overall consensus that there is a definite need for a CPD system as the quality of healthcare is dependent on professionals with updated competencies.
- The assessment of competence in clinical skills is an ongoing challenge.
- CPD learning activities to be outcomes based and the attainment of competence should be accepted as key to performance.
- There is a need for ongoing research and refinement of the Final CPD system.
- Structures, processes and legislation should be put in place to introduce, support and sustain the implementation of the Final CPD system.
- The SANC should review the process of nurses and midwives maintaining registration with a license to practise in a variety of disciplines where they have not practised for one or more years.
- Professional Associations and organised labour are to play an active role in marketing and sustaining the implementation of the Final CPD system.

6.4.6 Discussion on the adoption or rejection of the feedback provided for refinement of the Final CPD system

Emerging from the critical reflection on the feedback provided by the validators on the Final CPD system for nurses and midwives in South Africa, a discussion, according to the five criteria (Chinn & Kramer, 1995) as stipulated in the critical reflection tool, follows.

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6.4.6.1 Clarity of the Final CPD system

- The origin of the Final CPD system will be included in the introduction to demonstrate the reference to existing international CPD practices for nurses and midwives and the influence of socio-political dynamic factors on the Final CPD system for nurses and midwives in South Africa.
- The concepts will be defined separately as suggested, so that the clarity of the Final CPD system is enhanced.
- The request for the researcher to translate the roles and responsibilities of the role players and describe them at an applied level will be accommodated, as this will facilitate the understanding and implementation of the Final CPD system by the principal role players.
- With regard to the proposal by the majority of validators during the follow-up discussions of their critical reflection exercise, the researcher will recommended that training be embarked on to facilitate the process of nurses and midwives having a common understanding of reflective practice, self- and peer assessments and the compilation of outcomes-based annual learning plans and portfolios of evidence. It will also be recommended that such training make provision for clarity on the levels of learning that will qualify for recognition as CPD activities for a generalist nurse and midwife and for a specialist nurse and midwife. The generalist nurse and the midwife will be expected to include CPD activities with outcomes measured against the entry to the profession standards of the SANC and/or the standards of her employer. These standards are aligned to NQF level 6. Specialist nurses and midwives will be expected to include CPD activities with outcomes aligned to NQF levels 7 or 8 depending on the highest qualification she has attained.
- From a comment made by one of the validators it is evident that there was a misunderstanding that CPD activities will be accredited by the HWSETA. The Final CPD system does not require the approval or the accreditation of CPD activities.

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- The proposal of electronic submissions by the use of a smart card is a very good suggestion for the 21st century. However, it is currently not a viable option for the SANC in terms of its capacity, physical and material resources, and its information systems for implementing the Final CPD system. The researcher, having been employed at the SANC, is aware that there is a backlog in updating and refining its national learners' database, information management systems, Quality Management System and other duties related to their functioning as an ETQA. The researcher would recommend a further research for the development and capacity building of such an electronically managed CPD system.
- To ensure the compliance of line managers to sign off the Annual CPD Outcomes Achieved Form of the SANC for a nurse and/or midwife practising abroad, a clause will be inserted to accommodate the option of the nurse and midwife making a declaration to this effect on her Annual CPD Outcomes Achieved Form and presenting evidence of compliance with the Final CPD system of the SANC if and when requested by the SANC. This will address the issue of the possibility of non-compliance alluded to by the validator concerned. However, since the world has become a global village, it is important to note the current collaborative approach of regulatory bodies in different countries. Since South Africa is a member country of the International Council for Nurses (ICN) and the International Confederation of Midwives (ICM) little or no resistance is anticipated.

6.4.6.2 Simplicity of the Final CPD system

- The research study will make reference to the recommendation of the regulation of the Final CPD system to the SANC, so that the roles and responsibilities of the principal role players are made more binding to facilitate the sustainability of the Final CPD system.

- The Final CPD system was specifically designed to be work based and to address individual needs in the current area of practice of the nurse and midwife so that the issue of "no behavioural changes or not learning anything following the attendance of a workshop or training" is obviated. Work-based learning activities also ensure ongoing learning if:
  - The nurse and midwife cannot afford to attend a conference or workshop
  - There is a problem of shortage of staff as indicated repeatedly in the quotes from rural nurses and midwives
  - The workplace is remote and transport is neither readily available nor affordable.

- The adherence to the SANC's principles of simplicity, affordability, practicability, validity, realism and attainability (SANC, 2003:2) for the implementation of a CPD system for nurses and midwives in South Africa needs to be emphasised so that one CPD system may be applied to accommodate the divergent conditions of both urban and rural healthcare settings. Compliance with the principles of CPD and the implementation thereof should be perceived as a substitute for the attendance of conferences, seminars, clinical review meetings and workshops, Conversely, if a specific conference, workshop or seminar is identified by an individual nurse and midwife as necessary to complement the achievement of her annual learning plan outcomes and it is accessible in terms of time, staffing, transport and affordability, then she should attend. The nurse and midwife on compiling her annual learning plan discusses it with working colleagues and her line manager so that decisions are taken as a team and duty schedules arranged accordingly.

- The workplace skills plan is referred to in terms of addressing the identified needs of individual nurses and midwives. An informed and planned decision is taken on the available learning opportunities

according to the institution's and the individual nurse or midwife's priority needs. These approaches address the issue of nurses and midwives perceiving CPD as: "An additional burden in terms of time and costs; a money making racket" (Quote from critical reflection of a validator) and as nurses (n=3) practising in a rural healthcare settings stated: "If only we could work as a team then we can implement CPD".

- In response to two comments of validators that: "There is no correlation between Joint Performance Management and CPD", it could be argued that the researcher links the annual learning plan to the JPM system in the workplace to facilitate the effective achievement of the outcomes of the annual CPD learning plan in support of the labour legislation. The separation of the JPM and CPD activities could contribute to CPD being a stand-alone, arduous task that could result in non-compliance and dishonesty. The researcher needs to sound a caveat that the latter concepts are the dynamic factors that the Final CPD system requires for its effective implementation.

- Another essential reason for this approach is to promote working in partnership with the SANC with regard to monitoring compliance with the Final CPD system. Although this may require vigorous reviews, partnerships and collaboration, it recognises and builds upon the unique strengths and shared abilities of each of the principal role players of the Final CPD system. After all, collaborative practice is about mutual respect and working together in the best interest of the patient, family, groups, communities and the society at large (ICN, 2004:8). The application of democratic principles was adopted by the first democratically elected SANC in its transformed vision and mission statement.

It can thus be argued that the proposed CPD system is correctly aligned to the transformative National Health Plan and its Quality Assurance Policy, labour legislation and the SANC's vision and mission

statements, all of which are critical sub-components of the Final CPD system.

- It can be further argued that Joint Performance Management is linked to the daily practice of the nurse and midwife as the Final CPD system includes reflective practice, self- and peer assessment. These are also linked to the performance of daily workplace activities. Therefore, the nurse and midwife's line manager signing off the annual CPD statement and the individual nurse and midwife's signed declaration on the annual CPD statement was purposefully included to make this process more binding to the nurse and midwife. These measures would undoubtedly contribute to the authenticity of the Annual CPD Achievement of Outcomes Form of the SANC. The previously discussed arguments will also assist with preventing the feared effect: "CPD must not result in a complicated paper driven exercise" as stated by two validators.

6.4.6.3 Applicability of the CPD system

- In response to the concerns around the limited resources in the rural healthcare settings and how this would affect the implementation of a CPD system for nurses and midwives in South Africa, the researcher acknowledges that these constraints are ongoing challenges not only for the Final CPD system in particular, but also for healthcare provision in general. The National Department of Health has made concerted efforts to create incentives to retain staff in the rural areas. As mentioned before, a lack of resources (human, material and financial) are a reality and militate against any CPD system, more especially one that is prescriptive in terms of specifying the types of activities that would generate a certain number of points. This point system could set the CPD system up for failure in the rural healthcare settings. However, it could be argued that a CPD system that accommodates a flexible approach firstly enables the nurse and midwife to identify her learning needs through self- and peer assessment, and secondly to

communicate these needs to the line manager (employer) during the first performance review of a particular year. Joint Performance Management promotes this approach.

- In response to the comment that: “a culture of lifelong learning should be established during the formative years of the nurse and midwife”, a recommendation will be made to the SANC to make special efforts to accommodate this concern in its directives for basic nursing education and training programmes. Nursing and midwifery education and training institutions will thus be reminded and urged to continually reinforce this statement and entrench it in the minds of their learners.

The differentiation in the CPD learning activities of the generalist compared to those of the specialist nurse and midwife, and the linkage between the CPD learning activities and the highest qualification level in terms of the National Qualifications Framework (NQF), will be accommodated. This will ensure that CPD learning activities are appropriately addressed and outcomes driven according to the level of the professional, and not ‘a mere running through the motions’ as was expressed by a validator.

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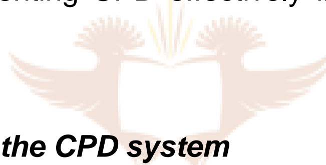
The review and call for 5% of portfolios is acceptable for the initial stages until the CPD system is well established and then it will be recommended that a more accountable method of monitoring compliance with the proposed CPD system should be developed. The process of auditing a 5% sample is currently being practised in the United Kingdom and at the College of Ontario in Canada and in Australia. Undoubtedly, a 5% sample of 177 000 nurses means that 8 850 audits would be conducted annually. With the current backlog and the prioritising of putting a Quality Management System in place for the SANC as a ETQA for Nursing and Midwifery education, the SANC could come up with a workable strategy of a staggered approach of selecting a 5% sample annually from, for example:

- In the first year of implementation of the CPD system, the audit has to include Registered nurses and midwives only
- Three years later when the administration of the CPD system is well established enrolled nurses are included.
- The following year enrolled nursing auxiliaries are included.

In response to the standard against which CPD will be weighted, a validator commented: "... There has to be a standard that states clearly what would count towards CPD, i.e. reading 5 articles =? points – Attending a workshop = ? points. It is not clear at all what the quality assurance of the standards will be; there is no weighting against a particular standard for the Final CPD system." The process of weighting is directly linked to point allocation and adds a measure of constraint, makes the CPD system too prescriptive and less flexible. The divergent resources of rural and urban contexts, increases the challenges of implementing CPD effectively in an already compromised rural environment.



6.4.6.4 Accessibility of the CPD system

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The concern expressed around how the public sector would put systems in place to provide the necessary training (n=6) is addressed by the labour legislation.

In response to the following comment that: "Accessibility cannot be evaluated based on the information provided. ... Obviously the cost involved to obtain the required CPD points will have a big impact on the accessibility of the CPD system", the Final CPD system makes no reference to points. The nurses and midwife determines the nature of the learning activity and in compiling her annual learning plan shall develop outcomes that are realistic to attain within her environment. However, should prevailing resources limit their ability to realise the outcome of their annual learning plans then, nurses and midwives will be expected to apply their assertiveness and influencing skills to negotiate for their training needs. Organised labour should also facilitate this process.

The remark by a validator that annual licensing may be unrealistic could rightly be so. The SANC, to fulfil its monitoring and controlling role optimally, will have to do the following:

- Develop regulations, policies, staff complement and procedures.
- Consider how to manage the auditing process for the Final CPD system in terms of the sample to be audited.
- Review putting a provisional licensing procedure in place to prevent the disruption of services.

Structure, process and outcomes standards have been compiled (refer to the roles and responsibilities of the SANC). A suggestion on the role of the CPD officer and her team members is also described in Chapter 5. The researcher may only make proposals, but regarding its resources, the SANC should be responsible for developing an achievable plan for the implementation of the proposed CPD system and ensuring that all the necessary structures, policies, procedures and regulations are put in place to facilitate the coordinate functioning of the CPD system.

6.4.6.5 Importance of the CPD system

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Although there was a general consensus around the importance of CPD for nurses and midwives in South Africa, concerns were expressed (n=5) about assessing competence in the clinical skills. The purpose of this research was not to prove that CPD will lead to competence, but to have a cadre of nurses and midwives that strive towards Continuing Competence. The researcher does however agree with validators (n=5) that competence is key to performance. A definite recommendation from the study will be that a follow-up research be conducted to firstly determine whether the Final CPD system improves the level of competence of nurses and midwives in South Africa, and secondly to refine the Final CPD system based on lessons learnt from its implementation over a period of time.

In response to the concern that nurses and midwives in South Africa maintain registration in many disciplines where they have not practised for many years,

a recommendation will be made to the SANC to rectify this matter. Nurses and midwives should maintain registration of their various qualifications with the SANC and only obtain a license to practice in those discipline(s) where they can provide evidence that they have updated their competencies.

The researcher acknowledges and agrees to the comment by a validator that providers of nursing and midwifery education and training will play an active role in laying the foundation of CPD in terms of the current outcomes-based methodology and ongoing outcomes-based follow-up assessments linked to CPD so that credits may be retained for evidence of competencies achieved within a particular discipline or area of speciality.

It is therefore evident that ongoing training, with the support of the professional organisations, should be put in place to develop the capacity of nurses and midwives with regard to outcomes-based methodologies and follow-up assessments.

The importance of following through with the feedback (n=2) that professional associations and organised labour are to play an active role in marketing and sustaining the implementation of the Final CPD system, cannot be over-emphasised.

The process of validating the Final CPD system by means of a critical reflection tool provided the researcher with critical insight to refine the suitability of the Final CPD system for nurses and midwives in South Africa.

6.5 Concluding remarks

6.5.1 Feedback by validators/appraisers accommodated

6.5.1.1 Clarity of the Final CPD system

- A change in the visual presentation to demonstrate the input, throughput and output effect of a system (Smit & Cronje, 2001:64).

- A translation of the roles and responsibilities of the role players and provision of a description of such roles and responsibilities at an applied level.
- A list of definitions of the concepts to enhance the clarity of the Final CPD system.
- The addition of facilitation to the roles and responsibilities of the SANC.
- Document the fact that nurses and midwives will cover the costs of the return-to-practice programme, or sponsorship could be obtained from future employers. Emphasise that costs for such a programme should not deter nurses and midwives from actively participating in it. The attendance of such a programme should be open to any nurse and midwife who identifies a need to be updated on entry to the profession competencies (NQF level 4,5 or 6) or specialist competencies (NQF level 7 or 8).
- Reference be made to the role of organised labour in the skills development processes, that is, consulting with and including them in the development of skills development plans so as to ensure the approval of such plans by the HWSETA.
- The SANC's role and responsibility in monitoring and controlling the Final CPD system should be linked to its role in developing and implementing a Quality Management System (QMS) as an ETQA.
- The nurse and midwife should be located uppermost in the tripartite relationship on the visual presentation. The double-tipped arrows demonstrating joint accountability should be darkened to pronounce its significance between the nurse and midwife and the SANC. The double-tipped arrow between the nurse and midwife and the employer is moderately shaded and the one between the SANC and the employer is very lightly shaded with a motive of initiating a collaborative approach to contribute towards the successful implementation of the Final CPD system.
- Training should be put in place by professional organisations and organised labour so that there is a common understanding of reflective practice, self- and peer assessments, outcomes-based annual learning plans and the compilation of a Portfolio of Evidence.

6.5.1.2 *Simplicity of the Final CPD system*

- Regulations should be promulgated for the Final CPD system so that the roles and responsibilities for the role players are more binding.
- The SANC has to ensure that the nurse and midwife do not end up with an unlicensed period by accommodating the granting of provisional licensure to those nurses and midwives who have been selected in the 5% auditing sample so that service delivery is not interrupted. The results of the auditing process shall determine the way forward for such provisional licensure.

6.5.1.3 *Applicability of the Final CPD system*

- Once well-established mechanisms are put in place for the effective functioning of the CPD system, more accountable methods for monitoring compliance can be established. Further research for the refinement of such processes is recommended.
- CPD activities should vary in accordance with the NQF level of the highest qualification obtained by the nurse and midwife. The registered nurse and midwife who has completed a four year comprehensive programme, Government Notice R425 of 22 February 1985, as amended, should engage in CPD activities that are measured against entry standards to the profession. The specialist nurse and midwife who has successfully completed a post-basic programme of study, R212 of 19 February 1993, as amended, should engage in CPD activities at NGF level 7, that is competencies that are expected of a specialist nurse and midwife.
- CPD learning activities should be aligned to outcomes-based education and thus the annual learning plan for the portfolio of evidence requires outcomes to be clearly documented and the SANC's Annual CPD Achievement of Outcomes Form also accommodates an entry for specific outcomes achieved.

6.5.1.4 Accessibility of the Final CPD system

The logistical capacity of the public sector especially in the rural healthcare settings remains an ongoing challenge. The government is currently reviewing its staff retention strategies and putting incentives in place to address this problem, thus the need for adhering to the principles of simplicity, accessibility, affordability, realism, attainability and practicability (SANC, 2002:2).

6.5.1.5 Importance of the Final CPD system

- Competence is key to performance thus recommendations from this study will reflect on this essential aspect.
- Recommendations made to the SANC that nurses and midwives maintain registration for qualifications obtained and only obtain a licence to practise in those disciplines where they have complied with CPD requirements.
- Ongoing training to be put in place with the support of professional organisations and organised labour.
- Professional organisations and organised labour to play an active role in marketing and sustaining the Final CPD system for nurses and midwives.

6.5.2 Feedback not accommodated

The following feedback was not accommodated, based in some instances on theoretical justification and in other instances on international experience:

6.5.2.1 Clarity of the Final CPD system

- The double-tipped arrow between the SANC and the employer was not removed as a validator requested, but made substantially thinner to introduce a transformative, collaborative approach that would add value to the coordinate functioning of the Final CPD system.
- Submission of the compliance with the Final CPD system electronically by means of a smart card. The SANC is currently concentrating on updating

its national learner database and QMS to fulfil its roles and responsibilities as an ETQA for nursing and midwifery education and training. Having accomplished this, this Final CPD system can be refined to receiving electronic information.

- The query about the SANC's ability to cope with a 5% auditing sample of 177 000. Auditing a sample to monitor for compliance is practised internationally in the United Kingdom, Western Australia is also adopting the 5% auditing mechanism to monitor compliance. The College of Nurses of Ontario makes use of a Quality Assurance Committee that is made of elected peers and public representatives to do an annual audit on a randomly selected sample of nurses to determine whether they are meeting the specified requirements of the Regulated Health Professions Act (CNO, 2001:2).

  The SANC is to adopt an approach that will make it manageable and realistic, for example adopting a staggered approach whereby initially 5% (or a percentage determined by the SANC) of registered nurses only are included in the stratified random sampling method. Later, as the CPD system is established then the enrolled nurses are included in the auditing sample and finally the enrolled nursing auxiliaries are also included.

6.5.2.2 Simplicity of the Final CPD system

- The query or suggestion that extra payment shall be expected from nurses and midwives that are selected for auditing of the content of the submission made to the SANC in their Annual CPD Achievement of Outcomes Form, is rejected. This auditing activity entails the completion of one A4 page by the nurse and midwife so that certain selected aspects of the contents of the portfolio are verified.
- The Annual CPD Achievement of Outcomes Form for entrepreneurs and nurses and midwives employed by agencies will only be signed by the individual nurse and midwife as a declaration that it is indeed a true reflection of CPD outcomes that she has achieved for a particular year.

The absence of an employer's signature should not deter from the fact that the declaration is an honest one.

6.5.2.3 Applicability of the Final CPD system

- The weighting of CPD learning activities by specifying the number of points per activity is rejected, as this will contribute to the inaccessibility of CPD learning activities for nurses and midwives employed in remote rural areas. Over and above this, the Final CPD system does not work on a point system. The emphasis is on the quality of the CPD learning activity rather than accumulating a specific quantity of points. This has been emulated by international practices where CPD systems have been implemented for nurses and midwives with no reference to points nor accredited providers of CPD activities
- The conservative method of a portfolio has been used in first world countries such as the United Kingdom since April 1995 when Post Registration Education and Practice (PREP) was implemented (Wallace, 1999:124). The United Kingdom uses the Personal Professional Profile (PPP), which actively reflects on what was learned and how it applied to the daily practice of the nurse, midwife and health visitor (Wallace, 1999:125). For each of the learning activities involved, a description and record is required of the following:
  - Its relevance to the practitioner's professional practice and development
  - What the practitioner hopes to achieve from it
  - The practitioner's assessment of the outcomes of the activities
  - The time spent on each activity and how it influenced the practitioner's work (NMC, 2002:8).

6.5.2.4 Accessibility of the Final CPD system

The costs of various CPD learning activities will not be a deterrent, as costs involved will be controlled by the nurse and midwife in terms of affordability, realism and practicability. Nurses and midwives shall reflect on their practices, perform self- and peer assessments and determine their learning activities in

"a flexible, innovative and yet adult way" (Wallace, 1999:110). The Final CPD system makes it accessible and attainable by all nurses and midwives. The following excerpt from the NMC highlights the relevance of such a system:

- "It doesn't have to cost the practitioner any money
- There are no approved learning activities
- No collection of points nor attendance certificates
- No approved format for Personal Professional Profiles
- It has to be relevant to the practitioner's area of practice and explain how it influences current and future practice
- It has to be motivated by the intention to provide the highest possible standards of care for patients" (NMC, 2002:7).

6.5.2.5 Importance of the Final CPD system

The purpose of the study is not to prove that a CPD system will lead to competent nurses and midwives. The Final CPD system is based on the purpose of PREP, which refers to: "PREP providing an excellent framework for Continuing Professional Development, which, although not a guarantee of competence, is a key component of clinical governance" (NMC, 2002:3).

Chapter 6 presented a critical reflection of the Final CPD system for nurses and midwives in South Africa. In Chapter 7 an evaluative summary of the study, and upon reflection, the limitations of this study is presenteds. Final conclusions are elucidated. Recommendations are made on aspects of CPD that require further research to improve its suitability and relevance within the South African context.

CHAPTER SEVEN

JUSTIFICATION, EVALUATION AND RECOMMENDATION

7.1 Introduction

Since 1994, the post apartheid government has engaged in extensive transformative processes that included the reviewing and restructuring of all relevant legislation, organisations, institutions and statutory bodies. These transformative demands resulted in the development and implementation of a new constitution and ensuing transformative legislation and policies. It is for this reason that the Department of Health, in attempting to transform the health system in South Africa, developed a strategy known as the Health Sector Strategic Framework, which sets out a 10-point plan. This plan states categorically that CPD programmes be:

- Developed by health professions and professional bodies
- Compliant with the learning needs of individual health professionals
- Developed to measure the competencies of health professionals on a continuing basis (Department of Health, 2001:3).

Furthermore, that

- Peer reviews and clinical audits be introduced at all healthcare facilities
- Healthcare personnel be trained in strategies to improve the quality of care rendered
- Plans for Continuing Professional Development be drawn up (Department of Health, 1999-2004, 31).

Over and above this other transformative developments in the education and labour frameworks, professional conduct hearings and national and international benchmarking influenced the need for a CPD system for nurses and midwives in South Africa. Ultimately the inclusion of a CPD system as one of the conditions to be met by the SANC to obtain full accreditation as a Education and Training Quality Assurance (ETQA) body (SAQA, 2001:2 unpublished report).

In an endeavour to meet this requirement and other rationale as discussed in Chapter 1, the SANC granted the researcher permission to work with the Education Committee of the SANC to develop the Draft CPD system See Annexure B).

The problem statement is that **there is no formalised, coordinated and regulated CPD system for nurses and midwives in South Africa.** The following research questions are relevant:

- What is the international trend with regard to CPD for nurses and midwives?
- What is the national trend with regard to CPD for healthcare professionals in South Africa.
- What will a CPD system for nurses and midwives in South Africa comprise?
- How will the CPD system for nurses and midwives in South Africa be implemented to ensure credibility?

The overall aim of this study was to develop a CPD system for nurses and midwives in South Africa. In view of this overall aim the following objectives were formulated:

- To explore existing knowledge frameworks on Continuing Professional Development for nurses and midwives in selected countries, internationally and for health professionals in South Africa
- To describe the Draft CPD system for nurses and midwives in South Africa
- To describe a Final CPD system for nurses and midwives in South Africa.

7.2 Research design

A descriptive, exploratory and contextual design was conducted. Firstly, international literature on CPD systems and other sources were explored and analysed within the context of nursing and midwifery internationally in selected

countries. These selected countries were Australia, the United Kingdom, the USA: California, Canada: College of Nurses of Ontario and Africa: Kenya.

Secondly, national literature on how Continuing Professional Development is implemented for health professionals who are practising their professions in South Africa was explored and analysed. Thirdly, the national dynamic factors that influence a CPD system for nurses and midwives in South Africa was analysed. All the information obtained comprised a description on the CPD system in each selected country. Each description followed the format of (a) purpose, (b) structure, (c) process, (d) outcome and (e) summary. Following the description of the selected CPD systems internationally and nationally, a description of the dynamic factors followed. This description comprised the theoretical framework in Chapter 3 which informed the processes of developing the Draft CPD system and the Final CPD system for this study.

This study was conducted within the context of the South African professional, ethical and legal framework for Continuing Professional Development for nurses and midwives in South Africa.

The population, for the purpose of this study was the use of various sources to obtain information on CPD systems. The international sources were textbooks on CPD, pamphlets, research reports, consumer discussion documents, websites of the various professional councils, electronic mail, postal services and summarised notes obtained through telephonic engines. The national source of information on healthcare professionals was obtained through brochures, information booklets, annual report of the HPCSA for 2002, articles on CPD in the Pharmacopoeia and site visits to the HPCSA and the Pharmacy Council of South Africa (See section 2.4.1).

The Draft and Final CPD systems were exposed to a population of validators/appraisers that are representative of the role players in this study. The Draft CPD system was exposed to nurses and midwives at international and national conferences, workshops, seminars and meetings of special interest groups (See Table 2.1). The Final CPD system was exposed to a

purposively selected population comprising senior nurse researchers from a Nursing Education Department with at least 10 years of research experience especially with regard to systems, models and theory development, organised labour for nurses and midwives in South Africa, senior managers from the private and public sector representing the employer, various categories of nurses and midwives practising both in urban and rural settings. Three of the validators/appraisers of the Final CPD system are incidentally also elected members of the SANC, but they did not participate in that capacity, in this study.

For this study two sampling methods were used, namely, convenience sampling and purposive sampling. Convenience sampling was used for the theoretical framework in Chapter 3 of this study to ensure theoretical validity of the Draft and Final CPD system, in terms of collecting data on CPD systems for nurses and midwives from international countries. The countries selected were determined by the researcher's ability to access adequate and complete information. Convenience sampling was also used to determine the face validity of the Draft CPD system at conferences and workshops of nurses and midwives (See Table 2.1).

Purposive sampling was used firstly for collecting data from healthcare professionals nationally. Secondly, it was used to select academic experts, organised labour, human resource management (from the private and public sector) and a representative sample of all categories of nurses and midwives (in both urban and rural areas) as validators/appraisers (See section 2.4.1. C.) to critically reflect on the Final CPD system. This critical reflection was used to refine the Final CPD system for nurses and midwives in South Africa. (See section 6.4.6).

7.3 Summary of the results

The Draft CPD system was developed from 9 June 2000 until May 2003. This Draft CPD system was exposed to a critical reflection by the stakeholders of

the SANC (See Annexure I), the profession at large (See Table 2.1) and the human resource directorates in each of the 9 provinces in South Africa.

In April 2003, the researcher was requested as part of a task team, to draft a newsletter (See Annexure M) that would be sent out to all the nurses and midwives that were registered/enrolled with the SANC. At a meeting in May 2003, the SANC decided that this newsletter be reviewed with the Registrar of the SANC and that definitions of the various concepts used be clearly defined to make the newsletter user-friendly (SANC, 2003 unpublished). It was then also agreed that a pilot study would be conducted to test the Draft CPD system. Neither the revision of the newsletter nor the pilot study was implemented as the term of office of the first democratically elected SANC ended and elections for the next SANC was underway.

In July 2003, the second democratically elected SANC was inaugurated and a decision was taken at the first meeting of this Council that all processes, including the Draft CPD system, be put on hold (SANC, 2003 unpublished) so that new SANC members be inducted. Thereafter a strategic workshop was held in December 2003 to enable the SANC members to plan and prioritise their official duties for their term of office that runs till 2008.

Since May 2003, there has been no developments or decisions around the Draft CPD system for nurses and midwives in South Africa. The researcher then developed the Final CPD system for nurses and midwives in South Africa. This Final CPD system was described according to purpose, context, definition of concepts, principal role players with a process description of each of their roles, outcome and summary. The theoretical framework in Chapter 3 and the Draft CPD system in Chapter 4 informed the process of developing the Final CPD system in Chapter 5.

The Final CPD system was exposed to critical reflection that was based on the following five criteria adapted from Chin and Kramer (1995:125) to confirm face validity:

A. Clarity of the CPD system
B. Simplicity of the CPD system
C. Applicability of the CPD system (applicability to nursing and midwifery)
D. The accessibility of the CPD system
E. The importance of the CPD system

A group of validators/appraisers (n=31) evaluated the Final CPD system for nurses and midwives in South Africa. The group of validators/appraisers coincided with the principal and other role players and comprised the following:

- Academic experts in research and model evaluation, one of them being a newly elected SANC member
- Senior managers from the public and private sector, one of them being a newly elected SANC member
- Nurses and midwives practising in an urban setting and those who practise in a rural healthcare setting
- Professional Associations and organised labour, one of them being a newly elected SANC member (See section 6.2 for a more detailed description of the representivity of these validators/appraisers).

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The results of this critical evaluation are briefly described according to the five criteria of Chin and Kramer (1995:125). In each instance a numerical value is reflected to indicate the total number of validators/appraisers that communicated a certain viewpoint in relation to a specific criterion of Chin and Kramer (1995).

A. Clarity of the CPD system

There was a general acceptance and agreement on the clarity of the CPD system. The visual presentation (figure 5.1) clearly conceptualises the CPD system and brings complex issues into a cohesive whole (n=20). The role of each of the principal role players and the purpose, structure, process, and outcome are clearly described (n=25). The flow diagrams illustrating the process description for each of the three principal role players is clear (n=27).

Despite this overall positive response there was concern from four academic experts that the visual presentation (Figure 5.1 in annexure 5.1) was 'too busy' and did not demonstrate the flow of the sub components of the CPD system (See section 6.4.1). This resulted in the researcher replacing the visual presentations during the refinement of the CPD system as indicated in Figure 5.1).

B. Simplicity of the CPD system

There was also a general agreement (See section 6.4.2) on the simplicity of the CPD system and that the relationships among the principal role players are clearly defined (n=20). It was indicated that legislation be put in place so that the roles and responsibilities of the three principal role players are more binding (n=3). Although there was a general agreement on the simplicity of the CPD system the researcher finds it necessary to reflect on the queries around the SANC's staff complement to perform the identified CPD duties (n=6), the SANC's financial capacity to monitor and control a CPD system and whether the SANC would cope with the work entailed in conducting a 5% audit of 173 000 nurses and midwives (n=4).

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C. Applicability of the CPD system (to nursing and midwifery)

All the validators/appraisers found the scope of the proposed CPD system to be all encompassing (n=31) (See section 6.4.3) and that the purpose of the CPD system applies to all nursing and midwifery practice areas (n=28). It is necessary to note that one validator/appraiser expressed her concerns that once mechanisms were put in place a more accountable method (than just a 5% audit) for measuring compliance should be implemented. It was also felt that the proposed CPD system will work well in urban public sector and in the private sector but there would be challenges in the rural environment where employer resources are limited (n= 10). There was a suggestion that the nature of the CPD learning activities be aligned to the NQF level of the highest qualification attained by the nurses and midwife (n=3). There should be a differentiation between the learning CPD activities of a generalist nurse

compared to a specialist nurse The need to align CPD learning activities to outcomes-based education was also recommended by (n=4).

D. Accessibility of the CPD system

The CPD system was found to be accessible to all nurses and midwives (See section 6.4.4). The visual presentations with accompanying explanations make it user friendly (n=18). However there were concerns as to how the public sector would implement the CPD system (n=6). The basis of this concern centred on the available resources and the logistical capacity of the public sector in the rural healthcare settings. One validator/appraiser expressed her feelings strongly that the SANC should consider a strategy that extends legislative obligations to the employer as the strategic provider of the service and its direct impact on the quality of the service. There was however agreement that self- and peer assessment as indicted in the Final CPD system would solve the accessibility aspect and that training needs would be more focused and clearly defined.

E. ***Importance of the CPD system***

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There was an overall consensus that there is a definite need for a CPD system (n=28) as it has the potential to influence the practice of the nursing and midwifery professions, nursing education and research (See section 6.4.5). The quality of healthcare is dependent on professionals with updated knowledge and skills (n=28). There was emphasis that CPD learning activities are outcomes based and the attainment of competence should be accepted as key to performance. A need was identified for the SANC to review the process of nurses and midwives maintaining registration with a license to practise in a variety of disciplines where they have not practised for one or more years.

The findings of the critical reflection by the validators/appraisers (n=31) provided valuable input for the refinement and credibility of the Final CPD system as is reflected in Chapter 5 of this study.

7.4 Evaluation of the study

A structured evaluation was conducted and includes the overall aim of the study, critical reflection, original contribution and limitations of the study.

7.4.1 The overall aim of the study

The overall aim of this study was to develop a CPD system for nurses and midwives in South Africa. This overall aim was achieved as reflected in Chapter 5.

7.4.2 Critical reflection

The critical reflection is described in firstly accordance with the overall positive findings and secondly reference is made to the aspects for concern.

There was a general agreement on the simplicity of the CPD system and that the relationships among the principal role players are clearly defined (n=20). The role of each of the principal role players and the purpose, structure, process and outcome are clearly described (n=25). All the validators/appraisers found the Final CPD system to be applicable to nursing and midwifery (n=31). In response to the importance of the CPD system, there was an overall consensus that there is a definite need for such a system and that the quality of healthcare is dependent on professionals with updated knowledge and skills (n=28).

The aspects that raised concern were the SANC's ability to administer and monitor the Final CPD system in terms of its current staff complement, its financial capacity and the reality of managing the workload linked to the annual auditing of 5% of 177 000 nurses and midwives (n=6). Queries were also raised about the feasibility of implementing the Final CPD system in the rural areas where resources are limited (n=10).

7.4.3 Original contribution

An original contribution is made through the development of a CPD system for nurses and midwives within a South African context. The justification of this original contribution is based on the following:

A. There is no formalised CPD system for nurses and midwives in South Africa
B. There are legislative requirements that specify the need for a CPD system for nurses and midwives in South Africa *(Department of Health*, 1999-2004:31; DOH, 2001:46; Nursing Bill Government Gazette No 25554 of 10 October 2003)
C. The SANC is mandated by parliament through the Nursing Act 50 of 1978, as amended, to protect the public and although the Final CPD system does not guarantee competence, it serves as a key component for clinical governance
D. A formalised and regulated CPD system is necessary in terms of national and international benchmarking for all healthcare professionals.

7.4.4 Limitations of this study

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The following limitations of this study are acknowledged:

- There was lack of progress at the SANC due to the end of the five year term of office of the 12th SANC and the inauguration of the new SANC in July 2003.
- The SANC did not validate the Final CPD system.
- The Final CPD system was not piloted.

7.5 Recommendations

Emerging from this research and based on the feedback of the validators/appraisers the following recommendations are made with reference to practice, nursing and midwifery education and research:

7.5.1 Practice

It is recommended that the Final CPD system be presented to the SANC for validation and piloting (SANC, 2003 unpublished). Furthermore, an implementation strategy should be developed to empower all the role players defined in this study (Tshabalala-Msimang, 1999:35). Lastly, the Final CPD system should be enacted and then monitored and controlled to ascertain compliance.

7.5.2 Nursing and midwifery education

With regard to the education of nurses and midwives it is recommended that the Final CPD system should be incorporated in all nursing and midwifery education and training programmes. Furthermore, reflective practice, self- and peer reviews and the development of annual learning plans according to the identified needs of each nurse and midwife should be incorporated into the structured clinical guidance programmes of each learner (basic and post basic programmes).

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7.5.3 Research

Regarding research, it is recommended that a long-term longitudinal study in terms of the purpose of the Final CPD system should be conducted to determine the reliability and credibility of the CPD system for nurses and midwives in South Africa (Polit & Beck, 2004). Furthermore, a relationship should be determined between a CPD system and the maintenance of competence of nurses and midwives in their specific areas of practice; quality outcome of health service delivery and the incidence of professional conduct hearings. Finally, an information system should be developed to accommodate the CPD system.

(http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndguidancepublications accessed 2005/03/12)

7.6 Conclusion

The implementation of a formal, coordinated and regulated CPD system for nurses and midwives in South Africa is necessary as part of a quality promotion initiative and to meet the requirements of the professional, ethical and legal framework of South Africa. Continuing Professional Development should be integrated and applied to the area of practice of the nurse and midwife and not be regarded as a separate costly activity. The principal and other role players referred to in this study should actively participate towards achieving the purpose of this study, which is: nurses and midwives striving towards Continuing Competence.

This chapter concludes the research. It provided an overview of the study by summarising salient points and processes of this research study, and reflected on the processes enabled an evaluation of the study and the identification of the study's limitations. Recommendations were made and now the challenge remains for nurses and midwives to follow up with ongoing research to address the concerns around Continuing Professional Development.

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BIBLIOGRAPHY

Ackoff, R.L. (1981) Creating the corporate future. New York, John Wiley & Sons. In: Department of Health (2001) *A policy on quality health care for South Africa.* Pretoria: Department of Health.

Atkins, S. and Murphy, K. (1993) Reflection: A review of the literature. *Journal of Advanced Nursing*, 18, 1188-1192.

ANC (African National Congress) (1994) *A national health plan for South Africa.* Johannesburg: ANC.

ANC (African National Congress) (1994) *The reconstruction and development programme: A policy framework*. Johannesburg: Umanyano publications.

ANA (American Nurses' Association) (2001-2003) C*ontinuing education online: American Nurses' Association, Kansas City*. Available from: http://nursingworld.org/cc/ccwelcom.cfm [Accessed 10 February 2003].

American Nurses' Credentialling Center Commission on Certification (2003) R*ecertification catalog.* Available from: www.nursingworld.org/ancc/certify/recert/catalogs/recertcat03.pdf [Accessed 10 February 2003].

Annas, G. and Grodin, M. (1996) In: Baldwin-Ragavin, L. de Cruchy, J. and London, L. (1999) A*n ambulance of a wrong colour: Health professionals, human rights and ethics in South Africa*. 1st edition. Western Cape: The Rustica Press.

Asmal, K. Asmal, L. and Roberts, R. (1996) In: Baldwin-Ragavin, L. de Cruchy, J. and London, L. (1999) A*n ambulance of a wrong colour: Health professionals, human rights and ethics in South Africa*. 1st edition. Western Cape: The Rustica Press.

ANCI (Australian Nursing Council Incorporated) (2000) C*ompetency standards for the registered nurse and the enrolled nurse.* Canberra: ANCI.

UNIVERSITY OF JOHANNESBURG

ANCI (Australian Nursing Council Incorporated) (1999) *Final Report: A study to identify the indicators of continuing competence in nursing.* Canberra: ANCI.

ANCI (Australian Nursing Council Incorporated) (2002) P*osition paper on continuing competency.* Canberra, ANCI. Available from: www.anci.org.au [Accessed 16 June 2002].

ANCI (Australian Nursing Council Incorporated) (2003) C*ode of professional conduct for nurses in Australia.* Canberra: ANCI.

ANCI (Australian Nursing Council Incorporated) (2000) N*ational competency standards for the registered nurse.* 3rd edition. Canberra, ANCI. Available from: http://www.nursereg.nsw.govau/rncompe.htm [Accessed 26 September 2000].

Babbie, E., and Mouton, J. (2002) *The practice of social research.* 2nd edition. Cape Town: Oxford University Press South Africa.

Baldwin-Ragaven, L., de Cruchy, J., & London, L., 1999. *An ambulance of the wrong colour. Health professionals, human rights and ethics in South Africa.* First publication. Cape Town: University of Cape Town Press.

Ball, C. (1996) In: South African Qualifications Authority. (2000) *The National Qualifications Framework: An overview*. Pretoria: SAQA.

Boelen, C., 1995. In: Mazaleni, N., 1999. *Paper presented at the 'National Summit on Nursing',* 23-27 August 1999. Conducted by the Department of Health, South African Nursing Council and The Health Systems Trust. South Africa: Benoni: Protea Hotel: Conference Centre: Kopanong.

Boud, D. (1992) The use of self-assessment schedules in negotiated learning. *Studies in Higher Education*, 17 (2), 185-200.

Burns, N., and Grove, S.K. (2001) T*he practice of nursing research, conduct, critique and utilisation.* 4th edition. Philladelphia: W.B. Saunders.

Brown, M., Kaplan, D. and Meyer, J. (2000) In: *Human resource development strategy for South Africa* (2002) Pretoria, Departments of Education and Labour.

Burns, S. and Bulman, C. (2000) Reflective practice in nursing: The growth of the professional practitioner. 2nd edition. Oxford Malden, MA:Blackwell Scientific.

Californian Board for Registered Nursing (undated) C*ontinuing education programme: Instruction for providers. A*vailable from: www.rn.ca.gov [Accessed 20 March 2000].

Californian Board for Registered Nursing (undated) *License renewal information.* Available from: http://www.rn.ca.gov/lrenewalinfo.htm [Accessed 20 March 2001[.

Californian Board of Registered Nursing (1994) *Nursing Practice Act, article 5.* http://www.rn.ca.gov/npa/title16.htm#1451.2 [Accessed 20 March 2001].

Canada (2003) Y*our rights and obligations: Government and politics in Canada.* Available from: http://www.sacbd.com/directory/blue/blue_3u.html [Accessed 20 March 2001].

Chinn, P.L. and Kramer, M.K. (1995) *Theory and nursing: A systematic approach.* 4th edition. St Louis: Mosby.

CNO (College of Nurses of Ontario) (1996) Q*uality assurance programme: Growing quality in nursing: Self-assessment tool.* Available from: www.cno.org [Accessed 20 March 2001].

CNO (College of Nurses of Ontario) (2001) Q*uality assurance: Reflective practice gets new tool. A*vailable from: www.cno.org [Accessed 20 March 2001].

CNO (College of Nurses of Ontario) (2002) C*ommunique: College of nurses of ontario: revising standards for an evolving profession.* Available from: www.cno.org [Accessed 16 June 2002].

CNO (College of Nurses of Ontario) (2002) *Practice standards: professional standards revised 2002.* Available from: www.cno.org [Accessed 16 June 2002].

CNO (College of Nurses of Ontario) (2004) *Practice setting consultation programme*. Available from: http://www.cno.org/qa/pscp/index.html [Accessed 9 August 2004].

CNO (College of Nurses of Ontario) (2004) *Practice setting consultation programme*: resurvey. Available from: http://www.cno.org/qa/pscp/resurvey.html [Accessed 9 August 2004].

CNO (College of Nurses of Ontario) (2004) Q*uality assurance: Reflective practice. A*vailable from www.cno.org [Accessed 9 August 2004].

Craft, M. (2005) Reflective writing and nursing education. *Journal of Nursing Education,* 44(2):53-57.

UNIVERSITY
OF
JOHANNESBURG

Creswell, J.W. (2003). *Research design: Qualitative, quantitative and mixed method approaches.* Second Edition. Thousand Oaks, California: Sage Publications.

Dube, M.G. (2000) Nursing crisis hits alarm bells. *The Independent on Saturday,* Saturday 5 March 2000, p.2.

Deloughery, G.L. (1998) *Issues and trends in nursing.* 3rd edition. St Louis: Mosby.

DENOSA (Democratic Nurses' Organisation of South Africa) (1998) *Ethical standards for nurse researchers.* Pretoria, DENOSA.

Department of Health. (1994-2000). *A synopsis of health policies and legislation.* Pretoria: Department of Health.

Department of Health (1999-2004) *Strategic framework.* Pretoria: Department of Health.

Department of Health (1998). *Saving Mothers: Report on Confidential Enquiries into Maternal Deaths in South Africa.* Pretoria: Department of Health.

Department of Health. (1999). A *patients' rights charter.* Pretoria: Department of Health.

Department of Health (2001) A *p*olicy *on quality in health care for South Africa.* Pretoria: Department of Health.

Department of Health (2002) Saving Babies: Third perinatal care survey of South Africa. Pretoria: Department of Health.

Du Toit, M.A. (1995) Die ontwikkeling van bestuursdenke. In: Kroon, J. (ed) (1997) G*eneral management.* 2nd edition. Pretoria: Kagiso.

De Vos. A.S. (2002) *Research at grass roots for the social sciences and. human service professions*. 2nd edition. Pretoria: Van Schaik.

Ditmeyer, S., Koepsell, B., Branum, V., Davis, P. and Lush, M.T. (1998) Developing a nursing outcomes measurement tool. *JONA*, 28(6), 10-16.

Fatchett, A.F. (1998) *Nursing in the new NHS: Modern, Dependable?*. 1st edition. London: Balliere Tindall.

Gray, A. (1999) *Nurses and the quest for rational drug use: the changing role of the clinical nurse in 2000. A*vailable from: http://www.hst.org [Accessed 20 March 2000].

Gerrish, K. (1993) An evaluation of a portfolio as an assessment tool for teaching practice development. *Nurse Education Today,* 13, 172-179.

Gumbi, R.V., Maganye, T., Ntsimane, S., Maqaqa, L., Ramadi, G., Kaye-Petersen, E., Barron, P., Strasser, S., 1999. *Report on conference: Taking transformed nursing to the next millennium: A national summit on nursing, 23-27 August 1999.* Conducted by the Department of Health, South African Nursing Council and The Health Systems Trust. South Africa: Benoni: Protea Hotel: Conference Centre: Kopanong.

HPCSA (Health Professions Council of South Africa) (2000) *Professional self-development: Guidelines for good practice in medicine, dentistry and medical sciences.* Pretoria: HPCSA.

HPCSA (Health Professions Council of South Africa) (2002) *Annual report.* Pretoria: HPCSA.

HPCSA (Health Professions Council of South Africa) (2004) Media statement, 20 April 2004: Continuous Professional Development: The way forward. Available from www.hpcsa.co.za. [Accessed 6 July 2004].

Human, P. and Strachan, B. (1996) *Transformation of the public health sector: An assessment of managerial capacity and the implications for management development.* Report produced for the Oliver Tambo Fellowship programme, Diploma in Health Management, Department of Community Health, University of Cape Town. Cape Town: University of Cape Town.

HWSETA (Health and Welfare Sector Training Authority) (2001-2002) *Sector skills plan: 1 April 2001-31 March 2002.* Pretoria: Department of Labour.

HWSETA (Health and Welfare Sector Training Authority) (2001) *Executive summary of the sector skills plan.* SANC, 76/C2-2001, unpublished.

International Confederation of Midwives, 1992 **In:** Myles, M.F. (1993) *A textbook for midwives* 12 edition Edinborough: Churchill Livingstone.

ICN (International Council of Nurses) 2000c. In: Initial draft: *International competencies for the generalist nurse* (March 2001). ICN.

UNIVERSITY
JOHANNESBURG

Jarvis, P. (1992) Reflective practice and nursing. *Nurse Education Today,* 12, 174-181.

Kotze, W.J. (2000) *South African Nursing Council* (*SANC): Nursing practice standards.* Pretoria, SANC.

Madden C.A. and Mitchell V.A. (1993) In: Wallace, M.G. (1999) *Lifelong learning: Prep in action.* 1st edition. Edinborough: Churchill Livingstone.

Makgotho, S. (2001) Woman dies in ambulance fall. *Sowetan,* Wednesday, 9 May 2001, p.4.

Mapledeck, T. (1995) *Towards a management development strategy for health services of the new South Africa.* Pretoria: Department of Health.

Masango, A. and Putter, S. (2002) *Continuing Professional Development (CPD) in South Africa: The vision and strategy of the Pharmacy Council.* Available from: profaffairs@pharmcouncil.co.za [Accessed 10 October 2002].

Masango, A., Putter, S., and Summers, R., 2002 Fifth international conference on lifelong learning in pharmacy 24-27 June, 2002 Rhodes University, Grahams Town, South Africa. Poster : Continuing Professional Development in South Africa: The vision and strategy of the Pharmacy Council. Available from http://www,ru.ac.za/academic/departments/pharmacy/conference/abstracts/abs23.htm [Accessed 23 August 2003].

Meservy, D. and Masond, M.A. (1987) *Impact of continuing education on nursing practice and quality of patient care.* Journal of Continuing nursing education 18 (6):214.

Mouton, J. (1998) *Basic concepts in methodology for the human science*. 1st edition, 2nd impression. Pretoria: Van Schaik.

Muller, M.E. (2002) *Nursing Dynamics*. 3rd edition. Johannesburg: Heinneman.

Muller, M.E. (1999) *Standards for registered nurses in South Africa.* Johannesburg, Rand Afrikaans University: Unpublished paper.

Mwamuye, S. (2001) *Report on: continuing education for nurses and midwives in Kenya.* Kenya Nursing Council: Unpublished paper.

Nolte, A.G.W. (1998) *A textbook for midwives.* First edition. Pretoria: J.L. van Schaik Publishers.

Ntsaluba, A. (1999) *Opening address. Paper presented at the 'National Summit on Nursing', 23-27 August 1999.* Conducted by the Department of Health, South African Nursing Council and The Health Systems Trust. Benoni, Protea Hotel. Kopanong, Conference Centre.

Nursing Board of Tasmania (1992) *Guidelines for re-registration.* Hobart: Nursing Board of Tasmania.

Nursing Board of Tasmania (1998) *Competence to practice: Annual audit.* Hobart, Nursing Board of Tasmania.

NBV (Nurses Board Victoria) (2000) *Guidelines for re-registration*. Melbourne, Nurses Board of Victoria.

Nurses Board of Western Australia (2002) *Discussion paper: Assessment of continuing professional competence.* Available from: suek@nbwa.org.au [Accessed 9 August 2002].

NMC (Nursing Midwifery Council) (2002) *The PREP handbook.* London, Nursing and Midwifery Council. Available from: publications@nmc-uk.org [Accessed 16 May 2002].

Pearson, A. (1999) *A study to identify the indicators of continuing competence in nursing: Final report January 1999.* The University of Adelaide, Department of Clinical Nursing. Commissioned by: Australian Nursing Council Incorporate.

Peters, M.N. and Naidoo, S. (1999) Nurse's deadly error: patient refused aid. *The Independent on Saturday,* Saturday 16 January 1999, p.5.

UNIVERSITY
OF
JOHANNESBURG

Peters, M.N. (2000) Rat gnaws at baby's heel while nurses sleep. *The Independent on Saturday,* Saturday 12 February 1999, p.4.

Pick W.M., Nevuthalu, K., Cornwall, J.T. and Masuku, M., (2000) H*uman resources for health task team.* Pretoria: Department of Health.

Polit, D.F. and Hungler, B.P. (1999) *Nursing research. Principles and methods.* 6th edition. Philadelphia: J.B. Lipincott.

Polit, D.F. and Beck, C.T. (2004) *Nursing research. Principles and methods.* 6th edition. Philadelphia, J.B. Lipincott.

Proctor, S. and Renfrew, M. (2001) *Linking research and practice in midwifery: A guide to evidence-based practice.* Edinborough; London: Balliére Tindall.

Putter, S. (2002) *Continuing Professional Development (CPD) in South Africa: The vision and strategy of the Pharmacy Council.* Available from: profaffairs@pharmcouncil.co.za [Accessed 10 October 2002)

Queensland Nursing Council (1997) In: Pearson, A. (1999) *A study to identify the indicators of continuing competence in nursing: Final report January 1999.* The University of Adelaide, Department of Clinical Nursing. Commissioned by: Australian Nursing Council Incorporate.

Redfern, E. (1995) Profiles, portfolios and reflective practice. Part 2. *Professional Update.* 3, 10.

Reid, B. (1993) But we're doing it already! Exploring a response to the concept of reflective practice to improve its facilitation. *Nurse Education Today,* 13, 305-309.

Rodgers, S. (2002) *Revised standards approved.* In: Communique, June 2002 (9). Available from: www.cno.org. [Accessed 20 November 2002].

Searle, C. and Pera S.A. (1995) *Professional practice: A South African perspective.* Third edition. Durban: Butterworth Publishers (Pty) Ltd.

Seldin, P. (1991) In: Stockhausen, L.J. (1997) The clinical portfolio. *The Australian Electronic Journal of Nursing Education.* Available from: http://www.scu.edu.au/school/nhcp/aejne/aechive/vol2-2/v2-2ijs.htm [Accessed 26 June 2003].

South African Health Review, (1998) 1st edition. Durban, The Press Gang. Available from http://www.hst.org.za/sahr [Accessed 29 June 1999].

South Africa (Republic) (1978) N*ursing Act 50 of 1978, as amended*. Pretoria: Government Printer.

South Africa (Republic) *Nursing Bill.* Government Gazette no 25554 of 10 October 2003. Pretoria: Government Printer.

SANC (South African Nursing Council) (1970) *Regulations for the investigation of alleged misconduct and the conduct of inquiries, R373, as amended*. Pretoria: Government Printer.

SANC (South African Nursing Council) (1984) *Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978, R2958, as amended.* Pretoria: Government Printer.

SANC (South African Nursing Council) (1985) *Regulations setting out the acts or omissions in respect of which the council may take disciplinary steps, R387, as amended.* Pretoria: Government Printer.

SANC (South African Nursing Council) (1994) *Terminology.* Pretoria, SANC.

SANC (South African Nursing Council) (1996) W*orking document.* int 323/m69. Unpublished.

SANC (South African Nursing Council) (1997) Professional Conduct Hearing Transcript. Unpublished.

SANC (South African Nursing Council) (1998) *Professional conduct hearing report*. Unpublished.

SANC (South African Nursing Council) (1999) *Professional conduct hearing report.* Unpublished.

SANC (South African Nursing Council). (2000) W*orking document.10/2000*. Unpublished.

SANC (South African Nursing Council). (2000) W*orking document.14/2000*. Unpublished.

SANC (South African Nursing Council). (2001). Minutes of SANC meeting held in November, 2001. Unpublished.

SANC (South African Nursing Council) Press release 1/2001. Available from www.sanc.co.za [Accessed 6 July 2004].

SANC (South African Nursing Council). (2001). *Report: National conference of the Education Committee of the SANC.* Unpublished.

SANC (South African Nursing Council) (2001) *Professional conduct hearing report.* Unpublished.

SANC (South African Nursing Council) (2002) *Professional Conduct Hearing Report.* Unpublished.

SAQA (South African Qualifications Authority) (2001) *The National Qualifications Framework: An overview.* Pretoria: SAQA.

Saunders, E. (2002) *Assessing human competence: Practical guidelines for the South African manager.* 2nd edition. Johannesburg: Knowres Publishing (Pty) Ltd.

Schaay N., Heywood A., and Lehmann, U. Health service management training In: *South African Health Review*, 1998 Health Systems Trust.

Searle, C. and Pera, S.A. (1995) *Professional practice: A South African perspective.* 3rd edition. Durban: Butterworth publishers (Pty) Ltd.

UNIVERSITY
OF
JOHANNESBURG

South Africa (Republic) (1997) *White paper on transforming public service delivery (Batho Pele White Paper) Notice 1459 of 1997.* Government Gazette. Pretoria, Department of Health.

South Africa (Republic) (1997) W*hite paper for transformation of the health system in South Africa. Notice 667 of 1997*. Pretoria, Department of Health, Government Gazette.

South Africa (Republic) (1996) C*onstitution Act 108 of 1996*. Pretoria: Goverment Gazette.

South Africa (Republic) (1993) *Occupational Health and Safety Act 85 of 1993, as amended.* Goverment Gazette.

South Africa (Republic) (1974) *Health Professions Act 56 of 1974, as amended.* Goverment Gazette.

South Africa (Republic) (1974) *Pharmacy Act 53 of 1974, as amended*. Goverment Gazette.

South Africa (Republic) (1998) S*kills Development Act 97 of 1998*. Goverment Gazette.

South Africa (Republic) (1999) *Skills Levies Act 9 of 1999*. Goverment Gazette.

South Africa (Republic) (1995) *South African Qualification Authority Act 58 of 1995.* Goverment Gazette.

South Africa (Republic) (1997) *Higher Education Act 101 of 1997.* Goverment Gazette.

South Africa (Republic) (1998) *Further Education and Training Act 98 of 1998*. Goverment Gazette.

Smit, P.J. and Cronje, G.J. (2001) *Management principles.* Lansdown, Juta.

Smith, L.N. (1999) *Workgroup of European nurse researchers: Annual report for the United Kingdom.* Available from: http://www.man.ac.uk/rcn/europe/wenr99rpt.htm [Accessed 25 May 2003].

Strasser, S. (1999) *Paper presented at the 'National Summit on Nursing', 23 – 27 August 1999.* Conducted by the Department of Health, South African Nursing Council and The Health Systems Trust. Benoni, Protea Hotel. Kopanong, Conference Centre.

Strasser S. & Gwele N. (1998) *Nurse oriented primary health care* **cited in** South African Health Review 1998 health Systems Trust

Subedar, H. (2004) Press release. Available from www.sanc.co.za. [Accessed September 2004]

The Concise Oxford Dictionary. (2001) 10th edition. New York: Oxford University Press.

Tshabalala-Msimang, M. (1999) *Paper presented at the 'National Summit on Nursing', 2-27 August 1999.* Conducted by the Department of Health, South African Nursing Council and The Health Systems Trust. Benoni, Protea Hotel. Kopanong, Conference Centre.

Tschudin, V. (1992) *Ethics in nursing: The caring relationship.* 2nd revised edition. Oxford: Butterworth-Hein.

UKCC (United Kingdom Central Council) (2000) Government strengthens regulation of nurses, midwives and other health professions. *Press statement*, 2 August 2000. Available from: http://www.publicnet.co.uk/publicnet/00080201.htm [Accessed 25 May 2003].

UKCC (United Kingdom Central Council) (1993) In: Wallace, M. (1999) *Lifelong learning: Prep in action.* 1st edition. Edinborough: Churchill Livingstone.

UKCC (United Kingdom Central Council) (1994) In: Wallace, M. (1999) *Lifelong learning: Prep in action.* 1st edition. Edinborough: Churchill Livingstone.

UKCC (United Kingdom Central Council) (1995b, 1996b) In: Wallace, M. (1999) *Lifelong learning: Prep in action.* 1st edition. Edinborough: Churchill Livingstone.

UKCC (United Kingdom Central Council) (1997a) In: Wallace, M. (1999) *Lifelong learning: Prep in action.* 1st edition. Edinborough: Churchill Livingstone.

UKCC (United Kingdom Central Council). (2001) In: Wallace, M. (1999). *Lifelong learning:* Prep *in action.* First edition. Edinborough: Churchill Livingstone.

Van Der Merwe, H. 2000. *Evaluation of the health sector hearing: Conceptualising human rights and reconciliation. Research report for the centre of the study of violence and reconciliation.* December 2000. Available from http://www.csvr.org.za/papers/papvam2.htm [Accessed 12 August 2003].

UNIVERSITY OF JOHANNESBURG

Verkerk, M., Lindemann, H., Maeckelberghe, E., Feenstra, E., Hartoungh, R., and De Bree, M. (2004) Enhancing reflection: an interpersonal exercise in ethics education. *Hastings Center Report* 2004, 34(6):31-38.

Wallace, M.G. (1999) *Lifelong learning: Prep in action.* 1st edition. Edinborough: Churchill Livingstone.

Whittaker, S., Carson, W., and Smolenski, M.C. (2000) Assuring competence: How should the profession respond? *Online journal of issues in nursing.* Available from: http://www.nursingworld.org/ojin/topic10/tpc10_htm [Accessed 25 May 2003].