CONTINUING PROFESSIONAL DEVELOPMENT IN SOUTH AFRICA: PERCEPTIONS AND ATTITUDES OF NURSES AND MIDWIVES

by

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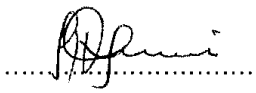
DECLARATION

I declare that **CONTINUING PROFESSIONAL DEVELOPMENT IN SOUTH AFRICA: PERCEPTIONS AND ATTITUDES OF NURSES AND MIDWIVES** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.



29 January 2019

SIGNATURE **DATE**

Mmamoroke Agnes Mnguni

CONTINUING PROFESSIONAL DEVELOPMENT IN SOUTH AFRICA: PERCEPTIONS AND ATTITUDES OF NURSES AND MIDWIVES

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ABSTRACT

The purpose of this study was to explore and develop understanding of nurses and midwives' perceptions and attitudes towards the implementation of CPD, aiming to provide them with a platform to make recommendations to enhance the attendance of CPD.The study was conducted in a public regional hospital in Limpopo Province, South Africa. The purposive exploratory descriptive qualitative research method was used. Data was collected through Focus Group Discussions. Participants comprised of three focus group discussions.

A semi-structured guide with open –ended questions was used and discussions were recorded with an audio recorder which were transcribed verbatim. Content analysis of the data was done.

The study yielded themes, sub-themes and codes during analysis. Participants perceived CPD to have benefits to keep nurses updated with knowledge, skills and improvement of attitudes. It improves quality patient care. However, they identified staff shortage, time constraints and lack of internet connection as the major challenges.

Key concepts

Attitudes; continuing professional development; midwife; nurse; perceptions.

OPSOMMING

Die doel van hierdie studie was om ‘n begrip van die houdings en persepsies teenoor die implementering van voortgesette professionele ontwikkeling (VPO) van verpleegkundiges en vroedvroue te verken, ten einde ‘n platform vir aanbevelings daar te stel om die bywoning van VPO te bevorder. Die studie was in 'n openbare streekshospitaal in die provinsie Limpopo, Suid-Afrika gedoen. ‘n Kwalitatiewe, doelgerigte, verkennende en beskrywende navorsingsmetode was gebruik om data is deur middel van drie fokusgroepbesprekings in te samel.

‘n Semi-gestruktureerde onderhoudegids met oop vrae was gebruik om klankopnames van gesprekke, verbatim te transkribeer. Data was ontleed deur middel van inhoudsanalise. Temas, subtemas en kodes is tydens die analise geïdentifiseer. Die deelnemers het VPO as voordelig beskou in terme van die opdatering van verpleegkundiges se kennis, vaardighede en houdings. Gehalte pasiëntsorg word sodoende verbeter. Hulle het egter personeeltekort, 'n gebrek aan tyd, en toegang tot die internet as ‘n struikelblok geïdentifiseer.

Kernkonsepte

Houdings, voortgesette professionale ontwikkeling (VPO), vroedvrou, verpleegkundige, persepsies.

TSHOSOBANYO

Maikaelelo a dipatlisiso tse (research), e ne e le go sekaseka le go tlhabolola kutlwisiso ya baoki le babelegisi ka ga tebo le maikutlo a bona mabapi le tshimololo ya go thlabolola dithuto bale tirong “CPD”. Maikaelelo e ne e le go ba neela tšhono ya go dira ditshwaelo go oketsa dipalo tse di tsenang dithuto tsa CPD. Dipatlisiso tse di diretswe kwa dipetleleng tsa kgaolo tsa botlhe, Porofenseng ya Limpopo mo Aforikaborwa. Go dirisitswe mokgwa wa dipatlisiso wa ‘*purposive exploratory descriptive qualitative research’* mo di patlisisong tse. Dikitso di kgobokantswe go ya ka mokgwa wa lekgotla ‘*Focus Group Discussion’.* Batsayakarolo ba ne ba arogantswe ka ditlhopha tse tharo tsa ‘*focus group discussions’*.

Kaedi e e rulagantsweng e e nang le dipotso tsa boitlhalosi- ka- botlalo e dirisitswe mme dipuisano tsa gatiswa ka rekhoto ya kgatiso-modumo morago tsa kwalwa fatshe ka mokgwa o di builweng. Tshekatsheko ya diteng tsa dikitso tse e dirilwe ka go latela mokgwa wa ‘*content analysis’*.

Dipatlisiso tse dineetse molaetsa mogolo, melaetsanyana le melao ka nako ya ditshekatsheko. Batsayakarolo ba bone gothlabolola dithuto bale tirong ‘CPD’ go nale mosola mo tsweletsong ya go neela baoki kitso, bokgoni le tokafatso ya maitshwaro. E tokafaditse boleng ba tlhokomelo ya balwetse. Le fa go ntse jalo, ba supile fa tlhaelo ya baoki, dinako tsa go dira le go tlhoka kgokelelo ya enthanete e le dikgwetlho tse kgolo.

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- My husband, Chris, son Tshepo and nephew Thabo, for their support, love, patience and prayers.
- Mr Sipho Mazibuko, the co-coder, for his input and assistance.
- Mr J Chokwe, for critically and professionally editing the dissertation.

Dedication

This dissertation is dedicated to the memory of my grandson, Thato, who through his tormenting illness made me to come out more stronger, patient and persistent; that made me to pursue my academic goal.

He was unable to witness my graduation. This is for him!

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LIST OF ABBREVIATIONS

APC	Annual Practicing Certificate
CHC	Community Health Centre
CPD	Continuing Professional Development
CEU	Continuing Education Units
CME	Continuing Medical Education
CNEE	Continuous Nurses Ethics Education
CP	Community Pharmacists
CPE	Continuing Professional Education
CPR	Cardio Pulmonary Resuscitation
EMR	Electronic Medical Records
EN	Enrolled Nurse
ENA	Enrolled Nursing Auxiliary
FGD	Focus group discussion
ICEL	International Consortium for Experiential Learning
ICM	International Council of Midwives
ICN	International Council of Nurses
IPA	Interpretative Phenomenological Analysis
LSI	Learning Style Inventory
NDoH	National Department of Health
PoE	Portfolio of Evidence
QI	Quality Improvement
RN	Registered Nurse
SANC	South African Nursing Council
SLR	Systematic Literature Review
UK	United Kingdom
UNISA	University of South Africa
VTE	Venous Thromboembolism
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Globally, all professionals have recognised Continuing Professional Development (CPD) as a primary method to enhance basic professional education regularly. The health care environment has been challenged by the environment, including, among others, globalisation, technological advances and climate changes (Chong, Francis, Cooper & Abdullah 2014:1). The International Council of Nurses (ICN) Code of Ethics for Nurses Revised (2012:3) advocates, "… the nurses carry personal responsibility and accountability for nursing practice and for maintaining competency by continual learning".

Uarije, Daniels, Kalondo, Amkongo, Damases-Kasi and Nabasenja (2017:18) concur with Chong et al (2014:1) that CPD is systematic and an ongoing process of education undertaken by health professionals to maintain innovative knowledge and develop professional skills. Uarije et al (2017:18) further recognise that changing technologies in medical imaging necessitated and justified the need for CPD among radiographers.

In the same vein, the South African Nursing Council (SANC) (2018:9) aligns itself with the contents of the Revised ICN Code of Ethics for Nurses (2012:9). CPD strengthens the accountability of practitioners to themselves, their profession, employer, their patients, clients, and communities to promote health, protect the public interest and deliver quality-nursing care in the South African community.

Several countries have implemented CPD in view of the important role it plays such as California in 1971 and later American Nurses Association advocated re-licensure for nurses in 1973 (Chong et al 2014: 1). According to Chong et al (2014:1), 23 states in United States of America had enforced legislation that requires nurses to participate in CPD in order to renew their license to practice. Chong et al (2014:1) further highlight that other countries such as United Kingdom, Australia, China, and Hong Kong passed

legislation to ensure the quality of nursing; that could be achieved only by ensuring that nurses were current.

In view of the above, the researcher felt that it was important to explore and describe the attitudes and perceptions of nurses and midwives in South Africa in accordance with Sections 39 and 59 of the Nursing Act, 2005 (Act No. 33 of 2005). SANC CPD compulsory for nurses and midwives. The purpose thereof is to promote and maintain professional standards of excellence. CPD will also ensure that the practising nurses and midwives remain up-to-date and relevant to the constantly changing health needs of the South African citizens (SANC 2018 9).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

1.2.1 The source of the research problem

SANC is in the process of developing the CPD system for nurses and midwives as mandated by Sections 39 and 59 of the Nursing Act, Act No. 33 of 2005 as amended (SANC 2005:93). The development of a CPD system for nurses and midwives in South Africa has been a growing priority for the South African nurses and midwifery profession. SANC has a responsibility to serve and protect the public in matters involving nursing and midwifery. It also has to uphold and maintain professional conduct, ethics and practice standards of nurses and midwives (SANC 2005:8). Globally, nurses have to accrue CPD points or credits over a set period in order to maintain registration with the statutory body. A wide range of formal and informal learning activities will generate CPD points. SANC requires nurses and midwives to accrue 15 CPD points in order to renew their Annual Practicing Certificates (APC) (SANC 2018:10). There are other legislative and policy directives that make CPD compulsory for nurses and midwives in South Africa (SANC 2018:10).

According to Viljoen, Coetzee and Heyns (2017:70), society demands competent and safe healthcare, which obligates professionals to deliver quality patient care using current knowledge and skills. Participation in CPD programmes is a way to ensure quality nursing care. In their study on challenges facing nurses, Mosol, Kei, Ob'woge and Ng'eno (2017:304) discovered that the context of work for nurses is rapidly changing owing to changes in care, innovative technologies and emergence of new

knowledge. They observed that participation of nurses in CPD was very low. The study was conducted in Western Kenya.

Osingata, Nalwadda, Ngabirano, Wakida, Sewankambo and Nakanjalo (2015:2) believe that knowledge in ethics will enhance nursing practice because it will enable nurses to identify ethical problems within nursing, come up with innovative solutions to solve those ethical issues and develop sound ethical beliefs and practices. It is clear that nurses with both professional ethics education and continuing education will be confident in their moral judgments and are more likely to use ethics resources and take moral actions, so says (Osingata et al 2015:3).

1.2.2 Background to the research problem

CPD is necessary for nurses to maintain and build on current knowledge and skills in the rapidly changing health care environment Uarije et al (2017:18) and Chong et al (2014:1) highlight the importance of CPD. They claim that society as well as the health care profession are placing greater accountability on healthcare professionals. Participation in CPD activities is recognised by various organisations such as governing bodies, accreditation organisations, certification boards, employers and the public as one of the most important for competencies that professionals must possess (Viljoen et al 2017:71). In South Africa, CPD programmes are viewed as systematic efforts to support professionals in remaining updated and competent. It is one of the focus areas of the National Department of Health (NDoH) (Viljoen et al 2017:71).

The process followed to implement a compulsory CPD programme using a top-down approach did not yield the desired outcome in a study that was conducted in South Africa by Viljoen et al (2017:71). The latter study was to enhance the competences of Critical Care Nurses using knowledge and skills in existing and new areas of practice to enhance quality of care (Viljoen et al 2017:71).

According to Casey, Cooney, O'Connell, Hegarty, Brady, O'Reilly, Kennedy, Hefferman, Fealy, McNamara and O'Connor (2016:654), monitoring the continuing professional competence of healthcare professionals is necessary to protect the public and establish the suitability of a nurse or midwife to give effective care. The study further asserts that the absence of competence will lead to suboptimal care and serious consequences for

patients. The World Health Organization (WHO) defines nurses' competence as "a framework of skills that reflect knowledge, attitudes, psychosocial and psychomotor aspects of care provision". WHO attributes competence to educational qualifications and practical abilities (Casey et al 2016:654).

In South Africa, the aim of CPD is to ensure that all nurses and midwives provide safe, ethical, competent quality care to the South African citizens within the legal parameters. These expectations can only be achieved if the nurses and midwives are knowledgeable and skilled with the right or positive attitudes and professional integrity towards the community (SANC 2015:9).

In line with what Casey et al (2016:655) state in their study, SANC also believes that nurses are responsible for their own professional development and competency provided the working environment is supportive. According to Chong et al (2014:5), it is clear that an effective and acceptable professional competence scheme for the maintenance of CPD requires consultation, assessment, development, implementation and evaluation; similar to what was experienced in Canada, Australia and New Zealand (Chong et al 2014:1). The nurses and midwives in this study at the selected regional hospital in Limpopo Province, South Africa, were attending workshops, conferences, and in-service education in order to prepare themselves for what SANC would require in renewal of Annual Practising Certificates (APC) once CPD system becomes implemented, but the attendance was very poor.

Chong et al (2014:1), in their study conducted in Malaysia, found that less than 50% of the nurses attended continuing professional education (CPE) activities. The Malaysian Nursing and Midwifery Board requires nurses to obtain 25 credits in order to renew their practising licenses. However, in this study, only 40.9% of the participants achieved the required points. The study shows that 30.05% had obtained less than 25 credit points, which had excluded them from relicensing. The highest attendance recorded at workshops was 43.5% and followed by 40.8% at conferences in spite of the nurses valuing continuing professional educational activities (Chong et al 2014:3).

In the Middle East, in spite of the CPD opportunities being available to registered nurses, a low attendance of CPD courses at institutions was observed over the years. It is reported that 43.5% was the highest attendance at workshops, 40.3% at conferences

and only 1.3% of the registered nurses (RNs) undertaking tertiary education (Chong et al 2014:3)

In their study, Chong et al (2014:5) found that nurses preferred clinical courses (renal, orthopaedic, ophthalmology, operating theatre, intensive care nursing, etc.) to research and tertiary education.

The researcher in this study hoped that the research findings of attitudes and perceptions of nurses towards CPD in the selected participating regional hospital would assist in influencing policy development. The latter would be in terms of national framework for monitoring and maintaining CPD for nurses and midwives to protect the public. SANC can learn lessons from the Malaysian nurses' study conducted by Chong et al (2014:5) that to improve participation in CPD activities, programmes are planned and implemented based on the nurses' needs. Institutions and programme coordinators have to create a culture that supports CPD and provide programmes that respond to the changing health care needs and trends. Collaboration among the nursing leaders in every area is vital to improve our practice in the nursing profession (Chong et al 2014:5).

1.3 STATEMENT OF THE RESEARCH PROBLEM

The rapid and recurrent changes in the health care sector and nursing practice challenge the practitioners that basic nursing education is no longer sufficient for a lifetime nursing career. In order for South African nurses and midwives to meet the changing health needs of the community, the regulatory body being SANC should come up with the strategies to improve the nurses' knowledge, skills and attitudes through CPD. Nurses need to participate in CPD programmes to ensure that they remain competent in relation to safe and effective nursing care.

Prior to the National rollout of CPD by SANC, some public health institutions started with the trial run of implementing the CPD. Nurses and midwives were engaged in a range of formal and informal CPD activities that yielded those CPD points that could qualify them to renew their APC when the SANC formally implement the CPD. According to the nursing management of the sampled regional hospital, more than 50% of nurses and midwives could not meet the minimum of seven (7) CPD points in six (6)

months, as expected from them. The problem continued over a period of two consecutive years.

The researcher intended to explore the perceptions and attitudes of nurses and midwives in order to understand the causes of the inability to accrue the minimum CPD points during the trial run. The attitudes and perceptions of nurses and midwives were not explored during the trial run. Thus, the participants were not given a chance to express their feelings towards the implementation of the CPD by the SANC.

1.4 AIM OF THE STUDY

1.4.1 Research purpose

The purpose of this study was to develop understanding of nurses and midwives' perceptions and attitudes towards the implementation of CPD in a public regional hospital in the Limpopo Province, South Africa; and to make recommendations to enhance the attendance of CPD activities as required by SANC.

1.4.2 Research objectives

Objectives and research questions are very much related to one another (Wilson 2014:56). By reading the key literature on the subject, the researcher will be able to identify a clear rationale for the study. The topic should be short and straight to the point; that will enable the researcher to formulate realistic aims and objectives in relation to the questions and topic under study (Wilson 2014:56).

- To explore and describe the views of nurses and midwives regarding CPD implementation in a public regional hospital in the Limpopo Province of South Africa.
- To explore and describe the attitudes of nurses and midwives regarding CPD implementation in a public regional hospital in the Limpopo Province of South Africa.
- To describe recommendations made by nurses to enhance the implementation of CPD

1.5 SIGNIFICANCE OF THE STUDY

The study focused on CPD that aims to develop nurses and midwives. The significance of the study was to highlight the importance of CPD to health establishments, and to the practitioners. The commitment of nurses and midwives to CPD is essential for the delivery of safe and effective health care. Through CPD, nurses can keep up with the technological and scientific changes that are occurring in health care settings. “Professional development is listed as one of the essential forces in structural empowerment; health institutions that are involved in CPD demonstrate better patient outcomes, safer patient care and greater nursing satisfaction” (Liphosa 2013:6).

The findings of this study may be used by the hospital management to address the causes of the poor attendance by nurses and midwives in the continuous development programmes organised at the hospital in preparation for the compulsory CPD implementation by SANC. The findings of the study may contribute to the body of scientific knowledge because there is scanty literature available in South Africa on perceptions and attitudes of nurses and midwives regarding CPD. The findings may also help the SANC to consider some of the recommendations in the implementation of the CPD nationally. The recommendations will also guide policy makers and other stakeholders in designing programmes that address the identified learning needs of nurses and midwives, which are guided by the health care of patients.

In relation to patients, quality health care provision will be beyond reproach if nurses and midwives are highly knowledgeable, skilled and competent owing to regular attendance of CPD programmes.

1.6 SETTING OF THE STUDY

Research setting is an environment that is selected for a specific purpose in research, which according to Perry (2014:16) is for data collection. The setting may be one or more settings, a naturalistic environment such as in peoples’ homes or at their places of work, or in highly controlled laboratory situation.

In this study, the researcher was able to collect data in the field at the site where participants experienced the implementation of CPD by the hospital management, in

preparation for the formal CPD implementation by SANC. The setting was at a Regional Hospital, Waterberg District, which is situated in Limpopo Province, South Africa.

1.7 DEFINITIONS OF KEY CONCEPTS

For the purpose of this study, the following concepts are used and clarified:

1.7.1 Attitude

'An attitude is a mental state of readiness, organised through experience, exerting a directive or a dynamic influence on the individual's response to all objects and situations to which it is related (Pickens cited in Borkowski 2015:47). .This is a mind-set that influences an individual to act in a particular way based on their experiences.

In this study, attitudes refer to the way nurses and midwives would respond on how they feel, think and behave towards the implementation of CPD in South Africa based on their experiences.

1.7.2 Continuing Professional Development (CPD)

"Continuing Professional Development (CPD) is a systematic and ongoing process of education undertaken by health professionals to maintain up-to-date knowledge and develop professional skills …" (Uarije et al 2017:18).

In this study, Continuing Professional Development (CPD) refers to the formal and informal educational activities in which nurses and midwives engage to improve their knowledge and skills. These can be short courses, workshops, seminars, nursing conferences, and in-service training.

1.7.3 Midwife

The International Confederation of midwives (ICM 2005) defines the midwife as:

> '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 practice midwifery. She is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period' (ICM 2005:3).

In South Africa, a midwife is a person registered to practice midwifery in terms of Section 14 (1) (a-m) of the SANC regulation No. R195 of 2013 (SANC 2013:12).

In addition to the ICM definition, the researcher will also assign the same meaning as in the SANC definitions, to this study.

1.7.4 Nurse

A nurse is a person registered in a category under Section 14 (1) (a-m) in order to practice nursing and midwifery in accordance with the SANC Regulation number R176 of 08 March 2013 (SANC 2013:12).

WHO reports that 'nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of the ill, disabled and dying people'.

Nurses in this study include registered nurses, staff nurses (enrolled) and enrolled nursing auxiliaries as referred to in the transitional arrangement of the R195 regulation (SANC 2013:12).

A registered nurse is 'a person who has met the prescribed education requirements for registration as a Registered Nurse or has acquired and maintains the competencies to practice as a professional nurse and registered as a professional nurse in terms of Section 31 (1) (a) of the Act (Nursing Act, No. 33 of 2005); acts independently in provision of nursing care '(South Africa 2005).

An enrolled nurse is a person who has met the prescribed education requirements as an enrolled nurse or has acquired and maintains the competencies to practice as an

enrolled nurse in accordance with Section 31 (1) (c) of the Act, (Act No. 33 of 2005); and works under the direct or indirect supervision of a registered nurse (South Africa 2005).

An enrolled nursing auxiliary is a person who has met the prescribed education requirements as an auxiliary nurse and has acquired and maintains the competencies to practice as an Auxiliary nurse, and registered as an Auxiliary Nurse in terms of Section 31 (1) (d) of the Act (Act No.33 of 2005); and provides elementary nursing care prescribed by the Registered nurse or Enrolled nurse (South Africa 2005).

1.7.5 Perceptions

Pickens cited in Borkowski (2015:57) defines perception as 'the process by which organisms interpret and organize sensation to produce a meaningful experience of the world'. He further clarifies that a person who is confronted with a situation or stimuli will interpret the situation or stimuli into something meaningful to him or she based on previous experience even if what he or she perceives is not reality.

In this study, based on participants' prior knowledge, experiences, opinions and understanding of CPD in qualitative study, the researcher explored how they give meaning to CPD implementation

1.7.6 View

According to the *Cambridge Dictionary* (2019) "view is an opinion, belief, or idea, or a way of thinking about something or a way of thinking about the world …".

In this study view refers to holding a particular opinion or way of thinking about something

1.8 RESEARCH DESIGN AND METHOD

Ingham-Broomfield (2014:36), in her study entitled, "a nurses' guide to qualitative research', highlights that qualitative research falls into five main designs, namely, Phenomenology, Ethnography, Grounded Theory, Historical method, and case study".

Research design, in this study, explanatory sequential design, guided the researcher to plan used to implement the purpose, objectives and general layout of the research and enabled the researcher to work through to explain the results in more depth (Ng 2017:23). The design choice, according to Ng (2017:23), enabled opportunities to gain in-depth understanding of the subject under study. Phenomenology, according to Ingham-Broomfield (2014:36), searches for multiple meanings attributed to a phenomenon and tries to provide a comprehensive description rather than an explanation. Several authors concur that phenomenology is a research design is used to describe the everyday world of human experience (Liamputtong 2013:117; Jirojwong et al 2011:113 cited in Ingham-Broomfield 2014:36).

In this study, in accordance with Ingham-Broomfield (2014:36), the researcher used the design to structure this study, collect and analyse information that was able to answer the research questions and assisted in achievement of the research objectives.

1.8.1 Qualitative research approach

The qualitative research approach was chosen in accordance with Creswell and Poth (2015:7) who assert that qualitative research involves an interpretive, naturalistic approach to the world. Denzin and Lincoln (2005:3) cited in Creswell and Poth (2015:7) describe qualitative research as involving "… an interpretive naturalistic approach to the world. Researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them". In this study, the researcher conducted the research with participants in their natural settings in line with qualitative studies, to make sense and understand people. In addition, the researcher was able to make an interpretation of what they see, hear and understand. Furthermore, Creswell and Poth (2015:7) aver that with this approach, the interpretations made by the researcher cannot be separated from the participants' backgrounds and their history, hence naturalistic qualitative approach.

Creswell and Poth (2015:7) posit that when applying qualitative research methods, the emphasis is put on the natural setting and the points of views of the research participants. Consideration is given to the researcher as person. The researcher is not the independent observer, a picture that is often drawn when natural scientists are depicted. In qualitative research, self-reflection about one's own attitude and position

and role in society is vital. Denzin and Lincoln (2005:21 cited in Creswell & Poth 2015:7) accentuate that ‘behind all research stands the biography of the gendered researcher, who speaks from a particular class, racial, cultural, and ethnic community perspective’. The researcher chose the qualitative approach because it is not desk research, but that the researcher would go out into whatever we consider the real world, observe and talk to people, interact with them [people] aiming to understand what is important to them and how the researcher perceives the world.

1.9 RESEARCH QUESTIONS

Creswell (2015:107) describes qualitative research questions as being open-ended, evolving, and non-directional; restate the purpose of the study in more specific terms; start with a word such as “what” or “how “”rather than “why”; and are few in number (five to seven). The author gives an example such as: “Tell me about yourself”, to more specific questions (Creswell 2015:108). In this study, the researcher formulated the research questions using the open-ended questions starting with the ‘what’ to obtain responses from the participants on their experienced perceptions an attitudes towards CPD implementation.

Research questions are important because they help the researcher to set boundaries when conducting the literature review (Wilson 2014:58).

- What are the views of nurses and midwives towards the implementation of CPD in a public regional hospital where the research was conducted?
- What attitudes do nurses and midwives have towards the implementation of CPD in a public regional hospital where the research was conducted?
- What recommendations can be made by nurses and midwives to enhance the implementation of the CPD?

1.10 ASPECTS RELATING TO RESEARCH DESIGN

1.10.1 Research design

An exploratory descriptive qualitative design was used to conduct the research. The researcher chose to use this design in order to explore and describe the perceptions of

nurses and midwives (Creswell, 2015:7) concerning implementation of CPD as required by SANC. This design will also empower the participants as one hears their voices expressing themselves as they relate their stories. The researcher set the environment in such a way that it minimised the power relationship between the researcher and the participants (Creswell, 2015:7).

1.10.2 Research methods

Kothari (2004:8 cited in Perry 2014:16) asserts that the research method refers to 'Methods the researcher uses to implement research processes while studying the research problem.' Yüsel and Yildirm (2015:10) highlight that data in qualitative data can be collected using other techniques, such as focus group discussions, interviews, observations, and video recordings. In addition to interviews, an observation method can be used to observe the research environment. In this study, the researcher employed three (3) Focus Group Discussions of participants and recorded the discussions; the researcher transcribed and analysed data together with members of the research team. (Refer to Chapter 3 for further information).

1.10.2.1 Population and sample selection

Sampling is related with the selection of a subset of individuals from within a population to estimate the characteristics of whole population (Sing & Masuku 2014:1). Sample is a portion of a population or universe. Many people often consider population to be people only. Population does not refer only to the number of people but refer also to total quantity of the things or cases that are the subject of the research (Ilker, Musa & Alkassim 2016:1). *Merriam-Webster Dictionary* cited in Gentles, Charles, Ploeg and McKibbon (2015:1772) defines sampling as "the act, process, or technique of selecting a representative part of the population for the purpose of determining parameters of characteristics of the whole population". The population for this study were all the nurses and midwives in the public regional hospital of Waterberg District in Limpopo Province. Permission was sought from the Nursing Service Manager of the Institution to conduct the data collection in the institution. Participants were released through the same channel to participate in the focus group discussion.

1.10.2 Data collection and data analysis

In this study, the researcher conducted the Focus Group Discussions (FGDs) with registered nurses, midwives, enrolled nurses, and enrolled nursing auxiliaries. The FGDs were conducted at the public regional hospital where the nurses work. The focus group discussion assisted the researcher to explore, discover and obtain depth in type of data obtained. This method made the participants to feel empowered because they shared conversations among themselves, with the researcher only facilitating. It [focus group discussion] assisted the researcher to obtain large amount of data in a short space of time. The researcher aimed to understand the themes, the issues, narratives and stories that the participants were prepared to share. Participants were assigned letters of the alphabets instead of names in order to ensure confidentiality, and written consent forms were obtained (O'Mahony, Wright, Yogeswaran & Govere 2014:2).

1.11 SCOPE AND LIMITATIONS OF THE STUDY

There was a possibility of bias in that the study is voluntary and nurses and midwives who have interest in CPD will most likely respond to the questions and provide strong views about CPD and as such, results cannot be generalised to other settings; the policies, development, accessibility of CPD may differ from one province to another. The study was conducted in one semi-urban public regional hospital of only one province out of nine provinces in South Africa, for feasibility purposes.

1.12 STRUCTURE OF THE DISSERTATION

The dissertation will be structured as follows:

- Chapter 1: Orientation to the study
- Chapter 2 Literature review
- Chapter 3 Research design and method
- Chapter 4 Analysis, presentation, and description of the research findings
- Chapter 5 Conclusions and recommendations

1.13 CONCLUSION

This chapter provided a background to the research problem based on literature review. The chapter also discussed the background to the research problem, research question, aim and purpose of the study, significance of the study, research methodology, ethical considerations and limitations of the study. The next chapter will review the literature about CPD.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the literature review on CPD for nurses and its relevance to this study. A literature review is an evaluative report of information found in the literature related to the researcher's selected area of study.

In this literature review, the researcher surveyed books, scholarly articles, and any other sources relevant to the CPD issue, as the area of research, to provide a description, summary, and critical evaluation of these works in relation to the research problem being investigated.

Boell and Cecez-Kecmanovic (2015:161) reiterate that literature review "provides an overview, synthesis and a critical assessment of previous research, challenge or problematize existing knowledge and identify or construct novel research problems and promising research questions".

2.2 AN OVERVIEW OF LITERATURE RESEARCH

2.2.1 Purpose of literature review

There are several reasons why researchers conduct literature reviews. The following are some of the reasons why researchers undertake literature reviews:

2.2.2 Types of literature reviews

Knowledge in a given field consists of three layers, namely: The primary studies that researchers conduct and publish; the reviews of those studies that summarise and offer new interpretations built from and extending beyond the primary studies and there are the perceptions, conclusions, opinions and interpretations that are shared informally in the field. The researcher aligns herself with the latter as it is related to the topic under

study. Authors classify literature reviews into argumentative review; integrative review; historical review; methodological review; systematic review and theoretical review (Fink 2014:2).

2.3 CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

CPD is a purposeful, statutory process whereby practitioners registered with SANC, engage in learning activities to maintain and improve their knowledge, skills, attitudes and professional integrity in order to keep up-to-date with new science, innovation and health care developments, and to practise safely, ethically, competently, and legally within their evolving scope of practice (SANC 2018:4).

Byrne (2016:18) perceives CPD as a 'systematic process that is both credible and transparent' to the public. Hence, CORU in Ireland was empowered to monitor compliance by health and social care registrants and made CPD mandatory. CPD is well established as good practice for healthcare professionals to undertake CPD; the process of lifelong learning which enables professionals to keep-up-to-date with knowledge and clinical skills, to ensure new techniques and research developments are integrated into patient care (Grossman, Cert, Reed & Che 2018:51 cited in Halton et al 2015; cited in Byrne 2016:20). The author in this study further defines CPD as the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop professional qualities required throughout their professional life. This definition is similar to how SANC (2018:9) defines CPD, which is "… to maintain and improve their knowledge, skills, attitudes and professional integrity to keep up-to-date with new science, innovation and health care developments …".

2.3.1 The implementation of mandatory CPD points accumulation for nurses and other health professionals

Grossman et al (2018:51) aver that dentists must undertake and record mandatory CPD hours to maintain their professional registration. This is part of the regulatory requirements of the General Dental Council (Grossman et al 2018:51). In their study, Grossman et al (2018:51) sought to answer the question: "What perceived CPD is needed to maximise the competence and confidence of dentists following Dental

Foundation Training completion with Health Education England, Kent, Surrey and Sussex?" In Ireland, Coordination of United Revolutionary Organizations (CORU) was established as the first multi-professional health and social care. This statutory regulator was introduced to regulate the registration of professionals under the Health and Social Care Act, 2005 (as amended, 2012) (Byrne 2016:9). The SANC, in line with how CORU was established in Ireland, has the authority to direct, approve and revise the CPD system for nurses and midwives in terms of the legislative and policy directives (SANC 2018:10).

In their study that was conducted in Namibia on Radiographers' attitudes towards CPD, Uarije et al (2017:18) define CPD as a systemic and ongoing process of education, taken by health professionals to maintain up-to-date knowledge and develop professional skills. They further emphasise that over a period, changing technologies in medical imaging, necessitated a need for CPD.

Uarije et al (2017:18) also indicated that formal and informal activities, which may be required to maintain up-to-date professional knowledge, skills and positive attitudes of healthcare professionals, are all incorporated in CPD. In the United Kingdom (UK), Australia, New Zealand and South Africa, it is mandatory for healthcare professionals to obtain a certain number of Continuing Education Unites (CEUs) to maintain their registration with their respective regulatory bodies. Uarije et al (2017:18) further suggest various ways such as workshops, presentations, directed reading programmes, journals, research and in-service education training pertaining to a healthcare professional' s line of work through which these units can be obtained. The study was intended to investigate the radiographers' attitudes towards CPD and determine the factors responsible for their attitudes towards CPD as well as their opinion towards mandatory CPD (ibid).

The regulation of health professions, as stated by (Byrne 2016:10), is gaining momentum internationally through either self-governed professional structures internationally or legislated bodies. In the UK, the Health and Care Professions Council (HCPC), established in 2001, regulates sixteen (16) professions. In South Africa, the Health Professions Council of South Africa (HPCSA), established in 1974, regulates twelve (12) professions through their boards. In Australia, a Health Practitioner Regulation Agency supports individual professional boards to regulate health

professions, and in Canada, most health professions are self-regulated through provincial authorities called colleges or orders (Byrne 2016:10). In South Africa, the Nursing Act, 2005 (Act 33 of 2005:3), stipulates as follows:

> conditions relating to CPD, which makes it mandatory (Sections 39 & 59:89); community service, which makes a one year community service obligatory (Section 40:90); use of certain titles (Section 43:93); removal from and restoration of name to register (Section 44:94); unfitness to practice due to impairment (Section 51:113); penalties for practising as professional nurse, midwife, staff nurse, auxiliary nurse or auxiliary midwife while not registered (Section 53:117) and penalty for misrepresentation inducing registration and false entries in register and impersonation (Section 54:118), regulates the nursing and midwifery practice

In line with how SANC regulates the nursing and midwifery profession as elaborated in the previous paragraph. Similarly, Coordination of United Revolutionary Organizations (CORU) in Ireland, each registration board is tasked with establishing and maintaining a register of members of its profession; approving and monitoring education and training programmes for entry to the profession; recognising qualifications gained outside the state and setting a code of professional conduct and ethics for registrants (Byrne 2016:11).

Chong et al (2014:1) acknowledge in their study conducted in Malaysia on current CPD practice among Malaysian nurses, that, because nurses are the largest groups of health care professionals globally, they are therefore required to participate in CPD to develop skills and competencies, and remain current in their practice. The ICN Code of Ethics for Nurses also advocated that nurses should remain current in their practice.

In Ireland, regulation of nurses and midwives, medical doctors and pharmacists, according to Byrne (2016:10), is legislated under the Medical Practitioners Act, 2007, the Nurses Act, 1985, and the Pharmacy Act, 2007. The author further assert that each of these professions is subject to regulation and must adhere to a professional code of practice and conduct. Halton et al (2015 cited in Byrne 2016:10) argue that the expanded regulation of health and social care professionals has occurred owing to

highly publicised cases of poor or dangerous practice. Dixon-Woods et al (2011 in Byrne 2016:10) is of the opinion that poor health practices by the health professionals has led to public outcry and led to demands for increased professional accountability and protection of the public. Some legislative and policy directives which inform the development of the CPD system in South Africa, include amongst others: the Constitution of the Republic of South Africa (Act No. 108 of 1996) chapter 2, Section 29 (1b); the National Health Act, 2003 (Act No. 61 of 2003) Section 52 (a & b); the National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/7 under 'Positive Practice Environment', make CPD compulsory for nurses and midwives (SANC 2018:10)

Nurses carry personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. In view of the important role of CPD to nurses, many countries such as California in 1971, the American Nurses Association in 1973 implemented mandatory CPD in order to renew their licenses to practice. China implemented CPD for nurses in 1996. Hong Kong and Malaysia have also introduced compulsory CPD (Chong et al 2014:2).

Hashmi, Mohammed, Adnan, Fahad, Hisham, Zaheer and Mohammed (2017:2) realised that pharmacy services needed an Extended Pharmacy Services (EPS), which required additional special skills, knowledge and facilities to be provided to people with special needs; this was a transition of roles of professional practice. The practice changed to patient-focused model; that necessitated a study to explore the perceptions and attitudes of Community Pharmacists (CP) about their extended role in the community in Lahore, Pakistan (Saadeh, Ghazale, Ali & Souheil 2018:1103).

Macaden, Washington, Smith, Thooya, Selvam, George and Mony (2017:930) stated that in India, the Indian Nursing Council (INC), has recently made CPD mandatory towards the renewal of professional registration. Macaden et al (2017:30) further indicate that the INC has stipulated a minimum of 30 credit hours per year or 150 hours of CPD-related activities over five (5) years.

Viljoen et al (2017:71) concur with other authors that CPD is necessary for nurses to maintain and build on current knowledge and skills in the rapidly changing health care environment. They further maintain that although CPD programmes are in the

development phase in South Africa, SANC currently regards CPD programmes the focus areas. They conducted a study on critical care nurses in a private hospital in South Africa to find out the reasons that prevented them from attending CPD programme that were arranged with all the necessary resources [facilitators, time, programme communicated]. The results indicated that the average attendance was less than 30%, and only 32% was able to provide the Portfolio of Evidence (PoE). The authors then concluded that unsatisfactory attendance of CPD programmes has serious implications for critical care nurses because competences are not updated, which can have negative impact on quality of nursing care. The programme did not achieve its goal (Viljoen et al 2017:71).

2.3.2 Perceptions and attitudes of nurses and other health professionals regarding mandatory CPD implementation

According to Byrne (2016:24), implications of mandatory CPD indicate that professional development is not simply adherence to regulatory standards, but rather a reflective process drawing on individual capacities and organisational supports, which are embedded in professional practice. In her study conducted with social care workers in 2014, the author further found that 35 percent of the respondents felt that organisational supports such as in-service training had little or no impact on their practice. The study showed that the employer played a pivotal role in encouraging and facilitating professional development. The study further observed that if employers were overly prescriptive in their supportive role that support risked being limited to organisational needs (Byrne 2016:24).

Ng (2017:24), in his study, used the explanatory sequential design, whereby he conducted the focus group interviews with relevant participants using qualitative methods. Owing to the location of the participants, based in different countries (Tanzania and Western Australia), and in order to obtain distinct information from each cohort, the qualitative phase was divided into two stages, which enabled focus group interviews with nurses and midwives from both countries. This strategy enabled the identification of education facilitators' and attendees' separate perceptions of CPD, their experiences and the effectiveness of the programme. The same questions were asked of both cohorts. The objective was also to determine the barriers and enablers of

providing CPD opportunities in Tanzania, and whether the development of knowledge sharing occurred among Tanzanian peers.

In order to ensure that there was linkage to accountability and fitness to practice, the mandatory CPD was introduced in Ireland (Byrne 2016:18). The latter author in her study that was conducted in Ireland reported that CPD would be a prerequisite for maintenance of registration and demonstrate fitness to practice. According to Byrne (2016:18), regulating the professions would require registrants to ensure that their "skills and knowledge are up-to-date, of a high quality and relevant to their practice". Mandatory professional development makes provisions for professions to be credited with professional status. In contrast to the above popular belief, researchers such as (Ross et al 2013; Fenwick, 2009; Beddoe & Duke, 2013) in Byrne (2016:19), assert that measuring compliance with CPD standards continues to be a challenge because it became evident in New Zealand, after random audit. The findings indicated that social workers were not planning in a purposeful way and demonstrated limited evidence of reflection; hence struggled to meet CPD requirements. In a similar manner, in a study that was conducted by (O'Sullivan 2003) cited in Byrne (2016:19), in UK found that physiotherapists were not maintaining a CPD portfolio owing to lack of time and skills, habit and lack of value attached to the benefits of engaging in the process.

Individual factors such as time, cost, personal circumstances, and balancing work commitments were found to be impacting engagement in CPD (Byrne 2016:25). Grossman et al (2018:51) conducted a qualitative study in which the themes emerged from the thematic analysis of the data in the results. They found that participants felt that knowledge represented CPD activities that were perceived to develop knowledge. Participants in the same study felt that skill represented CPD activities perceived to develop skill. In addition, they [participants] felt that attitudes and behaviour. CPD activities develop knowledge, skills, attitudes and behaviours (Grossman et al 2018:51).

According to Grossman et al (2018:51), the literature related to project findings stated that active learning was required to validate and implement knowledge. In addition, the Experiential Learning Cycle was important in developing skills. It was realised that planned and needs-led CPD increased the chances of behaviour change while the support from colleagues in clinical environment was seen to be facilitating development and behaviour. Moreover, participants indicated that barriers to CPD included time,

cost, access and working environment. Finally, the participants realised that Dental Core Training posts may provide opportunities to increase confidence (Grossman et al 2018:51). A range of activities to develop knowledge, skills, attitudes and behaviour were perceived by the participants as passive learning activities. The latter include reading, observation, non-practical courses, including e-learning; practical experience; practical courses; exposure to a range of patients and support and guidance from colleagues such as supervision, mentorship, feedback, and affirmation (Grossman et al 2018:51).

In South Africa, similar to what Grossman et al (ibid), identified in his study, employers, professional associations, societies, unions, and CPD providers have a responsibility to ensure that CPD is supported for all nurse and midwives, so that they are able to meet their CPD requirements. In order to enhance the implementation of CPD in South Africa, practitioners [nurses and midwives] are expected to identify learning needs and associated CPD activities. In addition, the can develop a personal learning plan, take responsibility for identifying relevant CPD activities, obtain approval from the supervisor to participate in CPD activities; nurses and midwives are expected to complete a portfolio of evidence and submit a completed declaration of compliance form to SANC. Should a practitioner be selected for auditing, SANC would require the practitioner to submit supporting documentation as and when it is required. SANC requires that all documentation be kept for three (3) years following the year of auditing (SANC, 2018:15).

According to Macaden et al (2017:938), in their study conducted in India, when participants were asked about their preferred modes of CPD delivery, the response was that more than half of participants reported that they had attended a CPD programme in the past 12 months. The participants in that study indicated that the key drivers to attending CPD training were to update knowledge; providing quality care; increasing competence; professional development and being more confident in providing care for patients. Macaden et al (2017:938) further argue that the majority of the participants perceived that professional regulatory bodies such as the Indian Nursing Council must monitor the quality of CPD programmes. On the contrary, Macaden et al (ibid), fewer participants perceived that nursing faculty in academic institutions, the government and employers must be accountable for the quality of CPD delivered. In addition to the findings of other researchers on the barriers to CPD, participants in the study that was

conducted by Macaden et al (2017:940) perceived barriers to CPD as geographic distance, lack of motivation, emotional stress, past negative experience, poor physical health, lack of family support, and no information, lack of relevant CPD, and poor conduct of CPD.

Byrne (2016:25) reports that the long-awaited statutory registration for the social care work profession was likely to be challenging. Issues related to professional title, eligibility to register, educational qualifications, and financial costs have already led to ambiguity and misunderstanding as to what regulation entails. In that study, the author found that some of the participants associated regulation with recognition as a profession, whereas, regulation alone does not constitute professional status. The author further indicates that a shared professional identity, which promotes high standards of practice and recognition of the quality and value of social care work, had to be driven from within the profession itself (Byrne 2016:25). According to Byrne (2016:26), CPD must be viewed as a joint responsibility, which may at times require negotiation and compromise both the individual and organisational needs are to be achieved. CPD should be of benefit to service users by enhancing service provision and individual professional practice. The author further asserts that whether the profession is ready or not, statutory registration and regulation will take place (Byrne 2016:51).

For CPD programmes to be effective, participants in the study conducted by Macaden et al (2017:944) in India, recommend that employers should be responsive to both professional and personal needs of employees and reflect strategic health priorities of the nation. The authors in that study stated that the findings from the survey have helped to establish the training needs of the nurses working in remote and rural India. The findings of the survey conducted also assisted in developing their managerial competencies which was in effect crucial to drive their health promotion initiatives with obstetric and new-born emergencies in remote and rural settings (Macaden et al 2017:944).

According to the study conducted by to Ng (2017:121) in Tanzania and Western Australia, the results of the study generated new and more in-depth understandings of the effectiveness of CPD, and strategies to sustain it into the future. South Africa can learn more from these findings. In spite of the barriers and the limitations that the author identified, there were lessons learnt and according to the author, ready to be shared

with the international world (Ng 2017:121). In that study, the results demonstrated that CPD and Continuing Education play a significant role in enhancing the nurse- midwives' knowledge and skills. The findings of that study, according to the author, Ng (2017:121), the nurse- midwives indicated that after participating in CPD, they articulated that they felt empowered and were inspired to take action by changing their practices and voicing concerns about their work environment.

In order to provide best practice and optimal patient outcomes, Ng (2017:122) realised that it was important to involve policy makers and government administrators to help maintain and sustain CPD into the future. The significance of the findings of Ng's (2017:123) study for nurses and midwives in Tanzania included the following, amongst others,

Implications for Clinical Education; Clinical Practice; for Health Organisations, Policy Makers, Training Institutions and Aid Development Programs; finally implications for Research. These implications according to Ng (2017:123) addressed how to overcome the identified barriers to CPD, how to manage shortage of staff and how to sustain the CPD programme at policy-making level.

2.4 CPD POINTS ACCUMULATION AS PART OF ADULT LEARNING

2.4.1 Lifelong learning and adult education

According to SANC (2018:9), CPD promotes life-long learning as well as safe, ethical, competent and evidence-based practice; it also provides opportunities for practitioners to pursue and achieve professional growth throughout their careers.

The American adult educator Malcom Knowles (1970) initiated the discussion where he claimed that adult learning was different from children's learning and had to be practised in different ways (Illeris 2018:7). He introduced a new discipline called andragogy, which was parallel to pedagogy for children to deal with adults' learning and education. He further indicated that the difference was that adults were able to profit by directing their own learning (Illeris 2018:7). Even though his idea met with opposition by established pedagogical theorists who never adopted his new term, the discussion became the

beginning of a development whereby lifelong learning and adult education in the following decades became core for new approaches to learning (ibid).

David Kolb proposed the theory and model of experiential learning in 1984. He postulates that all learning was experiential, aiming at covering human learning in general. Kolb's theory claims that there are two dimensions in all learning which he calls 'prehension' (grasping) and transformation (Illeris, 2018:12).

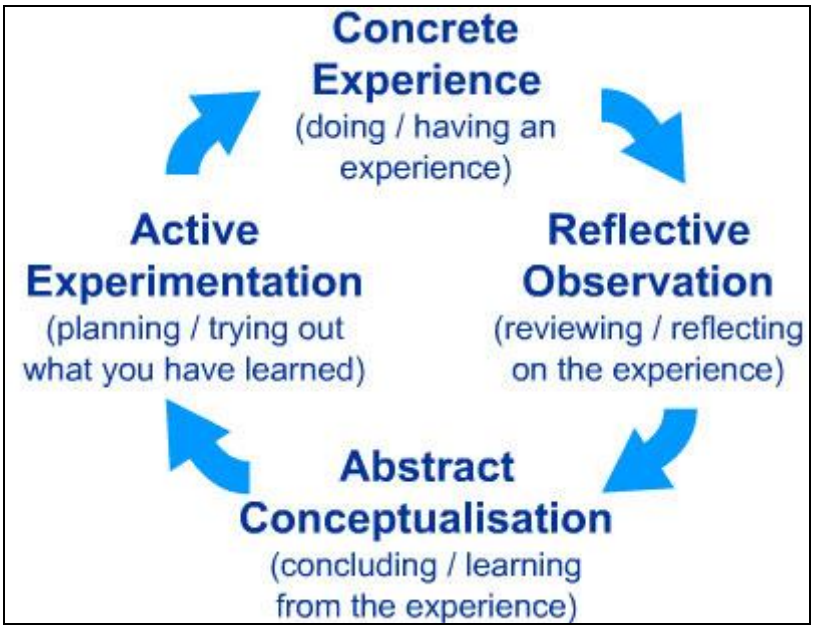

Figure 2.1 David Kolb's learning cycle

(McLeod 2017:1)

The diagram of the four boxes represents the four stages that Kolb claims must be fulfilled in order for learning to take place. Kolb's Learning Cycle is based on the John Dewey's claim that learning must be grounded in experience, Kurt Lewin's ideas of the importance of active learning, and Jean Piaget' s emphasis on the interaction between person and environment on intelligence (Centre for Teaching).

Table 2.1 Interpretation of the four stages of Kolb's Learning Cycle

Concrete experience	**Actually doing the activity**
Reflective Observation	Reflecting on performance in the activity, considering successes and failures
Abstract Conceptualisation	Apply theory to the experience of doing the activity
Planning Active Experimentation	Consider theory and reflection to guide planning for subsequent experiences

In his study, Çakiroğlu (2014:165) indicates that Kolb's Learning Cycle was used as a framework for determining learning styles. For instance, the author shows that the Converger favours the learning cycle of abstract conceptualisation and active experimentation. There is a relationship found among learning styles, learning conditions and conditions where learners can learn best (Çakiroğlu 2014:162). When attending the various activities of CPD, nurses will apply the learning styles to gain new knowledge and skills.

Table 2.2 David Kolb's Learning Styles and Conditions

Learning style	They learn best through	Condition
Diverger	Feeling and watching	Learn when allowed to observe and gather a wide range of information
Assimilator	Thinking and watching	Learn when presented with sound logical theories to consider
Converger	Thinking and doing	Learn when provided with practical applications of concepts and theories
Accommodator	Feeling and doing	Learn when allowed to gain 'hands on' applications

(Manochehr 2006 cited in Çakiroğlu 2014:166)

2.4.1.1 The converger

Cherry (2017) has the belief that people with this learning style have dominant abilities in the areas of Abstract Conceptualization and Active Experimentation. They are highly skilled in the practical application of ideas. Those who learn in this way are quite able to attain success in the practical application of ideas and theories. They tend to do best in situations where there is a single best solution or answer to a problem and make decisions (Çakiroğlu 2014:166).

2.4.1.2 The diverger

In contrast to the convergers, the author discovered that the divergers' dominant abilities lie in the areas of Concrete Experience and Reflective Observation. People with this learning style are good at seeing the "big picture" and organising smaller bits of information into a meaningful whole. Divergers tend to be emotional and creative and

enjoy brainstorming to come up with new ideas. Artists, musicians, counsellors, and people with a strong interest in the fine arts, humanities, and liberal arts tend to have this learning style (Cherry 2017:1). Their imaginative ability is strong. They tend to be people-oriented and react with emotions (Çakiroğlu 2014:166).

2.4.1.3 The assimilator

The author further reiterates that the assimilators are skilled in the areas of Abstract Conceptualisation and Reflective Observation. Understanding and creating theoretical models are some of their greatest strengths. They tend to be more interested in abstract ideas rather than in people, but they are not greatly concerned with the practical applications of theories. Individuals who work in Maths and the basic sciences tend to have this type of learning style. Assimilators also enjoy work that involves planning and research (Cherry 2017:1).

2.4.1.4 The accommodator

Accommodators choose to learn by doing and feeling. People with this learning style are strongest in Concrete Experience and Active Experimentation. They are intuitive and often study examples. They are more likely to be observers than activists (Çakiroğlu 2014:166). This style is basically the opposite of the Assimilator style. Accommodators are doers; they enjoy performing experiments and carrying out plans in the real world. Out of all four learning styles, Accommodators are the greatest risk-takers. They are good at thinking on their feet and changing their plans spontaneously in response to new information. When solving problems, they typically use a trial-and-error approach. People with this learning style often work in technical fields or in action-oriented jobs such as sales and marketing (Cherry 2017:1).

2.4.2 Nurses engage in CPD activities as part of their learning process

CPD is a purposeful, statutory process whereby practitioners registered with SANC engage in learning activities to maintain, improve their knowledge, skills, attitudes, and professional integrity. This is in order to keep up-to-date with the new science, innovation and health care developments. CPD will enable practitioners to practise safely, ethically, competently, and legally within their evolving scope of practice (SANC

2018:6). Nurses are adult learners who have the different learning styles and learn at different stages as alluded in David Kolb's learning cycle and learning styles. Some nurses learn better as presenters, demonstrators or participating in-group activities (Çakiroğlu 2014:166).

2.5 CPD ROLE IN IMPROVING PATIENT OUTCOMES

Cervero and Gaines (2015:131) conducted a study on the impact of CPD on physician performance and patient health outcomes. They found that the fundamental purpose of CPD is to "facilitate the successful performance of practitioners in the diverse practice characteristic of professional work". The authors of the study report that many research studies sought to understand the link between CPD and physician performance and patient health outcomes. They [authors] further posit that following several randomised controlled trials, it was shown that educational interventions under the right conditions could make a difference in physician performance and patient health outcomes. The study that the authors conducted showed that the primary influencers of improved outcomes were that CPD was based on practice-based needs-assessment; it is ongoing; uses interactive learning methods, and is contextually relevant (Cervero & Gaines 2015:131).

Ng et al (2017:19) conducted in Tanzania and Western Australia on the effect of CPD from the perspective of nurses and midwives who participated in continuing education programmes offered by Global Alliance Western Australia. They argue that literature should address the significance and influence of CPD, which benefits health service providers, staff and patient care outcomes. The authors in that study further maintain that there is a heightened criticism that suggests that foreign aid organisations report mainly outputs (quantity) rather than outcomes (quality). Furthermore, in considering the financial, physical and human resource input of foreign aid, Ng et al (ibid) assert the international development projects need to measure the effectiveness of such projects.

The effects on physician performance and on patient health outcomes were tested and analysed (Bloom 2005 cited in Cervero & Gaines 2015:131). Twenty-six (26) systematic reviews were conducted for the impact of educational methods including amongst others, didactic programmes, printed materials, opinion leaders, clinical practice guidelines, interactive education, audit and feedback, academic detailing and

reminders. It was found that those interactive methods (audit/feedback), academic detailing, interactive education and reminders were the most effective at improving performance and patient outcomes (ibid).

2.5.1 CPD of the future: A partnership between quality improvement and competency-based education

CPD seeks to improve patient outcomes by increasing health practitioners' knowledge and skills and changing behaviours, whereas Quality Improvement (QI) takes the approach of system and process change. According to Sargeant, Wong and Campbell (2018:125), combining the strengths of a CPD approach with strategies known to be effective from the field of QI has the potential to harmonise the contributions of each, and thereby to lead to better patient outcomes.

The authors in that study reiterate that competency-based CPD is envisioned to place health needs and patient outcomes at the centre of a CPD system. This will be guided by a set of competencies to enhance the quality of practice and the safety of the health system (Sargeant et al 2018:125).

Mazmanian, Davis and Galbraith (2009:135 cited in Cervero 2015:135) analysed thirty-seven (37) articles. They suggest that certain types of CPD may be used to improve patient outcomes, namely, multiple media, multiple techniques of instruction and multiple exposure to content to meet instructional objectives intended to improve clinical outcomes. Bloom (2005) and Mazmanian et al (2009:135) cited in Cervero (2015:135) recommend that future research should articulate the causal linkages among CPD, physician performance and clinical outcomes.

The authors propose that the future CPD system should adhere to principles as being grounded in the everyday workplace, integrated into the health care system, oriented to patient outcomes, guided by multiple sources of performance and outcome data, and team-based. More importantly, it should employ the principles and strategies of QI, and should be taken on as a collective responsibility of all health professionals, CPD provider organisations, regulators, and the health system (Sargeant et al 2018:125).

2.5.2 The state of quality and safety in health care

Sargeant et al (2018:126) conducted a study on the "current state of quality and safety in health care, and a call for integrating QI approaches into CPD". The results were that rates of preventable adverse events in hospitals have not declined despite considerable effort and investments to improve patient safety over the past 15 years. In their study conducted in Tanzania and Western Australia, Ng et al (2017:10) found that nursing, midwifery in developed and developing nations share similar challenges and concerns. The authors further maintain that the difference between the two was related to a matter of scale, based on health economics, equitable access, and social determinants of health. Ng et al (2017:10) found that the state of quality and safety in health care was compounded by the increase in disease burden, population growth and aged care; subsequently complex health issues will inevitably follow.

Compounding these challenges to the delivery of safe, high-quality care are ongoing concerns about rising health care costs and inappropriate use of resources. Though it is known that developed countries suffer from problems of health care resource overuse, a recent international study suggests there are numerous examples of overuse in developing countries. The international attention is now on the promotion of high-value care and the appropriate use of resources (Sargeant et al 2018:126).

Ng (2017:15) tested the efficacy of CPD interventions during the 'Train the trainer' workshops. The study found a higher level of nurses' satisfaction with teamwork that resulted in a significant decrease in missed care events. Some studies highlight the positive impact of CPD on patient safety and ultimately quality care (Nyamathi et al 2008; Kalisch, Xie & Ronis 2013 cited in Ng 2017:15). The lack of continuing education, compounded by the shortage of nurses, negatively affects professional standards and eventually health outcomes (Ng et al 2017:17).

2.5.3 Alignment between CPD and quality improvement

Batalden and Davidoff cited in Sargeant et al (2018:127) propose that in order to improve patient outcomes, better CPD or professional development and improved system performance (QI) are both needed, and that the broad engagement of all health care practitioners is essential. The authors in that study have observed that in the

traditional CPD approach, organisers of CPD might schedule grand rounds presentations or small-group interactive sessions to provide an update on the epidemiology of surgical complications, the relationship between team communication and surgical outcomes, and the evidence supporting the use of surgical safety checklists to improve outcomes. These traditional CPD approaches have a certain appeal; they are relatively feasible and of low cost; but they have limitations. They might address gaps in knowledge and awareness on their own; yet they are less likely to impact the performance and system-level changes, e. g. by improving inter-professional teamwork or ensuring that the use of the surgical checklist is integrated into the daily clinical workflow of the surgical team necessary to improve outcomes (Sargeant et al 2018:127).

Cervero et al (2015:136) accentuate that CPD does improve practitioners' performance and patient health outcomes though the reliance had impact that is more positive on physician performance than on patient outcomes. The authors in that study further observed that CPD lead to greater improvement in both practitioner performance and patient outcomes if it was more interactive, using more methods, involving multiple exposures, is longer and focused on outcomes that are considered to be more important than practitioners (Cervero et al 2015:136).

2.5.4 Competency-based approach CPD

Sargeant et al (2018:127) underscore previous educational strategies that were used to support the health care practitioners, in particular the physicians, were organised around an intensive short course models that used lectures as the predominant means of disseminating knowledge from expert teachers to learners who remained largely passive. The purpose was to ensure that they were kept up-to-date with the latest evidence informing clinical practice. The result was that although CPD does impact knowledge, its impact on physician behaviour and patient outcomes is small. Ng (2017:10) argue that in order to keep pace with the progressive world of emerging disease outbreaks and contemporary technology, nurses and midwives must stay abreast of new knowledge, be educated and competent to provide the effective care that the population needs.

Several researchers believe that by optimising the capabilities of the workforce and working with regulatory bodies, education and practice institutions can create sustainable inroads and developments (Australian Nursing and Midwifery Council (ANMC) 2009; Dickerson 2010; Garafalo 2012; WHO 2016 cited in Ng et al 2017:10).

In addressing the issue of alignment between CPD and Quality Improvement, Cervero et al (2015:136), is of the opinion that the systematic reviews concur that the research regarding mechanisms of action by which CPD improves practitioner performance and patient health outcomes is in the early stages and needs greater theoretical and methodological sophistication. The authors of that study further advice that the next step in the research should use explicit principles of instructional design to address the strategies are optimally effective under which conditions and for what purposes (Cervero et al 2015:136).

2.5.5 The transition to competency-based CPD for medical education could apply to CPD for nurses during community service

Wiltse, Kelly and Fairman (2015:709) conducted a study entitled, 'Postgraduate nurse practitioner residency programmes: Supporting transition to practice'. They highlight that residency training for physicians is a long-standing tradition — not so for nurses. The authors further indicated that until the early 1970s, hospitals used nursing students who were working in the hospital's diploma programmes as an institutional workforce in lieu of hiring an adequate number of nurses who had already earned their diplomas. According to the authors' observation in this study, diploma nurses exited their hospital-based programs with the ability to function immediately in an acute care setting-performing procedure, understanding institutional culture, and quickly easing into floor management. Wiltse et al (2015:709) report that training and experiences of this type suited hospitals of the 1950s and 1960s were geared toward normal deliveries and uncomplicated surgical cases. However, as obstetrics, treatments, and patients grew more complicated and as the population aged and chronic disease proliferated a different type of nurse and nursing education became necessary (Wiltse et al 2015:709).

Transitioning nursing education into colleges and universities meant forfeiting the long hours of "service" that had been part of the diploma programmes, for, instead, better-

educated nurses who had the critical thinking skills required by changing patient demographics. Today's nurses provide safe, effective care with excellent patient outcomes. However, providers must allow new nurses or those who change practice sites adequate time to transition into practice, to achieve efficiency, to gain role satisfaction, and to be able to manage a typical patient load (Wiltse et al 2015:709). Researchers have documented the effectiveness of nurse residences for post baccalaureate nurses in providing these professionals with an increased sense of confidence and with the additional skills necessary to move quickly into higher-level competencies, while at the same time decreasing costs to employers through reduced turnover (Wiltse et al 2015:709).

The situation is different for postgraduate advanced practice nurses - that is, nurse practitioners (NPs), nurse anaesthetists, clinical specialist nurses, and nurse midwife, who, through programme accreditation, rigorous certification exams, and competency-based standards, graduate with the skills, and knowledge to achieve licensure (Wiltse et al 2015:709). A solution and why residences matter, the authors in that study believe that an excellent option would be a network of local, consistently funded, multidisciplinary team residencies including nurses, physicians, pharmacists, social workers, and others who would help socialise one another to working in a team and practicing in a primary care setting. Wiltse et al (2015:711) report that as more and more Americans gain health insurance and begin to seek out health care providers, primary care NPs will be essential to meet demand. The authors of the study further report that providing almost 20% of primary care in the United States, NPs are already a critical part of the primary care workforce, although many of the newly insured are young and healthy. Much of the population seeking primary care is more complex, chronically ill and older (Wiltse et al 2015:711). The authors in that study state that 1Wnurse practitioners may need transition-to-practice support, but they do not need additional regulatory hurdles to practice. Without data supporting the need for a required residence, Wilts et al (2015:711) state that mandating such programs through State regulation becomes an unwelcome means of attempting to control NPs in practice. Institutions offering postgraduate transition-to-care programs for NPs will be attractive employers, so report the authors. The authors of the study report that these programmes should support new NPs or those transitioning to new areas of practice, provide them with the opportunity to gain valuable management skills, help them formalise their identity as NPs, and affirm their confidence as they take on their new

roles. According to Wiltse et al (2015:711) suggest that the available multidisciplinary programmes, such as fellowship programme provide added value for patients and providers alike and can serve as models for programmes in many types of institutions and primary care settings (Wiltse et al 2015:711).

2.5.6 Collective competency

In the study conducted on a realistic synthesis of effective CPD, Manley, Martin, Jackson and Wright (2018:136) reported that CPD was complex and highlighted differences in practices, terminology and approach across various disciplines and various countries. In the authors' opinion, in this study, the variance in CPD activity was observed with mandatory and voluntary systems; formal and informal delivery of CPD existing alongside each other in some setting (Manley et al 2018:136). The authors in this study further found a relative dearth of evidence about the impact of CPD on healthcare outcomes and professional practice. According to Manley et al (2018:137), the areas of CPD transformations are interdependent, but some may require focus before others to achieve full benefit in the workplace and optimal organizational performance.

2.5.7 Workplace learning

Manuti, Pastore, Scardigno and Giancaspro (2015:2) conducted a study on 'formal and informal learning in the workplace: a research review'. It was reported that workplace learning is a key part of the process, driven by the impact of changes in demographics, skills demands, technologies, and people's relationships and roles within various institutions, organisations, and communities. Consequently, the authors assert that is currently experiencing many global changes. A transition from school to work is no longer confined to occasional formal activities in classroom environments (Manuti et al 2015:2). Knowledge is not necessarily individualised, and the way an entire organisation learns can be instrumental in its innovation and profitability. Therefore, the notion of lifelong employability is replacing the most traditional label of lifelong learning as long as short-term employment is rapidly substituting lifetime employment within the same organisation (Forrier & Sels 2003; Van der Heijden et al 2009 cited in Manuti et al 2015:2). Therefore, to understand changes in the knowledge society, it is necessary to understand workplace learning. Workplace learning cannot be investigated as a

separate process, which has nothing to do with the wider social and economic context – characterised by a changing meaning of work, knowledge, learning – that in part shapes and drives what we think of as, or want for, workplace learning. If workplace learning is not contextualised in this way, workers will be prepared with the skills and competencies for today but not for tomorrow (Cullen et al 2002 cited in Manuti et al 2015:2). Which would run counter to much of the point of workplace learning as something more than simple training with a narrow focus on surface-level skills (Matthews 1999; Winch & Ingram 2002 cited in Manuti et al 2015:2).

According to Manuti et al (2015:1), workplace learning has a broader project and potential to link development of the individual with development of the organisation or business, through an emphasis on sustained development and learning processes as well as learning outcomes. If changes in society and economy have loosened learning from the classroom, then the workplace is also more than just a physical location (Jacobs & Park, 2009 cited in Manuti et al 2015:2).

Manley et al (2018:137) concur with Manuti et al (2015:1), who, in their study, argue that the workplace and organisation present contextual influences on CPD content, the value attached to the workplace as a learning resource and how the workplace is used to enable practice improvements. Work-based CPD built on learner-driven assessment and self-awareness within a supportive organisation and facilitated reflection enhance role clarity, opportunities for role development and engagement with meaningful change. Transforming the individual's professional practice embraces aspects of other transformation theories to incorporate collective effect on the team and organisation in understanding contributions to service improvements (Manley et al 2018:137).

The second level of transformation, according to Manley et al (2018:137), emphasises the facilitation skill-set required across workplace teams to enable others to use knowledge through active inquiry and evaluation of their own and collective learning and professional practice. Researchers in this study report that a workplace that engages in active sharing and using different types of knowledge in practice blends various knowledge types to inform professional decision making and fosters skill in facilitating inquiry, evaluation of practice and leadership. Authors of this study acknowledge that effective transformation of knowledge generates knowledge rich cultures and active contribution to practice development, innovation and creativity. They support the

transformation of workplace culture to implement workplace and organizational values and purpose. Manley et al (2018:138) further acknowledge the need for an organisation that upholds change with plans for ongoing improvements and the capacity to maintain the change. The proposition for the theory about transforming workplace culture through CPD is that organisations that are ready to change promote development and implementation of shared values to enhance patient experiences, team cohesiveness, effectiveness in workplace cultures and organizational leadership (Manley et al 2018:138).

2.5.8 Formal versus informal learning in the workplace: reconciling perceptions on learning outcomes

Despite the rather unanimous acknowledgement of informal learning as a complementary dimension of workplace learning Ellinger (2005) and Marsick (2009) cited in Manuti et al (2015:8). In their study conducted on formal and informal learning in the workplace, reported that little is known about "how it can best be supported, encouraged, and developed" (Marsick & Volpe 1999:3 cited in Manuti et al 2015:8). Actually, although most scholars tend to view informal learning within the workplace positively, some have pointed towards its drawbacks in relation to its processes and learning outcomes (Skule 2004 cited in Manuti et al 2015:8). On a practical level and largely from an organisation-centred focus, (Dale and Bell (1999) cited in Manuti et al (2015:8) point out that it may be too narrowly based so the employee only learns part of a task or superficial skills, which may not be transferable; it may be unconscious and not be recognised. This neither builds confidence nor lead to development; it is not easy to accredit or use for formal qualifications; and the employee may learn bad habits or the wrong lessons (Manuti et al 2015:10). From an employee-centred and a broader social focus, the authors of this study argued that the emphasis on, and interest in, informal learning within the workplace overlooks and/or obscures a variety of problematic issues, Fuller and Unwin (2003) cited in Manuti et al (2015:8), draw attention to the perspective that an overvaluing of informal learning could lead to fewer opportunities for employees to participate in formal 'off the job' training. As well as indicating that this could reduce the possibilities for expansive participation, Fuller and Unwin (2003, 2004) cited in Manuti et al (2015:8), also raise the issue of knowledge control within the workplace.

The authors of this study, further questions on what counts as valid knowledge, who defines it and whose interests will such knowledge serve, which are increasingly being addressed and discussed (see among others Blacker,1995; Spencer, 2001 cited in Manuti et al 2015:8). Some authors draw attention to how informal learning leads to various forms of job intensification, which is being obscured through workplace cultures, and the new worker subjectivities that are produced through them (Du Gay 1996; Edwards 1998; Garrick & Usher 2000; Solomon 1999; Usher & Solomon 1999 cited in Manuti et al 2015:8). They [authors] argue that workplace cultures and informal learning processes involve forms of control, which, ultimately, are shaping employees identities and subjectivities.

This argument is largely built upon Foucault's (1980; 1995) cited in Manuti et al (2015:9) notion of disciplinary and regulatory power whereby power is not exercised from above (e.g. from the employer or manager) but from within individuals themselves, a form of self-surveillance which is conditioned through the discourses that surround them.

The analysis presented here interrogates the value and validity of seeing formal and informal dimensions of learning as separate rather than parallel, as they are co-present in any learning situation both in and out the workplace. That is, learning is predominantly determined by the complex social practices in any learning setting, which integrate what are sometimes termed formal and informal components. Therefore, as shown above, in all or nearly all situations where learning takes place, elements of both formal and informal learning are present. But the most significant issue is not the boundaries between these types of learning but the interrelationships between dimensions of formality/informality in particular situations. This is particularly evident in working contexts, where often formal and informal learning practice overlap, as for instance in non-paid and voluntary work, Livingstone (2008) cited in Manuti et al (2015:9), thus contributing to the acknowledgement and to the development of (partially) new skills/competences (Jacobs & Parks 2009; Manuti et al 2015:9).

2.5.9 Community service and required skills from nurses - nursing residency programme

Manley et al (2018:140) found that in order for health practitioners to be relevant in their clinical practice, all the stakeholders must make sure that they are competent to meet

varied population health needs and that care delivery is person centred, safe and effective. The authors in this study further presented guidance to CPD stakeholders to be explicit and intentional in CPD activity to achieve intended improvements (ibid).

In order to meet societal changes, according to Manley et al (2018:137), transformation of skills need to change; a team approach in their observation is needed to develop competencies in the workplace. The supposition is that no one person can deliver all the competences and skills required to support effective healthcare. Effective use of human resources and flexible ways of working provide the immediate context for CPD focus. The deductions for skills transformation emphasise a holistic approach to developing the full skillset required for efficient teams in healthcare (Manley et al 2018:137).

Assessments for gaps in systems and team skills inform CPD for transforming skills to match society's changing healthcare needs. Manley et al (2018:129) report that transforming skills impacts on service user experiences, team effectiveness, career progression opportunities and organisational partnerships.

2.6 IMPLEMENTATION OF COMPETENCY-BASED CPD IN SOUTH AFRICAN CONTEXT

Schutte, Barkhuizen and Van der Sluis (2015:724) conducted in South Africa entitled, ‘Exploring the current application of professional competence in Human Resource Management’. They found that HR competencies are poorly applied in selected South African workplaces. The authors in this study indicated that competencies that were indicated as having the poorest application were talent management, HR metrics, HR business knowledge, and innovation. The white ethnic group experienced a poorer application of all human research management (HRM) competencies compared to the black African ethnic group (Schutte et al 2015:724).

The findings of the research by Schutte et al (2015:724) highlighted the need for management to evaluate the current application of HR practices in the workplace and the extent to which HR professionals are involved as strategic business partners. The research that was conducted by Schutte et al (2015:724).highlights the need for the current application of HR competencies in South African workplaces to be improved.

Armstrong and Rispel (2015:1) conducted a study on ‘Social accountability and Nursing Education in South Africa’. They reported that South Africa has strategic plans on human resources for health and nursing education, training, and practice and has a well-established system of regulation and accreditation of nursing education through the SANC. The study further underscore that the key informants criticised the following: the lack of national staffing norms; sub-optimal governance by both the SANC and the Department of Health; outdated curricula that are unresponsive to population and health system needs; lack of preparedness of nurse educators; and the unsuitability of the majority of nursing students. Armstrong and Rispel (2015:1) further indicate that these problems are exacerbated by a perceived lack of prioritisation of nursing, resource constraints in both the nursing education institutions and the health training facilities, and general implementation inertia.

Munyewende, Levin and Rispel (2016:15) found that the South Africa's health sector reforms based on PHC require competent nursing managers to ensure successful implementation of these reforms. The study that was conducted further indicated that although the socio-demographic characteristics of PHC nursing managers show that they have extensive experience in the health sector. The study findings suggest the need for additional training in financial management. These skills in financial management could be enhanced through CPD programmes and furthermore, additional training must be aligned with health system goals and supported by a positive practice environment (Munyewende et al 2016:15).

2.7 CONCLUSION

This chapter discussed the process that is followed during a literature review, definition, purpose, and types of literature review, study habits, learning performances, distance learning, competency-based approach, and Kolb’s theory of experiential learning as it applies to health care practitioners. CPD in nursing is important as it improves quality of patient care through the competences that the nurse has developed and improves professional development.

Chapter 3 discusses the research design and methodology of the study.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter presents the research design and method adopted as relevant to this study. These include sampling; research methods of data collection; data analysis; scientific rigour, and ethical considerations.

3.2 PURPOSE OF THE STUDY

The purpose of this study was to develop understanding of nurses and midwives' perceptions and attitudes towards the implementation of CPD in a public regional hospital in the Limpopo Province, South Africa; and to make recommendations to enhance the attendance of CPD activities.

3.3 RESEARCH QUESTIONS

Creswell (2015:107) in his study conducted on 'A concise introduction to mixed methods research' stated that he prefers some writers who offer suggestions for writing qualitative research questions, (e.g., Creswell 2003; Marshal & Rossman 2006). Creswell (2015:107) further asserts that he concurs the conceptualisation of Marshall and Rossman (2006) of research questions into four types: exploratory (e.g., to investigate phenomenon little understood), explanatory (e.g., to explain patterns related to phenomenon), descriptive (e.g., to describe the phenomenon), and emancipatory (e.g., to engage in social action about the phenomenon). Creswell (2015:107) describes qualitative research questions as being open-ended, evolving, and non-directional; restate the purpose of the study in more specific terms; start with a word such as "what" or "how" rather than "why"; and are few in number (five to seven). The author states that the qualitative questions may be posed in various forms, from the "grand tour" (Spradley 1979; 1980) that asks, "Tell me about yourself," to more specific questions (Creswell 2015:108). In this study, the researcher formulated the research questions using the

open-ended questions starting with the ‘what’ to obtain responses from the participants on their experienced perceptions and attitudes towards CPD implementation.

Research questions are important because they help the researcher to set boundaries when conducting the literature review (Wilson 2014:58).

3.4 RESEARCH OBJECTIVES

Wilson (2014:58), in his book on ‘Essentials of Business research: A guide to doing your research’, describes an aim as a general statement of what research sets out to achieve and an objective as being a more specific statement relating to the defined aim of the research.

Objectives and research questions are very much related to one another (Wilson 2014:56). By reading the key literature on the subject, the researcher will be able to identify a clear rationale for the study. The topic should be short and straight to the point; that will enable the researcher to formulate realistic aims and objectives in relation to the questions and topic under study (Wilson 2014:56).

3.5 RESEARCH DESIGN

Ingham-Broomfield (2014:36), in her study conducted on ‘a nurses’ guide to qualitative research’, asserts that qualitative research falls into five main designs, namely, Phenomenology, Ethnography, Grounded Theory, Historical method, and case study. The explanatory sequential design guided the researcher to plan and implement the purpose, objectives and general layout of the research and would enable the researcher to work through to explain the results in more depth (Ng, 2014:23). The design choice, according to Ng (2014:23), enabled opportunities to gain in-depth understanding of the subject under study. Phenomenology, according to Ingham-Broomfield (2014:36), searches for multiple meanings attributed to a phenomenon and tries to provide a comprehensive description rather than an explanation (Liamputtong 2013:117; Jirojwong et al 2011:113) in Ingham-Broomfield (2014:36), state that phenomenology as a research design is used to describe the everyday world of human experience.

An exploratory descriptive qualitative design was used to conduct this study. Moreover, the researcher chose to use this design in order to explore and describe the perceptions of nurses and midwives with regards to implementation of CPD as required by SANC (Creswell 2015:7). This design also empowers the participants as one hears their voices expressing themselves as they relate their stories. The researcher set the environment in such a way that it minimised the power relationship between the researcher and the participants. The participants were free to engage in conversations. The design assisted the researcher in analysing the issues from an in-depth perspective.

3.5.1 Qualitative research

Qualitative research involves evaluating and comparing interventions in a subjective manner, where the views and experiences of the research participants are analysed (Gerrish & Lacey 2010 cited in Perry 2014:15). Tappen (2011:37) cited in Perry (2014:15) postulates that qualitative research is an inquiry process that allows for the exploration of a social or human problem. The author in that study further explains that the researcher builds a holistic picture, analyses the words spoken, reports detailed views of the participants, and conducts the study in natural setting.

The qualitative study approach was chosen in accordance with (Creswell & Poth 2015:7 cited in Ng 2017:26) who state that qualitative research involves an interpretive, naturalistic approach to the world. Denzin and Lincoln (2005:3) cited in Ng (2017:26) describe qualitative research as involving "… an interpretive naturalistic approach to the world". The authors of that study further indicates that researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. Creswell (2015) cited in Ng (2017:26) asserts that to learn from the participants, the researcher should begin by posing general open-ended questions that allow individuals to answer questions and provide information without constraints. Ng (2017:26) further emphasises that in order to align with the naturalist paradigm, participants should be recruited and studied in their natural setting (Jirojwong et al 2014; Keele 2011 cited in Ng 2017:26).

In line with the study conducted by Ng (2017:26) and other qualitative studies, the researcher in this study conducted the research with participants in their natural settings, to make sense and understand people. The researcher was able to make an

interpretation of what they see, hear and understand. Furthermore, Creswell (2015:7) underscores that with this approach, the interpretations made by the researcher cannot be separated from the participants' backgrounds and their history, hence naturalistic qualitative approach.

Perry (2014:15) posits that the researcher is not an independent observer, a picture that is often drawn when natural scientists are depicted. In qualitative research self-reflection about one's own attitude and position and role in society is vital. Denzin and Lincoln (2005:2) cited in Perry (2014:15) continue to say that "behind all research stands the biography of the gendered researcher, who speaks from a particular class, racial, cultural and ethnic community perspective". Data in qualitative research are reported in a literary style with the participants' interpretations. According to Streubert, Speziale and Carpenter (2011:22) cited in Perry (2014:15), quotations, commentaries and narratives enrich the report of the researcher.

The researcher chose the qualitative approach because it is not desk research but that the researcher will go out into whatever we consider the real world, observe and talk to people, interact with them [people] aiming to understand what is important to them and how the researcher perceives the world. Creswell (2015) in Ng (2017:26) notes that the advantage of qualitative research is to allow participants' experiences to be understood. In the context of Ng (2017:26) 'study, the qualitative method captured the participants' voices and views of CPD in Tanzania. This is in line with this study where the researcher explored the participants' views and feelings on CPD implementation for nurses and midwives in South Africa.

3.5.2 Exploratory descriptive design

Creswell (2015) and Fischler cited in Ng (2017:22) suggested asking 'what methods takes priority when collecting and analysing data?' and to 'consider the sequence to conduct the research'. To explore means to probe, research, examine, seek, look into or analyse an event or people to become familiar with it or them through testing or investigating. In accordance with Perry (2014:16), exploratory research intends to gain a detailed picture of the participants' views through eliciting of descriptions. Perry (2014:16) further describes the importance of exploratory studies; it is described as being useful to discover information about the little known phenomena when prior

research is not known. Huttlinger (2012:168) and Saldana (2011:29) cited in Perry (2014:16) allow for the research questions to be answered through field work and presents a factual account of what is happening. The author further maintains that description allows the participants to describe their understanding and their own experiences of the phenomenon (Perry 2014:16).

3.6 RESEARCH METHODS

Kothari (2004:8) cited in Perry (2014:16) asserts that the research method refers to 'methods the researcher uses to implement research processes while studying the research problem.' In addition, Yüsel and Yildirm (2015:10) highlight that data in qualitative research can be collected using other techniques, such as focus group discussions, interviews, observations, and video recordings. In addition to interviews, an observation method can be used to observe the research environment. In this study, the researcher employed three (3) focus group discussions of participants and recorded the discussions. The researcher transcribed and analysed data together with members of the research team.

3.6.1 Sampling method

Merriam-Webster Dictionary cited in Gentles et al (2015:1772) defines sampling as "the act, process, or technique of selecting a representative part of the population for the purpose of determining parameters of characteristics of the whole population". Sampling entails the selection of a subset of individuals from within a population to estimate the characteristics of whole population (Sing & Masuku, 2014:1). In the same vein, a sample is a portion of a population or universe. Many people often consider population to be people only. Population does not refer only to the number of people but refer also to total quantity of the things or cases which are the subject of the research (Ilker et al 2016:1).

In her study conducted on 'a nurses' guide to qualitative research', Ingham-Broomfield (2014:37) avers that sample population could be very diverse in qualitative research. The author of that study further reiterates that the sample can vary from one individual to small groups and to institutions. According to Ingham-Broomfield (2014:37), sampling can use a number of different sources of data such as diaries, old newspapers and

letters. In qualitative research in contrast to quantitative research, Ingham-Broomfield (2014:37) suggests that subjects are called participants or informants rather than subjects. Different forms of sampling in qualitative research include amongst others, convenience, purposive and intensity (Polit & Hungler 2013; Borbasi & Jackson 2012; Jirojwong et al 2011 cited in Ingham-Broomfield 2014:37).

In their study on 'sampling techniques and determination of sample size in applied statistics research: an overview', Masuku and Singh (2014:1) describe a sampling technique as the method for the selection of individuals on which information are to be made. The authors in that study further point out what needs to be considered in the selection of individuals for sampling, including, amongst others: carrying out investigations on an entire group; select a random sample and consider the heterogeneity within the group while applying proper sampling technique (Singh & Masuku 2014:1).

In their study, Singh and Masuku (2014:1) identified the following sampling techniques used in qualitative research:

- Purposive sampling which is selected according to purpose of the study.
- Random sampling where each unit included in the sample will have certain pre assigned chance of inclusion in the sample.
- Simple random sampling where each unit included in the sample has equal chance of inclusion in the sample.
- Stratified random sampling where the group is divided into strata and the subgroup or strata chosen because evidence is available that are related to outcome (Singh & Masuku 2014:4).

Other sample techniques mentioned by the authors of that study were quota sampling, spatial sampling and independent sampling.

In their study conducted on 'comparison of convenience sampling and purposive sampling', Ilker et al (2016:1).underscore that it is crucial for a researcher to determine which non-probability sampling technique is applicable to the study conducted. They further highlight that the technique to be used depends on the type, nature and purpose of the study. Ilker et al (2016:1).) indicate in their study that when subjects are chosen

because of the close proximity to a researcher, the researcher is making a convenience sampling and a purposive sampling if a researcher has something in mind and participants that suits the purpose of the study will be included.

Purposive sampling technique is the deliberate choice of a participant due to the qualities the participant possesses (Ilker et al 2016:2).It is a non-random technique that does not need underlying theories or a set number of participants. The researcher decides what needs to be known and sets out to find people who can and are willing to provide information by virtue of knowledge and experience (Ilker et al 2016:2).). The authors of that study further maintain that this method is used in qualitative research to identify and select information-rich cases for the most proper utilisation of available resources. In addition, they further buttress that the selection of individuals or groups will be based on those who are proficient and well informed with a phenomenon of interest in addition to knowledge and experience (Ilker et al 2016:2).). Based on the fact that purposive sampling methods include homogeneous sampling, which according to Ilker et al (2016:3).focuses on candidates who share similar traits or specific characteristics in terms of age, cultures, jobs or life experiences. Purposive sampling methods place primary emphasis on saturation. According to Ilker et al 2016:4), saturation refers to obtaining a comprehensive understanding by continuing to sample until no new substantive information is acquired.

The researcher in this study, based on the characteristics of the purposive sample stated above that all met the objectives of the study, chose the non-random purposive sampling. The participants in this study were a homogeneous group of all nurses and midwives in the public regional hospital of Waterberg District, Limpopo Province.

3.6.1.1 Research setting

Research setting is an environment that is selected for a specific purpose in research, which is for data collection (Perry 2014:16). The setting may be one or more settings, a naturalistic environment such as in people's homes or at their places of work, or in highly controlled laboratory situation. This study was conducted in a boardroom, an environment that the participants were familiar with, which is in a public regional hospital in Limpopo Province, South Africa. The researcher was able to collect data in the field

at the site where participants experience the implementation of CPD by the hospital management, in preparation for the formal CPD implementation by SANC.

3.6.1.2 Population

Sampling is related with the selection of a subset of individuals from within a population to estimate the characteristics of whole population (Sing & Masuku 2014:1). A sample is a portion of a population or universe. Many people often consider population to be people only. Population does not refer only to the number of people but refer also to total quantity of the things or cases, which are the subject of the research (Ilker et al 2016:1). *Merriam-Webster Dictionary* in Charles et al (2015:1772) defines sampling as "the act, process, or technique of selecting a representative part of the population for the purpose of determining parameters of characteristics of the whole population".

The population for this study were all the nurses and midwives in the public regional hospital of Waterberg District in Limpopo Province. The researcher used the non-random purposive criterion-based sampling for participants at the site. The researcher was interested in participants who had the best knowledge concerning the topic at hand. All nurse categories from the various hospital departments participated in the focus groups. The participants were from the following wards: Casualty; Outpatient Department; Medical; Surgical; Paediatric; Operating Theatre; Orthopaedic and Maternity wards. The sample size was 22 nurses comprising of eight registered nurses, eight enrolled nurses and six enrolled nursing auxiliaries; that was the size that led to data saturation. Saturation is a point at which the researcher feels that to continue collecting data beyond this number will not reveal further insights into the issues under discussion, namely, perceptions and attitudes of nurses and midwives. Gutterman (2015:3) underscores that sampling in qualitative research is not a matter of representative opinions, but a matter of information richness, appropriateness and adequacy. He further suggests that for studies using interviews, the mean number of participants should be 45.

The researcher selected these participants in the belief that they would reveal the information about their attitudes and perceptions towards CPD implementation by the regional hospital, in preparation for the compulsory CPD implementation by SANC.

According to LoBiondo-Wood and Harber (2010:221) cited in (Perry 2014:17), a population has particular properties that will make it a well-defined set. A population can involve millions of people or it can include several hundred people. In this study, the population included all the nurses and midwives in the public regional hospital, Limpopo Province in South Africa. Accordingly, the researcher has selected these participants in the belief that they will reveal the information about their attitudes and perceptions towards CPD implementation by the public regional hospital, in preparation for the compulsory CPD implementation by SANC.

3.6.1.3 Sampling of participants

The researcher used the non-random purposive criterion-based sampling for participants at the site. The researcher was interested in participants who have the best knowledge concerning the topic at hand. Gutterman (2015:3) asserts that sampling in qualitative research is not a matter of representative opinions, but a matter of information richness, appropriateness and adequacy. He further suggests that for studies using interviews, the mean number of participants should be 45.

The researcher can decide as to whether participants share significant and meaningful experience concerning the phenomenon under investigation. They may also have significant and meaningful experience concerning the phenomenon under investigation. Participants had to be able to describe their experiences and views on implementation of CPD; therefore, they had to be purposively selected. The intention was to conduct focus group discussions with the target group using open-ended questions in a semi-structured manner (Ng 2017:40). Criterion-based selection is commonly used as a sampling method. In this method, the researcher should specify some common criteria for all participants in order to select a group of participants with shared experiences. The criteria for inclusivity were all the nurses (registered nurses, enrolled nurses and enrolled nursing auxiliaries) and midwives in a public regional hospital in Limpopo Province. Exclusivity criteria pertained to all the nurses who were still undergoing basic nursing training because they are not yet qualified to carry on with CPD (Yüsel & Yildirm 2015:9).

A semi-structured focus group guide with open-ended questions was used to guide the discussions with the nurses and midwives. Semi-structured in-depth interviews were

easy to administer and participants were not required to read. The researcher was able to access non-verbal cues that provided important data. It also allowed the researcher to probe more if mixed messages were observed. More importantly, this method is flexible because it allows the researcher to follow conversation as they unfold. In order to understand and interpret what one hears properly, the researcher kept on seeking clarity throughout conversations. During conversations, the researcher maintained her primary role of being a 'listener' and recorded her views and feelings.

Probing was done once the primary questions were asked and answered. An audiotape was used to record the discussions. Field notes were written and a mobile phone was used as the recording backup. The setting was in a quiet room that was conducive in the maintenance of confidentiality and privacy. Descriptions of the perceptions and attitudes provided the facts and the context in which they occurred.

The process of data analysis is to assemble or reconstruct the data in a meaningful manner, which is transparent, rigorous and thorough while remaining true to participants' accounts (Noble & Smith 2017:42). Like other qualitative methods, gathering and analysing data are conducted concurrently in descriptive qualitative approaches, therefore adding to the depth and quality of data analysis. It is also common to collect all the data before examining it to determine what it reveals. The researcher used lockable cupboards to store the audiotapes and field notes. The recordings were converted into computer files with passwords created to keep them safe. In addition, audiotapes were transcribed verbatim. The researcher ensured that verbatim actual work was captured correctly prior to analysis. Content analysis was followed. The researcher used the six generic steps detailed by Patton (2002) in O'Mahony et al (2014:3) which are:

- Organisation and preparation of data
- Reading through the data to get a general sense of the meaning
- Generation of themes
- Representation of themes
- Interpretation (O'Mahony et al 2014:3)

3.6.1.4 Sample size

Focus group discussions. Normally, the sample size cannot be predicted at this stage, as it will depend upon data saturation. In this study, the researcher used the sample size of 22 nurses and midwives of all nurse categories [professional nurses, enrolled nurses and enrolled nursing auxiliaries]. This is a point at which the researcher felt that to continue collecting data beyond this number would not reveal further insights into the issues under discussion, that is, perceptions and attitudes of nurses and midwives towards CPD implementation in their public regional hospital.

3.6.1.5 Ethical issues related to sampling

3.6.1.5.1 Trustworthiness

The researcher in this study ensured rigour or trustworthiness by retaining all documentation, including among others, the ethics approval, interview questions, information leaflets, consent forms, and records of interviews. During the course of the study, the researcher also kept notes on how interviews were planned and the experiences of the interviews (Ng 2017:31).

It is well-documented in the literature that the core of all research is to ensure its rigour, if not, studies are unreliable (Ng 2017:29). The author further explains that rigour is a methodological process that defines data accuracy and reflects the truth as the participants see it. Rigour is sometimes referred to as a quality-control measure for research (Laher 2016 cited in Ng 2017:29). In this study, the researcher adhered to the principles of trustworthiness as stated in the opening paragraph.

Maintenance of scientific rigour (Claydon 2015 cited in Ng 2017:29) argues that the quality and design of the study is critical to ensure confidence in the final research product. According to Creswell (2015), rigorous procedures for both [quantitative and qualitative] components are critical in good mixed-methods studies. In contrast to quantitative studies, the qualitative study reveals accurate, credible and trustworthy findings to ensure rigour (Ng 2017:29). “Credibility deals with the focus of the research and refers to the confidence in how well the data address the intended focus, the aim of trustworthiness in qualitative inquiry is to support the argument that the inquiry’s findings

are worth paying attention to" (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs 2014:1). The four (4) alternatives for assessing the trustworthiness of qualitative research are supported by the pioneers of qualitative research, including Lincoln and Guba (1985), and are as follows:

3.6.1.5.2 Dependability

Elo et al (2014:2) refer to dependability as the stability of data over time and under different conditions. Prion and Adamson (2014) cited in Elo et al (2014:2) identified the key element of dependability as having a thorough description of the research methodology. Dependability can be confirmed by being clear and specific in the description of the research purpose, and by following the research process whereby the method of the study is openly described, discussed and presented.to ensure rigour. In this study, the researcher retained all documents such as ethics approval, interview questions, information sheets, consent forms, field notes, and records of the interviews (Ng, 2017:33). The researcher analysed the transcript with an independent coder and supervisor to confirm the codes and themes, and to enhance dependability of the results.

3.6.1.5.3 Credibility

Credibility is defined as the truth of the findings that represents a correct interpretation of the participants' views (Cope 2014; Neuman 2005 cited in Ng 2017:30). During the focus group discussions and interviews, the researcher in this study kept on clarifying responses provided by the study participants to ensure that their views were correctly understood. More importantly, such statements validated and confirmed interpretations. Another method that the researcher used to validate information in focus groups and interviews was by the use of digital audio- recordings. Recordings were transcribed by the researcher. Each transcript was read repeatedly to avoid duplication when recording the results. To establish data credibility, the researcher reviewed all the audio files, and crosschecked the textual data transcribed (Ng 2017:30). Member checking was done with some of the participants after each focus group discussion to judge the credibility of the research findings (Casey et al 2016:654). The emerging themes were discussed with independent co-coder and supervisor to attain independent and objective view (Ng 2017:30).

3.6.1.5.4 Confirmability

According to Elo et al (2014:2), confirmability refers to the objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning. In addition, Prion and Adamson (2014) cited in Elo et al (2014:2) see confirmability as the absence of bias and assumptions in the researcher's view. Qualitative research tends to assume that each researcher brings a unique perspective to the study. To ensure transparency, at the beginning of each interview, the researcher informed the research participants that the study was conducted for research purposes only and that the researcher was not operating in a manager's capacity (Ng 2017:32).

The author further maintains that the researcher should maintain awareness and a conscious effort to consistently follow, rather than lead, the focus group and interviews. Confirmability refers to the degree to which the results could be confirmed or corroborated by others. More importantly, the researcher in this study ensured that the data accurately represented the information that the participants provided by summarising responses with the participants at the end of each focus group discussion and ensured that the interpretations of the data were not those of the researcher.

Cope (2014) cited in Trochim (2016:17) suggests that findings with rich quotations from the participants that depicted each emerging theme should be presented in the research report to ensure confirmability. The researcher conducted a data audit that examined the audit trail to ensure that data collection and analysis procedures were accurate to prevent the potential for bias or distortion (Trochim 2016:17). Codes and themes were also confirmed by the supervisor and the independent coder.

3.6.1.5.5 Transferability

Prion and Adamson (2014) cited in Elo et al (2014:2) define transferability as the applicability of the findings in a study to other population in different settings. Elo et al (2014:2) refer to transferability as the potential for extrapolation, which relies on the reasoning that findings can be generalised or transferred to other settings or groups. The researcher in this study kept the records meticulously to provide a good audit trail.

The researcher accurately reported on the research methodology such that it was possible for others to emulate, but applying it to their context. In this study, the notion of transferability is possible to a certain extent as the findings could be applicable to other parts of South Africa and developing countries. Therefore, this will provide meaning to individuals not involved in the study and readers will be able to relate their own experiences to the results (Cope 2014 cited in Elo et al 2014:2).

Researchers should provide sufficient information on the informants and the research context to enable the reader to assess the findings' capability of being "fit" or transferable. However, the criterion of transferability is dependent on the aim of the qualitative study and may only be relevant if the intent of the research is to make generalisations about the subject or phenomenon (Diane 2014:89).

3.6.1.5.6 Authenticity

According to Elo et al (2014:2), authenticity refers to the ability and extent to which the researchers fairly and faithfully express the feelings and emotions of the participants' experiences in a faithful manner. The authors further underscore that they show a range of realities (Lincoln & Guba 1985; Polit & Beck 2012 cited in Elo et al 2014:2). By reporting in this descriptive approach, readers grasp the essence of the experience through the participant quotes. In this study, the researcher made sure that the participants' feelings and emotions were expressed by recording participants' quotes.

Whittemore et al (2001) cited in Elo et al (2014:4) proposed primary and secondary validity criteria for critiquing qualitative research. Primary criteria include credibility, authenticity, criticality, and integrity, with credibility and authenticity being similar to the criteria proposed by (Lincoln & Guba 1985 cited in Elo et al 2014:2). Criticality refers to the researcher's decision process and critical appraisal of the evidence and interpretations. Integrity refers to critical reflection to uphold valid interpretations of the data (Diane 2014:89).

3.6.1.6 Ethical considerations

The *Business Dictionary* [online] defines ethics as the branch of knowledge that deals with matters of right and wrong. It refers to moral principles that govern a person's

behaviour or the conducting of an activity. Furthermore, ethics involves systematising, defending, and recommending concepts of right and wrong conduct. In this study, ethics refers to a system of values to which a researcher should adhere while dealing with research participants. “All research that involves human participants needs to be carried out in accordance with fundamental principles of respect, beneficence and justice” (Liphosa 2013:23).

The researcher obtained approval to conduct research from the University of South Africa, Department of Health Studies, Research Ethics Committee (see Annexure A); the Limpopo Provincial Department of Health (see Annexure B); as well as the participating Regional Hospital (see Annexure C). All letters were sent to the respective settings (Provincial Department of Health, and the Regional Hospital). Prior to obtaining consent, all participants received information leaflets (see Annexure D) outlining the purpose of the study and requesting their participation in the study. Consent (see Annexure E) was also obtained for audio recording the discussions during the focus group discussions.

The researcher adhered to the ethical principles of research as outlined:

3.6.1.6.1 Autonomy

The rights, dignity and autonomy of participants were respected. The participants had the right to voluntarily participate in the study. There were not going to be any negative consequences if participants opted to refuse to participate or withdraw from the focus group. The rights of participants and institutions should supersede the researcher’s goal in pursuit of knowledge, Unisa Policy on Research Ethics (Unisa 2013:10).

3.6.1.6.2 Non-maleficence

This refers to preventing harm to the participants. The setting or environment for the focus group discussions was conducive physically and emotionally. The participants’ views were kept confidential. Participants were requested not to share what was discussed in the boardroom with other people outside the room. Participants and researchers signed a confidentiality binding form to ensure confidentiality of discussed information (see Annexure F).

3.6.1.6.3 Anonymity

In her dissertation on ‘ Perceptions of the nurses’ CPD and its contribution to quality patient care’, Liphosa (2013:24) accentuates that the research participants have the right to anonymity and the right to assume that the data collected will be kept confidential. She further states that anonymity exists if the subject’s identity cannot be linked with her or his individual responses. The identity of the participants in this study was not revealed to anybody outside the boardroom. Pseudo names (letters of alphabet, A-H) were used during the FGDs and reporting of the results.

3.6.1.6.4 Confidentiality

Confidentiality, according to Burns and Grove (2009:196) cited in Liphosa (2013:24), refers to the way in which researchers manage private information that is shared by participants in order to ensure that this information is not shared with other people without proper authorisation. Therefore, the discussions were kept confidential. Participants signed a confidentiality binding form to agree to keep discussed information confidential (see Annexure F). In the participants’ letters that the researcher gave to them, has stated that the data collected might be published in nursing journals, and neither the participants nor the institution’s name would be disclosed (see Annexure D).

3.6.1.6.5 Justice

Justice refers to the participants’ right to fair treatment. In order to comply with this principle, the researcher honoured all the agreements that are stated in the information leaflet and was not going to have any grudges against the participants who could have withdrawn from the study. The principle holds that participants should be treated fairly and be given what is due to them. In this study, participation was voluntary. The recorded interviews and field notes were locked away, and access was limited to the researcher (Polit & Beck 2006:91 cited in Liphosa 2013:24).

3.6.1.6.6 Scientific integrity

The researcher intended to conduct the research that would be relevant and essential for pursuance of knowledge and public good. The researcher was honest and transparent about her own limitations and tried to minimise risks. More importantly, the researcher adhered to the Unisa Policy on Research Ethics (Unisa 2013:9), while conducting this study. Research findings are reported accurately without any distortion.

3.6.1.6.7 Obtaining informed consent

Informed consent is a process, not a form. It is the researcher's responsibility to educate the participants about their rights, the purpose of the study, the procedures to be undergone, the benefits and the potential risks of participation so that participants can participate willingly. Burns and Grove (2009:200) cited in Liphosa (2013:25) state that obtaining informed consent from participants is essential to conducting ethical research. Informed refers to the communication of ideas and content by the researcher to the prospective participant. Consent is an agreement to participate in the study (Liphosa 2013:25). The verbal and written consent was obtained from participants (see Annexure E).

3.6.1.6.8 Risks that participants may be exposed to

Physically, the participants were not exposed to any risks. There might have been the risk of fear where participants might be victimised by their employers if the information divulged during the discussion was not kept confidential by fellow participants. Accordingly, the researcher referred participants to the confidentiality binding forms that they have signed to mitigate this risk.

There were no costs incurred by the participants and no harm was envisaged during data collection. The researcher made it clear to participants that there would be no compensation for participation and that there was also no indemnity.

3.6.2 Data collection

In their study on ‘Qualitative Research: Data Collection, Analysis and Management’, Sutton and Austin (2015:228) postulate that whatever philosophical standpoint the researcher is taking and whatever method the researcher chooses, whether focus group or one-to-one interviews, the process will involve the generation of large amounts of data. The authors in that study further report that in addition to the variety of study methodologies available, there are also different ways of making a record of what was said and done during an interview or focus group discussion. In this study, the researcher conducted the focus group discussion and made hand-written notes and audio-recorded the proceedings. That was followed by recordings being transcribed verbatim before the data analysis was commenced (Sutton & Austin, 2015:228). The authors in their study suggested that roughly it could take the researcher eight hours to transcribe one 45 minute audio-recorded interview, which can generate 20-30 pages of written dialogue (Sutton & Austin 2015:228). In this study, it took the researcher 30 days to transcribe verbatim three hours audio-recorded interview. In this regard, it is imperative to have a systematic process of collecting information and to collect only variables that are required, using an instrument designed or adapted for the study. It is important to implement a data-gathering method to collect specific data that can help answer the research question (Curtis & Drennan 2013:3).

3.6.2.1 Data collection approach and method

Focus groups discussions are used to explore different topics in the clinical, educational and management areas within nursing. Perry (2014:18) asserts that a focus group is very flexible, as it is unstructured and results from the focus group are user-friendly and easy to understand. The author further explains that focus group discussions assist in information recall and allow for rich data to be produced. Focus group discussions allow the participants to share their views and experiences in a non-threatening and non-judgmental environment. Focus group discussions have advantages for researchers in the field of health and medicine. They can encourage participation from people reluctant to be interviewed on their own or who feel they have nothing to say. The author continues to describe the focus group discussions as a form of group interview that capitalises on communication between research participants in order to generate data.

3.6.2.2 Development and testing of the data collection instrument

Perry (2014:19) advises that focus group discussion preparation should start with the compilation of a list of the participants according to the wards where they work and their shift allocation in order to contact them. The researcher should make sure that the location and time of the focus group discussion is clear to all participants. However, the setting should not bias the information. A convenient room, which was private was sought where conversations could be held in confidence. In this study, the researcher organised refreshments, which included juice and cookies for participants in order to create a relaxed atmosphere. The group size should range between six to ten participants and the sessions may last from one (1) to two (2) hours (Perry, 2014:19). In this study, the researcher conducted the focus group discussions with 22 participants; the first (1st) and second (2nd) focus groups had eight each and the third focus group had six participants. The information concerning focus group discussions, information leaflets, confidentiality binding forms, consent forms, notebook for field notes and digital audio-recorder were all arranged beforehand.

A set of guiding questions (see Annexure G) was developed prior to conducting the focus group interviews. The supervisor reviewed questions. In this study, the researcher had adhered to the requirements and also conducted a trial interview with peers at work (Ng 2017: 42).

The researcher developed the criteria to gather relevant information to maintain a consistent method of data collection and research control, and ensured that only the required data were extracted. The data were collected manually. The mock exercise that was conducted consisted of three (3) colleagues, registered nurses working from different departments. Two (2) of them were females and one (1) male. The same questionnaire that was used for the data collection were used and the focus group discussion was audio- taped. The length of the focus group discussion was an hour and it was conducted in an office. This exercise helped the researcher to ensure that the questions were well constructed, open-ended, with a clear focus on the study.

3.6.2.3 Characteristics of the data collection instrument

Ryan, Gandha, Culbertson and Carlson (2014:328) assert that focus groups may be used to gather different kinds of evidence. According to Ryan et al (2014:329), focus groups generate evidence that is commonly used for evaluating diverse programmes and policy. The authors of that study further state that focus groups can be used in needs assessment, programme and theory development, implementation and outcome evaluation (Ryan et al 2014:328). Focus group discussions are flexible and efficient and add to the social dimension to verbal data in evaluation (ibid).

The authors of that study propose that focus groups be designed with a focus on the type of evidence to be generated. Depending on the evaluation purpose and context, evaluators may be interested in gathering opinions, which reflect people's stable personal dispositions (Ryan et al 2014:328). The authors of that study further clarify that the focus group is a particular type of group interview where the moderator or the researcher asks a set of targeted questions designed to elicit collective views about a specific topic (Ryan et al 2014:329).

Although interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, focus groups explicitly use group interaction as part of the method. This means that instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each other's experiences and points of view. Moreover, this method is particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way. In this study, the researcher used the focus group discussions to obtain information on participants' experiences on CPD implementation in their workplace, a public regional hospital in Limpopo Province. The researcher in this study proved to be an effective technique for exploring the attitudes and perceptions of participants. Hence the researcher had opted for this method in conducting the research on attitudes and perceptions of nurses and midwives toward the implementation of CPD by the SANC (Ryan et al 2014:329)

The downside of such group dynamics is that the articulation of group norms may silence individual voices of dissent. The presence of other research participants may

compromise the confidentiality of the research session. In her study on 'the pitfalls and promise of focus groups as a data collection method', Cyr (2016:3) highlights that in focus groups, a group of individuals is convened to discuss a set of questions centred on a particular topic or set of topics. The author further asserts that the primary objective of focus groups is to generate conversations that uncover individual opinions regarding a particular issue. The author also states that focus groups help to reveal group consensus, where it exists on the issue at hand (Cyr 2016:3). In this study, the researcher convened a group of 22 participants to discuss their views on the implementation of CPD in their public regional hospital. Conversations were generated and participants discussed the topic that was on the table and somewhere the participants agreed with one another, but they also differed in opinion in other instances. This supports Cyr's (2016:3) assertion.

3.6.2.4 Data collection process

The participants and the researcher were seated in a circle with no boundaries between them. The "please do not disturb meeting in progress" sign was posted on the door of the venue. Each participant was given a card with an alphabet that identified them as speakers. That was to ensure anonymity during the recording of the focus group discussions (Perry 2014:20).

The researcher commenced each focus group discussion by explaining the purpose of the study, declaring ethical clearance approval, clarify of any questions participants had after reading the information leaflet. Participants were requested to give informed consent, sign the confidentiality-binding form and return them to the researcher prior to commencing with the interviews.

The researcher's purpose of the study was to explore the perceptions and attitudes of nurses and midwives towards the implementation of CPD by the SANC in a regional hospital, South Africa. In this instance, the researcher obtained information through talking directly with categories of nurses and midwives at their work place, using the topics on the interview guide and probing further to gather their views and feelings. Importantly, during this process, codes [letters of alphabets, A-H] were used to de-identify the people who were participating in the programme; this was done in order to uphold research control and confidentiality (Ng 2017:36). Some guidelines to the

participants included among others: that there will be no right or wrong answers, only differing points of view; one person should speak at a time while recording; that one does not need to agree with others, but must listen respectively as others share their views and that participants should turn their mobile phones off (Ng 2017:49).

In this study, the researcher explained that the aim of the focus group was to encourage participants to talk to each other rather than to address themselves to the researcher. The sitting arrangement allowed this process to take place because all participants, the researcher and field worker were seated in a circle around the table. This made everybody to feel at ease and that all participants were equal. The researcher took a back seat at first, but later in the session adopted a more interventionist style: urging debate to continue beyond the stage it might otherwise have ended and encouraged the group to discuss the inconsistencies both between participants and within their own thinking (Ng 2017:49).

The researcher remained neutral to ensure that everyone felt comfortable expressing their opinions. The researcher avoided non-verbal gestures such as nodding, or shaking of the head, raising eyebrows, agreeing or disagreeing with comments or praising participants. The note taker/field worker was a volunteer, unemployed youth with a degree in Bachelor of Science in Computer Science, obtained with the University of Pretoria. She was fully orientated by the researcher on what was expected of her during the data collection proceedings .The recorder or note taker/ field worker helped with equipment and refreshments, arranged the room, welcomed participants as they arrived, sat in designated location, took notes throughout the discussion, operated the recording equipment and did not participate in the discussion and asked questions when invited. She gave oral summary to participants at the end of each focus group discussion as part of maintaining the rigour. The note taker was advised that when taking notes, one must anticipate that others will use your field notes. Consistency and clarity are essential during note taking because field notes are sometimes interpreted days or weeks following the focus group when memory has faded (Ng 2017:53).

Field notes contain different types of information and it is therefore essential that this information is easily identified and organised. The field notes contain the following:

- **Quotes**

Listen for notable quotes, the well-said statements that illustrate an important point of view, place name or initials of speaker after quotations. Capture as much as you can and where there is missing information, use three periods to indicate that.

- **Key points and themes for each question**

Participants will talk about several key points in response to each question, which are often identified by several different participants. Sometimes they are said in a manner that deserves attention even if they are said once. At the end of the focus group, the note taker will share these themes with participants for confirmation.

- **Follow up questions that could be asked**

Should the facilitator not be able to follow-up on important points or seek clarification on vague but critical point, the note taker may follow up on such questions at the end of the focus group.

- **Big ideas, hunches, or thoughts of the recorder**

At times the note taker may discover a new concept that did not make sense before; such insights are helpful in later analysis.

- **Other factors**

Factors that might aid in analysis such as passionate comments, body language, or non-verbal activity should be noted. The note taker should also watch for head nods, physical excitement, eye contact between certain participants, or other clues that would indicate level of agreement, support or interest (Ryan et al 2014:329)

In this study, the researcher conducted focus group discussions (focus group discussions) with registered nurses, midwives, enrolled nurses and enrolled nursing auxiliaries. The focus group discussions were conducted at the public regional hospital where the nurses work. The focus group discussion assisted the researcher to explore,

discover and get depth in the type of data obtained. This method makes participants to feel empowered because they share conversations among themselves, with the researcher only facilitating. It [focus group discussion] assisted the researcher to obtain large amount of data in a short space of time. The researcher sought to understand the themes, the issues, narratives, and stories that the participants are prepared to share.

The researcher needed the rich information from participants. A semi-structured focus group guide (see Annexure H) with open-ended questions was used to guide the discussions with the nurses and midwives. Semi-structured in-depth interviews are easy to administer and participants do not require to read. The researcher is able to access non-verbal cues that can provide important data. It also allows the researcher to probe more if mixed messages are observed.This method is flexible because it allows the researcher to follow conversations as they unfold. In order to understand and interpret what one hears properly, the researcher will keep on seeking clarity throughout conversations. During conversations, the researcher maintained her primary role of being a 'listener' and recorded their views and feelings.

Probing was done once the primary questions were asked and answered. An audiotape was used to record the discussions. Field notes were written and a mobile phone was used as the recording backup. The setting was in a quiet boardroom that was conducive in the maintenance of confidentiality and privacy. The 'please do not disturb, meeting in progress sign' was posted on the door of the boardroom. Descriptions of the perceptions and attitudes provided the facts and the context in which they occurred.

3.6.2.5 Ethical consideration related to data collection

Participants were assigned letters of alphabet (A-H) instead of names in order to ensure confidentiality and written informed consent forms were obtained. Furthermore, participants were informed that interviews and their expressed opinions would be recorded via the digital audio-recorder. They [participants] were told that collection of verbal data would be transcribed and analysed. Participants were assured of their confidentiality and protection throughout the study and that there would be no ramifications for anyone who chose to withdraw from the study (Ng 2017:49).

3.6.3 Data analysis

The process of data analysis is to assemble or reconstruct the data in a meaningful manner that is transparent, rigorous and thorough while remaining true to participants' accounts (Noble & Smith 2017:39). The researcher in this study, like with other qualitative methods, gathered and analysed data concurrently. The researcher was able to use descriptive qualitative approaches that assisted to add depth and quality of data analysis. The qualitative research "gold standard" for quality research is data saturation. Instead of relying on the number of participants, which was 22, in this study, the researcher focused on different perspectives and opinions of all participants. The limited literature on reporting data saturation and transparency in qualitative research has supported an inconsistent research standard suggesting researchers have not adequately reported data saturation to promote transparency (Hancock, Amankwaa, Revell & Mueller 2016:2124). Hancock et al (2016:2124) underscore that the current approach states that thematic data saturation is reached when there are no new emerging ideas in the data. The researcher in this study continued to probe the participants until saturation was reached with the third (3rd) focus group discussion.

The fact that data saturation has multiple meanings results in it having limited transparency (O'Reilly & Parker 2013 cited in Hancock et al 2016:2125). The authors further state that the researcher is obliged to present their research findings in a manner that permits transferability; they [researchers] discuss the need to present thematic sentences in the form of sets to enhance the visualisation of the data for clarity and transferability. Without a clear presentation of research findings, the reader cannot transfer the results placing trustworthiness in question. In this study, the researcher stated all the findings in a manner that could be transferable to other viewers.

Determining data saturation for a focus group is challenging. Few articles discuss data analysis of focus group data and application of the data to ensure trustworthiness. Hancock et al (2016:2125) argue that focus group data must be reviewed in its entirety analysing the data as a group, then individual opinions not conforming to group consensus must also be considered. Manoranjitham supported the author and Jacob (2007) cited in Hancock et al (2016:2125) in that focus group data must be presented in descriptive form highlighting differing individual beliefs. In contrast, Kidd and Parshall (2000) cited in Hancock et al (2016:2125) accentuate that there is not a single unit of

analysis but the individual, group, or both could be the focus of the analysis (Hancock et al 2016:2126). The researchers further identified that employing flexible analytical approaches to identify influences on the individual or group must be considered prior to developing conclusions. The researchers set their criteria for data saturation at five responses per theme and subtheme based on group analysis. Each time the participant discussed a theme or subtheme, the response was logged. In summary, the authors employed three different methods of data analysis to confirm saturation and transparency, namely, data saturation by group; data saturation by individual participant and data saturation by day of study (Hancock et al 2016:2127). In this study, the researcher employed data saturation by group and by individual.

The recordings were converted into computer files with passwords created to keep them safe. Audiotapes were transcribed verbatim. The researcher ensured that verbatim actual work is captured correctly prior to analysis. Content analysis was done.

The researcher used the six generic steps detailed by Patton (2002) cited in Ng (2017:47) which are as follows:

- Organisation and preparation of data: the researcher travelled to a Regional Hospital in Limpopo province where the focus group interviews were conducted as permitted by the authorising institutions.(Saunders et al 2012) purported that such a sampling approach and collection of data can be facilitated in a short duration (Ng 2017:47).
- The researcher read through the data to get a general sense of the meaning. All the data were re-read several times; transcripts were cross checked, with the recordings and edited for accuracy. This practice further enabled the researcher to familiarise herself with the data where the researcher made brief notes in a separate notebook as themes emerge from the large amount of qualitative data (Ng 2017:50).
- Generation of themes to find patterns of meaning across the data (Crowe, Inder, & Porter 2015 cited in Ng 2017:50).
- A broad list of themes were initially identified and reviewed several times to refine and generate subthemes.
- Representation of themes.

- Interprétation (O'Mahony et al 2014:3).

The transcripts were read, coded and categorised into themes and sub-themes. For example, throughout the interview, matters pertaining to the challenges that participants experience in their workplace were noted. The Qualitative Data Analysis process included:

- Organising data: patterns and themes
- Exploring data: meaning of data
- Interpreting or reflecting on data: make sense of what it means

In order to confirm the themes, the researcher, independent coder and the study supervisor coded the first transcript, therefore agreeing on a framework to use to analyse the remaining two transcripts. Content analysis is a research method for studying virtually any form of communication, consisting primarily of coding and tabulating the occurrences of certain forms of content that are being communicated" (Rubin & Babbie,2016:401). It is a process of categorising verbal or behavioural data to classify, summarise and tabulate data. It can either describe or interpret (what is the data?) (what is meant by the data?)

The model of qualitative content analysis helps to identify the research question, what the researcher is trying to explain. The researcher would then determine the analytic categories based on literature and research question (Lune & Berg 2017 cited in O'Mahony et al 2014:3).

3.6.3.1 Steps for conducting qualitative data analysis

When researchers speak of qualitative content analysis, they are mostly likely referring to the analysis of written texts. Content analysis can be conducted utilising a variety of data sources, including text, video or audio. In this study, the discussion of the basic steps involved in the process of qualitative content analysis focuses on textual content. Content analysis should be able to answer the following questions:

- What are the key objectives of the research study?
- What are the relevant constructs associated with the research objectives?
- What is already known about these constructs in conjunction with the current research issue and objectives? (Roller & Lavrakas 2015:234).

The answers to these questions give the researcher the necessary tools to design a credible content analysis that accurately measures specific constructs as well as the overall research objectives. The materials that the researcher needs to prepare in order to conduct textual content analysis entail converting audio recordings or group discussions into transcripts. In this study, the researcher went back to the audio as necessary to fine-tune the transcripts for accuracy and collecting the textual content of interest. The researcher also used the eight basic steps in the qualitative content analysis method are dived into two (2) phases, namely:

Phase 1: Data generation (coding)

Coding the content leads to generation of data that will be analysed in Phase 2.

Phase 2: Data analysis (categorisation and interpretation)

Analysing the data created in Phase 1.

This was done by identifying categories and themes by the researcher.

Finally, the researcher developed interpretations of the findings. See phases and steps as summarised in figure 3.1 (Roller & Lavrakas 2015: 235).

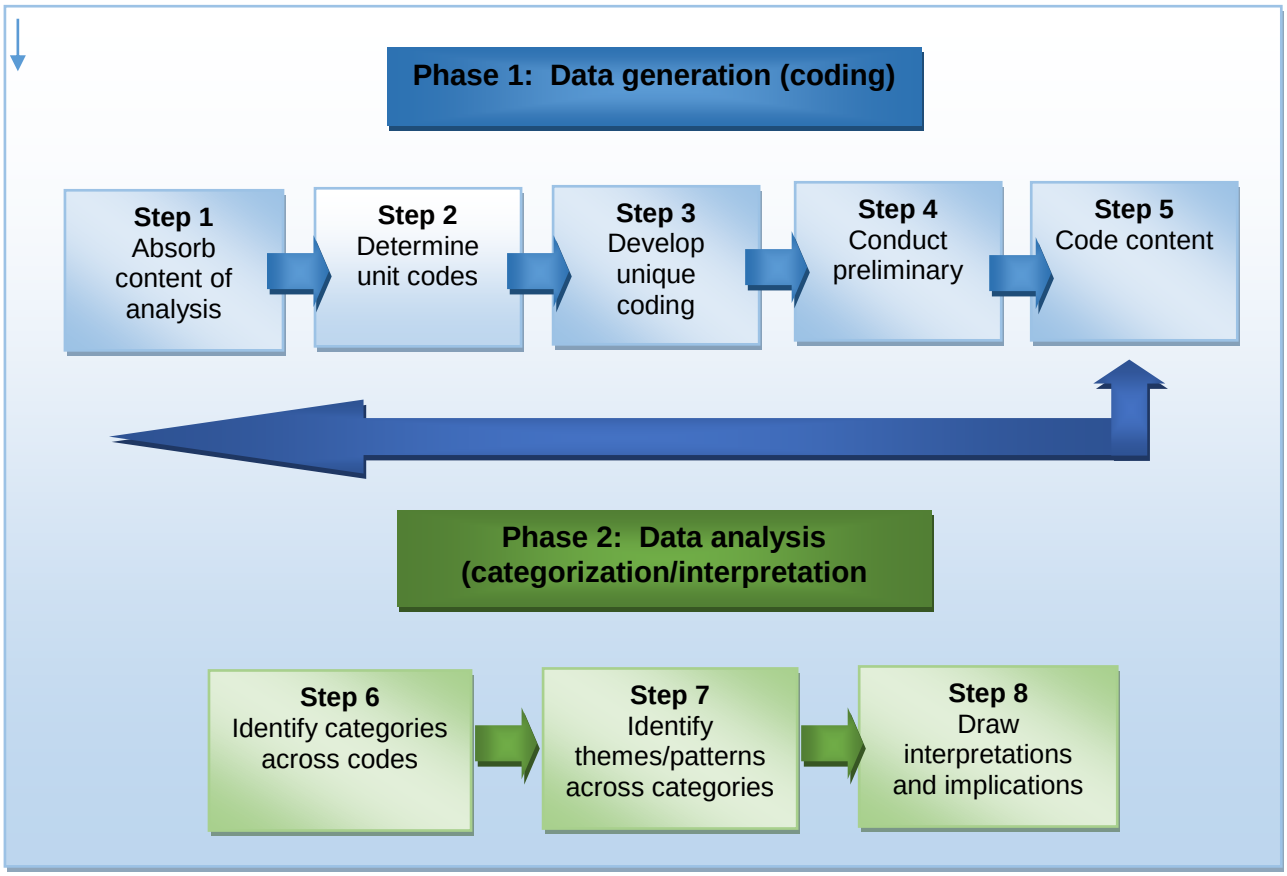

Figure 3.1 Phases and steps in qualitative content analysis

(Adapted from Roller & Lavrakas 2015:235)

Phase 1: Data generation (coding)

- **Absorb the content**

The first (1st) critical step in content analysis was to gain an understanding of the complete content, which was the data from all data sources. The aim was for the researcher to get a sense of the whole picture and not to attempt to find meaning. This was accomplished by reading and re-reading the written material. Word and phrase repetitions; the researcher scanned the primary data for words and phrases most commonly used by respondents, as well as, words and phrases with unusual emotions. This assisted the researcher to start connections in the content (Roller & Lavrakas 2015:235).

- **Determine the unit of analysis**

This unit might be particular to the text - such as the entire response to a particular question or each sentence in the content, or might be particular to the providers of the

content such as research participants. At times, researchers use some aspect of the text itself as a unit of analysis. According to Milne and Adler (1999) cited in Roller and Lavrakas (2015:236), sentences are far more reliable than any other unit of analyses. Sentences usually give contexts to words, which would otherwise have little meaning. The appropriate unit of analysis will vary from study to study (Roller & Lavrakas 2015:236).

- **Develop unique codes**

After the researcher had studied the content in step 1 and focused on the unit of analysis in step 2, the researcher was now prepared to systematically 'comb' the content to develop a coding scheme. Codes enabled the researcher to condense typically large amounts of textual content into manageable and analysable format. To develop the codes, the researcher carefully read text from the perspective of the research objectives and associated constructs as well as the context in which particular words were spoken or ideas were conveyed (Roller & Lavrakas 2015:236). Accordingly, the researcher looked at the objectives in broad terms so as not to miss unanticipated insights in the content. Each code was clearly defined, unique and independent from the other codes. The researcher used operational definitions that assisted in coding reliably. The researcher accurately identified the correct code and order to later find meaning in the data, and not vague once such as 'quality' or 'convenience' (Roller & Lavrakas 2015:236).

In this study, the coding scheme was recorded in a codebook that detailed the name or label of the code, its definition and verbatim example from the data. The codebook is a live document. It is not stagnant because code development in qualitative content analysis is an interactive process, by which new codes are added and existing codes are revised as the researcher gains new insights in the course of coding. The researcher continuously updated the codebook, improved and enhanced it (Roller & Lavrakas 2015:237).

- **Conduct preliminary coding**

Once the initial codes have been developed, their viability is tested by coding a subset of the content. This is the pilot test of the proposed coding scheme. Two or more co-

coders will independently conduct the preliminary coding so that at a later stage they can meet with the researcher to compare their code assignments, discuss and resolve any discrepancies. This check on intercoder consistency is critical to the credibility and analysability of the outcomes of all content analysis studies. Following the discussions with other coders, the researcher might derive a new understanding of the codes as well as content itself. Primary and secondary data comparison; the researcher compares the findings of the focus group discussions with the findings of literature review and discuss the difference between them. Resolutions with the coding are made by consensus or by the principal researcher who has the final responsibility and authority to make decisions if there is no consensus. The researcher will also use any issues that arise from the preliminary coding to update the codebook with revised or additional code (Roller & Lavrakas 2015:237).

- **Code the content**

The coders go about assigning codes to the entire set of contents that is being analysed in a particular study. It is during this period that the principal researcher meet regularly with coders to learn about, discuss, and resolve any unanticipated issues in the coding of the content that do not appear to correspond with the existing coding scheme. The importance of capturing context is essential to the content analysis method. Therefore, coders should also be trained in that aspect. Drawing meaning and inference by way of context in qualitative research is central to the qualitative content analysis method. Through a complete and accurate account of the context pertaining to a particular code assignment, the researcher may be led to inappropriate interpretations that ultimately weaken the usefulness of the research (Roller & Lavrakas 2015:237).

Phase 2: Data analysis (categorisation/interpretation)

- **Identity categories across codes**

At this stage, the researcher can then look for meaningful categories across codes that will help illuminate possible connections and patterns. This is the best time to identify these categories after coding the dataset, rather than before, because the coding scheme will likely have shifted much during the process. A category is any group of codes, along with the textual data to which they are assigned, which share an

underlying construct. The categories, the same as the coding process, are based on scrutiny at both the manifest and latent levels, which allow the categorisation to be conducted without the loss of context and, to the contrary, enriching the meaning of data (Roller & Lavrakas 2015:238)

- **Identify themes or patterns and relationships across categories**

Once the data are coded and the pertinent categories are established, the researcher will be ready and prepared to look across the codes that define each category and across all categories to discern themes or patterns in the data. This identification process can be highlighted by using colour marking pens to signify the coded data based on particular categories and codes. Data can be displayed in the form of a worksheet or virtual map. A worksheet should have the categories running as 'fields' or column headings across the top and each case that is being studied running vertically representing a row. Within each cell of this grid, the researcher can record the input from each case pertaining to each category. Once completed, the data display can be colour highlighted to reveal the extent of mentions of a particular concept or construct, as well as to provide a visual depiction of the conceptual patterns in the data. Visual maps are also very effective in enabling the researcher to see the connections from which patterns can be more easily identified (Roller & Lavrakas, 2015: 239).

- **Draw interpretations and implications from the data**

At this last step of the content analysis, the researcher should already have started with her own interpretations of the data and formed preliminary implications. It is important for the researcher to verify these interpretations and implications at this stage by way of triangulation (this means comparing the interpretations and implications drawn by multiple researchers on the same data and data display) and negative or deviant case analysis. Search for missing information: If there is information that the researcher was expecting to find from the participants, but not mentioned, such information should be highlighted (Roller & Lavrakas 2015:239).

Summarising the data: At this stage, the researcher links the research findings to research aim and objectives. Noteworthy quotations from the transcript will be included in the findings to highlight major themes and possible contradictions.

3.7 CONCLUSION

This chapter discussed research methodology and design. The population, sampling, data collection, and data analysis were discussed. Ethical considerations and measures taken to ensure trustworthiness were presented. Chapter 4 will present data analysis and interpretation.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

Chapter 3 described the methodology and research design adopted in this study. This chapter presents the data analysis and interpretation of the results. Data were obtained from the focus group discussions that were conducted in a public regional hospital in Limpopo Province, South Africa. This included the demographic data, content analysis, data analysis, themes, sub-themes, and codes.

Austin and Sutton (2015:4) argue that doing qualitative research is about putting oneself in another person's shoes and seeing the world from the other person's perspective. In their study on data collection, analysis and management, the authors contend that the most important aspect of data analysis and management is to be true to the participants. Austin and Sutton (2015:4) maintain that the researcher is trying to hear participants' voices so that the researcher can be able to interpret and report on them for others to read and learn from; it should not be the voice of the researcher. The data that emerged from the descriptions given by the participants should be reported as such and should not lose its meaning. In this study, the researcher listened and heard the voices of the participants in the focus group discussions and was ready to report on them for others to access and learn. The participants in this study were composed of eight registered nurses, eight enrolled nurses and eight (6) enrolled nursing auxiliaries. A total of 22 nurses participated in the study from the public regional hospital in Limpopo Province.

4.2 CONTENT ANALYSIS

The process of data analysis is to assemble or reconstruct the data in a meaningful manner, which is transparent, rigorous and thorough while remaining true to participants' accounts (Noble & Smith 2017:39). Content analysis is a detailed and systematic examination of the contents of a particular body of material for the purpose

of identifying patterns, themes or biases within that material. It is the gathering and analysis of textual content. It is performed on forms of human communication (ibid).

4.3 DATA MANAGEMENT AND ANALYSIS

The researcher in this study, like with other qualitative methods, gathered and analysed data concurrently. The researcher was able to use descriptive qualitative approaches that assisted to add depth and quality of data analysis. The qualitative research "gold standard" for quality research is data saturation. Instead of relying on the number of participants, which was 22, in this study, the researcher focused on different perspectives and opinions of all participants. The limited literature on reporting data saturation and transparency in qualitative research has supported an inconsistent research standard suggesting researchers have not adequately reported data saturation to promote transparency (Hancock et al 2016:2124). Furthermore, Hancock et al (2016:2124) maintain that the current approach states that thematic data saturation is reached when there are no new emerging ideas in the data. The researcher in this study continued to probe the participants until saturation was reached with the third focus group discussion.

The fact that data saturation has multiple meanings results in it having limited transparency (O' Reilly & Parker 2013 cited in Hancock et al 2016:2125). The authors further maintain that the researcher is obliged to present their research findings in a manner that permits transferability. They [researchers] discuss the need to present thematic sentences in the form of sets to enhance the visualisation of the data for clarity and transferability. Without a clear presentation of research findings, the reader cannot transfer the results placing trustworthiness in question. In this study, the researcher stated all the findings in a manner that could be transferable to other viewers.

Determining data saturation for a focus group is challenging. Few articles discuss data analysis of focus group data and application of the data to ensure trustworthiness. Hancock et al (2016:2125) argue that focus group data must be reviewed in its entirety analysing the data as a group, then individual opinions not conforming to group consensus must also be considered. In this study, the researcher employed data saturation by group and by individual.

The researcher used lockable cupboards to store the audiotapes and field notes. The recordings were converted into computer files with passwords created to keep them safe. Audiotapes were transcribed verbatim. The researcher ensured that verbatim actual work is captured correctly prior to analysis. Content analysis was done. The researcher used the six generic steps detailed by Patton (2002) cited in Hancock et al (2016:2125) which are:

The researcher travelled to a regional hospital in Limpopo Province where the focus group interviews were conducted as permitted by the authorising institutions (see Annexures A- D). Ng (2017:47) purports that a sampling approach and collection of data can be facilitated in a short duration. The focus group discussion was used by the researcher in this study to obtain data. The researcher read through the data to get a general sense of the meaning. All the data were re-read several times and transcripts were cross-checked, with the recordings and edited for accuracy. This practice further enabled the researcher to familiarise herself with the data where the researcher made brief notes in a separate notebook as themes emerge from the large amount of qualitative data (Ng 2017:50). The researcher generated themes to find patterns of meaning across the data (Crowe, Inder & Porter 2015: 616). A broad list of themes was initially identified and reviewed several times to refine and generate subthemes (O'Mahony et al 2014:3). The transcripts were read, coded and categorised into themes and sub-themes. For example, throughout the interview, matters pertaining to the challenges that participants experience in their workplace were noted. The Qualitative Data Analysis process was followed by the researcher, which included organising data patterns and themes; exploring data for meaning and interpreting data to make sense of what it meant.

The first transcript was coded by the researcher, independent coder and the study supervisor to confirm the themes and codes, therefore agreeing on a framework to use to analyse the remaining two (2) transcripts. Content analysis is a research method for studying virtually any form of communication, consisting primarily of coding and tabulating the occurrences of certain forms of content that are being communicated" (Rubin & Babbie, 2016: 401). It is a process of categorising verbal or behavioural data to classify, summarise and tabulate data. It can either describe or interpret (what is the data?) (what is meant by the data?).

In this study, the discussion of the basic steps involved in the process of qualitative content analysis focused on textual content. Content analysis should be able to answer the following questions. The researcher was able to obtain responses to the key objectives of the research study and what is already known about these constructs in conjunction with the current research issue and objectives? (Roller & Lavrakas 2015:234).

The researcher conducted textual content analysis by converting audio recordings or group discussions into transcripts. This included going back to the audio tapes when the need arose, fine-tuned the transcripts for accuracy and collected the textual content of interest. Most importantly, the researcher made sure that she understood the complete content, which is data from all data sources by absorbing the content. The aim was for the researcher to get a sense of the whole picture and not to attempt to find meaning. The researcher was able to accomplish this by reading and re-reading the written material. Word and phrase repetitions; the researcher noted the primary data for words and phrases most commonly used by respondents, as well as, words and phrases with unusual emotions (Roller & Lavrakas 2015:235).

The unit of analysis might be particular to the text such as the entire response to a particular question or each sentence in the content, or might be particular to the providers of the content such as research participants. At times, researchers use some aspect of the text itself as a unit of analysis. According to Milne and Adler (1999), sentences are far more reliable than any other unit of analyses. In this study, the researcher used sentences to give context to words which would otherwise had little meaning. Roller and Lavrakas (2015:236) assert that the appropriate unit of analysis will vary from study to study.

According to Roller and Lavrakas (2015:236), codes enable the researcher to condense typically large amounts of textual content into manageable and analysable format. In this study, to develop the codes, the researcher carefully read the text from the perspective of the research objectives and associated constructs as well as the context in which particular words were spoken or ideas were conveyed (Roller & Lavrakas 2015:236). The researcher in this study ensured that each code was clearly defined, unique and independent from the other codes.

The researcher used a codebook to record the unique codes that details the name or label of the code, its definition and verbatim example from the data. The codebook is a live document; it is not stagnant because code development in qualitative content analysis is an interactive process by which new codes are added and existing codes are revised as the researcher gains new insights in the process of coding. The codebook is continuously updated, improved and enhanced (Roller & Lavrakas 2015:237). In this study, the researcher and the independent co-coder kept the codebook alive by adding new codes as and when they were identified. At a later stage, the researcher and the co-coder met to compare their code assignments, discussed and resolved the discrepancies. This check on intercoder consistency is critical to the credibility and analysability of the final outcomes of all content analysis studies. Following the discussions with other coders, the researcher derived a new understanding of the codes as well as content itself. The researcher compared the findings of the focus group discussions with the findings of literature review and noted the difference between them. Resolutions with the coding are made by consensus or by the principal researcher who has the final responsibility and authority to make decisions if there is no consensus. Accordingly, the researcher used the issues that arose from the preliminary coding to update the codebook with revised or additional code. The researcher assigned codes to the entire set of contents that was being analysed in this study (Roller & Lavrakas 2015:237).

The researcher started to look for meaningful categories across codes that helped to illuminate possible connections and patterns. The researcher in this study saw it as the best time to identify these categories after coding the dataset, rather than before, because the coding scheme will likely have shifted much during the process (Roller & Lavrakas 2015:238).

The researcher displayed data in the form of a worksheet or virtual map. Three columns were drawn on the worksheet with ‘fields’ or column headings across the top and each case that is being studied running vertically representing a row. Within each cell of this grid, the researcher recorded the input from each case pertaining to each category. Once completed, the data display was colour highlighted to reveal the extent of mentions of a particular concept or construct, and provided a visual depiction of the conceptual patterns in the data. Visual maps are also very effective in enabling the

researcher to see the connections from which patterns can be more easily identified (Roller & Lavrakas 2015:239).

As the last step of the content analysis, the researcher drew interpretations and implications from the data. The researcher also checked for missing information that is the information that the researcher was expecting to find from the participants, but not mentioned. The researcher highlighted such information (Roller & Lavrakas 2015:239).

The researcher summarised the data and linked the findings to research aim and objectives. She included noteworthy quotations from the transcripts in the findings to highlight major themes and possible contradictions.

4.4 RESEARCH RESULTS

Content analysis of the transcripts yielded three (3) themes with associated sub-themes and codes emerging from the collected data during the three (3) Focus Group Discussions. These were:

- Theme 1: Views regarding CPD implementation at the Public Regional Hospital
- Theme 2: Attitudes of nurses and midwives regarding CPD Implementation at the Public Regional Hospital
- Theme 3: Recommendations to enhance CPD implementation for nurses and midwives

4.4.1 Demographic data

The demographic data reflect the participants' gender and nursing category. The nurses and midwives' years of experience in the profession were not obtained. The groups consisted only of nurses belonging to one race. Moreover, the groups were purposively selected for meeting the criteria of being exposed to CPD implementation for the past two years in their regional public hospital where they are working.

A total of 22 nurses, of whom three were males and 19 were females, participated in the focus group discussions. registered nurses were eight (8), enrolled nurses were also eight and enrolled nursing auxiliaries were six.

Table 4.1 depicts the demographic attributes of the participants

Table 4.1 Demographic information

	Focus group 1 (n= 8)	**Focus group (2=8)**	**Focus group 3 (6)**
Gender	Males: 1 Females: 7	Males: 1 Females: 7	Males: 1 Females: 5
Nurse category	Registered nurses: 8	Enrolled nurses: 8	Enrolled nursing Auxiliaries: 6

Twenty-two (22) nurses, of whom three were males and 19 females, participated in the focus group discussions. Registered nurses were eight (8), Enrolled nurses were also eight (8) and Enrolled nursing Auxiliaries were six (6).

Note: Theme 1 has two sub-themes and 18 codes; Theme 2 has two sub-themes and eight codes and theme three has five sub-themes and eight Codes. The verbatim quotes of focus group discussions are represented as per focus group transcription number and participant alphabet, e.g. Focus group transcription 1 and participant H will be quoted as Tr1, PH.

4.4.2 Theme 1: Views regarding CPD implementation at the Public Regional Hospital

Participants identified the benefits and challenges regarding CPD implementation in their hospital. Table 4.2 depicts Theme 1, its two sub-themes and their codes.

Table 4.2 Theme 1: Views regarding CPD implementation at the Public Regional Hospital

Theme 1	Sub-themes	Codes
4.4.1 Views regarding CPD implementation at the Public Regional Hospital	4.4.1.1 Sub-theme 1: Benefits of CPD attendance	Code 1: Up-to-date knowledge and skills Code 2: Peer group teaching Code 3: CPD activities promote networking and team building Code 4: Correlation of theory and practice
	4.3.2.2 Sub-theme 2: Challenges regarding CPD implementation	Code 1: Lack of educational resources Code 2: Shortage of staff Code 3: Portrayal of SANC as a 'scare crow'

4.4.2.1 Sub-theme 1: Benefits of CPD attendance

Code 1: Up-to-date knowledge and skills

Participants reported that it was important for nurses and midwives to attend CPD activities and events in order that they may develop knowledge, skills, improve their attitudes, and add value to the profession. They indicated that nursing is not stagnant and those who attend CPD activities provide safe patient care because they learn about new diseases and how to manage them and how to deal with both adults and paediatric emergencies.

> Tr2, PH
>
> "Nursing is not stagnant … is continuous … now these days when you check CPR (cardio-pulmonary resuscitation), you are not going to check the airway first, you are going to check the pulse first. So, … If you are not going to attend the ... CPD points, then you will never know., just because most of the time we are busy in the ward, you can't just sit down and say let's give a lecture of this, sometimes in casualty when you sit down, and want to give a lecture, the patient comes , and we all stand up attend the patient ,then you'll never go back and give the

lecture, then usually, in our wards, it's busy everyday it's not easy, sometimes you can do that, sometimes you can't do, sometimes we do but we failed, just because to do that in our wards, In our wards, it is busy every day, you can't give lectures. Most of the time in the wards because it is always busy".

Tr1, PE

"We need to know or in-service ourselves, we need to revive ourselves for continuity of care …"

Tr2, PG

"CPD point is very much important according to my view … nursing is not something, stagnant, it's something developing; when we go to CPD point… development, they are teaching us about something and … it is very much important for us**,** probably because, … some other nurses we have some attitudes towards patients, and then since CPD points was introduced we are improving, … nurses are having attitude since CPD was introduced to us, we have changed a lot …"

Participants viewed CPD as very important in that presentation of new diseases in casualty and orthopaedic cases were presented. They learned what was taking place in other wards/units, thus gaining new knowledge.

Tr2, PB, Pg3

"I think it's very important to us just because when you go to the CPD points, they are presenting some of diseases that you might know how to treat it or to manage the patient, then, sometimes we work in casualty and they are presenting casualty cases and then someone from orthopaedic, he will present with something that they have been seeing in orthopaedic that I did not know how to treat it, ward, then I did not know from orthopaedic …"

Tr2, PF

"CPD is very fruitful; because we are developing us, it is reviving nursing (demonstrating with hands), because we learning … we are learning a lot of things, I am working in orthopaedic ward, it is a specialised ward, but sometimes when we go to CPD, we learn different conditions from somebody working in surgical ward or paeds, a lot of things, Orthopaedic learning a lot of things from surgical wards (showing with hands) or paeds."

I am working with fractured patients, of which is specialised, I can't just be like this, but when I attend CPD, I become broad. It is very fruitful."

It was also reported that proficiencies in emergency care are developed. Participants in this study reported that nurses developed skills in resuscitation of both adults and paediatrics; stereotypes pertaining to one's unit/ward were removed at CPD. Participants agreed that CPD has helped them to update their knowledge and skills on CPR as it changes rapidly. They indicated that currently CPR starts with pulse, not airway any longer, therefore making CPD very important.

Tr2, PH

"CPR of the past is not the like CPR of this nowadays. Last, ... The CPR of the old, when the patient is fainting you start checking the airway, but CPD of today, you start with the jugular, the pulse of the patient, not the airway. It is very much important…check pulse first"

Tr2, PB

" Resuscitation of the paeds (patients), … you will be learning more, even if you come across such a problem of emergency, you will be saving the lives of patients, you cannot say you don't know the resuscitation of paeds, I know to rescus adults, there is a difference thing between resuscitation of paeds and adults, you see … if you are working in maternity … you only learn the things that you come across in maternity, then you don't even know about resuscitation of paeds but you only know resuscitation of adult life of patients. You don't know resuscitation of paeds, then somebody can come in CPD in the boardroom, then she will be presenting about, that."

Code 2: Peer group teaching

Participants felt that those who attend CPD activities add value to those who remain in the unit, colleagues who have attended CPD presentations, develop others, so said the participants. They [participants] felt that not all nurses can attend CPD workshops. Therefore, those who have attended would share the information with those who did not manage to attend. As such, participants felt that they get more information from those who attended workshops.

Tr2, PD

"I think it's more important because not all of us go to the workshops and if somebody from another ward has gone to the workshop, from our wards, there is no one from the workshop, in other wards there is someone from the CPD point in other words, if we go to the CPD points, they give us more information about their workshops, on CPD points there is someone who has attended the workshops, then they develop us, workshops, then they develop us. In other wards, there's someone has been workshops, they will give us more information. In other wards there is somebody who has been workshopped …"

CPD reminds nurses and midwives of their obligations, of their purpose and how to take care of their patients. The participants were of the view that CPD is progressive because it enables nurses and midwives to gain more knowledge and enables them to educate one another in terms of professional ethics, professional management, professional leadership, and better relations.

Tr2, PC

"… hen we are there, it reminds us why we are here for patients, because we are here for the patients … it reminds us that, on how to take care of our patients in the wards, and to teach one another."

Code 3: CPD activities promote networking and team building

Participants stated that CPD assisted them with coping mechanisms for issues that they would not discuss with other colleagues, such topics were handled at CPD presentations.

Tr2, PB

"CPD activities help nurses to deal with issues that they cannot share with others. Topics addressed at CPD on burning issues, make participants to learn coping mechanisms to deal with difficult issues they face in life So If you will be dealing with a burning issue that you cannot even reveal it to someone a burning issue to the others. When we are together in the CPD points (activities), may be they can give us a topic on how to deal with burning issues or how to deal with this, then we gain a lot…"

They [participants] further stated that attendance at CPD improves interpersonal relationships. For the lower categories, they indicated that CPD helped them to build confidence and reminded all nurses about their obligations of rendering quality patient care. Participants viewed CPD as offering team-building opportunities; they got to know each other and make relationships. They felt that they spent most of their time in hospital.

Tr2, PB

"CPD promotes interpersonal relationships and team building opportunities. When we get together we will know each other in the hospital that who is he or who is that, and we are going to … something like, to entertain ourselves; we are here 99% of our year, whatever, whenever, we are in the hospital …"

Code 4: Correlation of theory and practice

Participants reported that CPD assisted them to correlate theory with practice, which had always been a challenge. In addition, they appreciated that CPD had motivated them to remain up-to-date with new developments; they cited an example of CPR, which has evolved over time. Participants stated that CPD has assisted them to learn new conditions, especially in Casualty and Maternity wards. The lower categories indicated that CPD removed the stereotypes that they always carried. They felt that CPD helped them in that they can now assist in emergency deliveries.

Tr2, PE

"… CPD helps nurses and midwives a lot … we are having those who are from in the maternity you'll' find that they will call you to come and assist patients in labour how to give birth. CPD builds nurses' confidence to intervene in emergency situations, especially for enrolled nursing auxiliaries …"

Participants reported that CPD was very crucial and beneficial. They reported that there were other conditions that nurses and midwives would learn at CPD sessions. They reiterated that there was a problem of correlation of theory and practical in the wards. Therefore, CPD enabled nurses and midwives to learn skills and conditions. There are

other conditions that nurses and midwives will learn at CPD that they did not know before. Nurses stated that attending CPD was very crucial and had benefits.

> Tr1, PG
> "… what I feel about the implementation of CPD … it's really a good thing in short … because here is where you learn more skills and conditions. Because if you check, there are other conditions that we just know, but when coming to the implementation in the ward, correlating theory that you know and together practical, it's a problem. If you go to the CPD point and we learn more knowledge, that is in certain conditions, then we are able to correlate whatever we have just learnt in the practical situation, So, I think it is very a nice thing and we should just continue doing and attending because it is very crucial and very beneficial."

Participants reported that nurses gain knowledge on specialised care in other units, beyond what transpires in their units such as orthopaedics and maternity. Nurses and midwives should not give excuses for not attending CPD, they lose out

> Tr2, PB
> "If you are working in maternity, you only know procedures in maternity. If you come across with an orthopaedic patient with fracture, you will be knowing how I am going to immobilise the fracture, if you are working in maternity, you will never know how to immobilise the fracture. So if you go to CPD points, they will teach you how to immobilise the fracture, and you will gain knowledge, so if you go to the CPD points, they will teach you how to immobilise the fracture …"

4.4.2.2 Sub-theme 2: Challenges regarding CPD implementation

Code 1: Lack of educational resources

Participants aver that CPD implementation in their institution does not go without challenges. They cited lack of resources and shortage of staff as the main barriers to CPD. The institution where the study was conducted was cited as not having Internet connection to allow for eLearning and eBooks to be accessed. The library was cited by participants as being too small and did not have updated books for reading and learning.

Tr1, PD

"… Internet connection is very important … eBooks, resent books and internet connection ((demonstrating with hands) …"

Code 2: Shortage of staff

In this study, participants stated that shortage of staff was preventing nurses to attend CPD activities because they have to look after patients in the units and have to be allocated on night duty most of the time. Participants indicated that the CPD coordination was challenging as only one (1) CPD presenter was allocated for all CPD activities in the institution, including scheduling of CPD activities. They felt that in spite of the presenter being available for CPD, nurses and midwives would not attend owing to shortage of staff experienced in the wards/ units. Nurses and midwives were overloaded and as such non-attendance of CPD activities could even go beyond a month.

Tr1, PB

"Due to shortage of staff, you find that in a month we attend once or twice instead of every week. More staff! If I have somebody, I will be able to attend, but if there is no one in the ward, I am not attending at all. I can't attend the CPD … because there is no one in the ward."

Tr2, PC

"… according to me, since CPD started, I didn't go to attend; because of our shortage in our ward; to me I don't think it is important because of shortage … if we have shortage in the ward to go to attend there and then you leave the patients in the ward and nobody attend, nobody attending the patients, I … I don't think it's important for me and like in our ward we have a lot of shortage …"

Tr1, PH

"… I am working night shift, too much night shift in (names the ward) … I have never went to CPD points, I have never went there, the thing is … is it compulsory to go to boardroom … (Pause) to present? Or is it ok to present in the ward? because … there is shortage of staff, there, you are going to stay

there, and in and to attend the CPD points, and at the ward you are going to find it the way you left it, and you continue from where you left."

Code 3: SANC portrayed as a 'scare crow'

Participants felt that management threatened them that SANC was going to remove them from the Council Register if they did not comply with CPD requirements. They reported that SANC was portrayed by the nurse managers as a 'scare crow' to threaten nurses for non-attendance and non-accrual of CPD points.

Tr2, PA

"… they say (nurse Managers) the SANC is going to penalise us, and then, you can't even pay SANC to get APC because you don't even have the 15 CPD points that the SANC want. We will be doing this because we do not want to go, I can just go and sit, and get a signature and maybe I don't learn anything when I am not learning anything different challenges, you should not go attend because it is a threat, go willingly. Not that they are going to penalise me with something."

Tr2, PE

"… according to our institution, it's a threat, because … they say if you don't have 15 points you are going to be penalised. It means it is ours because of we sacrifice and we go to night shift because we go night shift, because there is shortage of staff … because during the day maybe I can go when I go to leave going but most of the time I am going to work night, because for now, I have kids, I will work 2years day, if it was not because of the kids, I was going to work night even not going to attend this workshop, because our knowledge, our managers told us that it is a threat."

Tr2, PA

"I think the SANC may recommend it, but not to penalise other people if they failed to raise those points because there is shortage."

4.4.3 Theme 2: Attitudes of nurses and midwives regarding CPD Implementation at the Public Regional Hospital

Participants identified the benefits and challenges regarding CPD implementation in their hospital. Table 4.2 depicts Theme 1, its two sub-themes and their codes.

Table 4.3 Theme 2: Attitudes of nurses and midwives regarding CPD Implementation

Theme 2	Sub-themes	Codes
4.4.3 Attitudes of nurses and midwives regarding CPD implementation at the Public Regional Hospital	4.4.3.1 Sub-theme 1: Negative attitudes towards CPD implementation	Code 1: Work overload as a deterrent to CPD attendance Code 2: Discrimination between nurse categories Code 3: Lack of insight regarding the scopes of practice for various nursing categories Code 4: Prioritising patient care over CPD attendance Code 5: Confusion regarding the allocation of CPD points versus the renewal of the practising license Code 6: No consultation by SANC, No CPD activities attendance by nurses Code 7: Lack of resources for CPD implementation
	4.3.3.2 Sub-theme 2: Positive attitudes towards CPD implementation	Code 1: Peer teaching embraced Code 2: Current knowledge in practice leads to improved patient outcomes

Sub-theme 1: Negative attitudes towards CPD implementation

Participants gave many excuses to support their non-attendance of CPD sessions and non-accrual of CPD points, 'hiding behind the thumb'. Among others, excuses were ever busy wards throughout the year; not being treated equally with other nurse categories; not being given chances to teach and express views; penalties from SANC for non-accrual of 15 CPD points, and not to be compared with other Health Professional Councils in as far as the accrual of CPD points was concerned.

Code 1: Work overload as a deterrent to CPD attendance

Participants reported that they were overworked owing to shortage of staff and cannot afford to leave patients in the wards and attend CPD sessions. They also cited many night shifts as a deterrent to attend CPD sessions. Participants felt that it was better to remain with patients in the ward than to attend CPD sessions. This view indicated that there was a lack of knowledge on the value of CPD with regard to improvement of patient care. They reported that the situation made them to be despondent and it was a deterrent for them in attending CPD sessions.

> Tr2, PA
>
> "Like other wards, nurses may attend (CPD) because (very emphatic) they do not have ward rounds over the weekends, every day; but, paeds, casualty, maternity, they have ward rounds 365 days a year. Doesn't matter whether it's holiday or what, we have ward rounds, because in maternity there are babies, in paeds is medical, medical doctors they came every day, and casualty they also worked every day came every day and there is a doctor every day. In paeds and orthopaedic admit and prepare babies. And in paeds, there are three divisions, on Monday, orthopaedic, they operations, it's a busy day. Also Tuesday they admit, orthopaedic patients they admit surgical, they go and prepare babies take babies to theatre. In paeds, every day we are busy, unless if we are quiet over the weekend if we don't have many medicals. Because surgical and orthopaedic they don't come over the weekend doctors, but in medicals every day (very emphatic)."

Shortage of staff makes accrual of CPD points at times not possible; sometimes some participants do not attend CPD. When participants were asked by the researcher how many times they attended the CPD activities in a month, the response was as follows:

> Tr1, PH
> "… sometimes we don't; Oohh! In a month? (Pause). We should not say sometimes, we don't? In a month? Since last year, I have attended only twice ..."

> Tr1, PE
> "… Maybe you find that the person who was supposed to present the CPD points on that day is on sick leave or on leave, or on night duty…"

> Tr1, PB
> "… then next week you present another one, so, it's like next week you present another subject, it's like, you don't get it all … I don't get it all; like that subject is presented to one person, and the others did not get it especially when we come to the point where you … you … the other subject has two points and the other one is having one point or half point, so they differ in points …"

Code 2: Discrimination between nurse categories

The lower categories [enrolled nursing auxiliaries] lamented that there was a discrepancy in the allocation of CPD points and themes of delivery. According to participants, all categories should accrue similar CPD points under similar CPD delivery themes. They further cited that they felt discriminated because according to them [participants], they were not allowed to do presentations but only to listen. This according to them was discrediting them because they continued to accrue lesser CPD points than the registered nurses.

> Tr3, PA
> "The lower categories are not even supposed to present, you know, and remember the more you present, the more you earn points, and if we do not present, we earn less! They should look at the proposed themes, so that we can balance the categories, because it looks like we are segregated."

Tr3, PC

"… and when I fail to reach the 15 CPD points, can I go to pay the Nursing Council for my … (Pause …) License?

Tr3, PA

"I feel like we are somehow, segregated or undermined; I feel not treated equally. I feel not motivated actually, because we are not treated equally with other colleagues ... Not given chance to express views and intelligence … because we are not treated equally with other colleagues. At some point I feel like not to attend when I being coached to attend, because I cannot always go attend, can't just go there and listen to someone teaches me, whereas I know that I can also teach, I feel somehow actually demoralised, in terms of this, it is demoralising, in terms of feeling when you are not given chance to teach …"

Code 3: Lack of insight regarding the scopes of practice for various nursing categories

Participants felt that SANC should prescribe similar topics for all categories. This view by the participants indicates that the lower categories of nurses are not aware of the different scopes of practice that are available for different categories of nurses.

Participants preferred that all nursing categories balance similar themes of delivery because the lower categories felt that they were segregated and treated unequally.
This view shows that there is lack of understanding on how themes of delivery and allocation of CPD points were spread across all nursing categories. All nurses cannot learn similar content in their accrual of CPD points. The scopes of practice differ across all nursing categories and should be considered in distributing themes of delivery in CPD.

Tr3, PB

"SANC must give us a one way to learn nurses, the whole nursing categories to learn one thing … to learn one thing. SANC must give us something like the lessons, topics to be addressed in order to do preparation. The whole nursing categories to learn something which is one thing (mmmhh, mmmhh … agreeing with each other). SANC should give us topics in order to do a preparation before we go there."

Code 4: Prioritising patient care over CPD attendance

Participants stated that they felt pressurised by the SANC to accrue 15 CPD per annum as it was linked to the renewal of the APC. They felt that the 'rule' should be discarded by the SANC as they wanted to remain practicing nurses in spite of the requirements on CPD points' accrual. They felt that it was more important to them to look after patients in the wards than attend CPD. The shortage of staff made them feel that even if they attended the CPD, they would still find patients as they left them, nothing will have changed.

> Tr1, PA
>
> "The hospital is still the same ward because we are still working in the same environment, same people, and no change. Because we heard rumours from our managers, that if you don't attend this because you are getting points, if the SANC come, they need points, if you don't have points; it means they will erase us, we are still waiting, if they can erase us because of we must attend the patient than CPD, because we need to attend the patients, not CPD."

Code 5: Confusion regarding the allocation of CPD points versus the renewal of the practising license

Participants felt that CPD point allocation was confusing to lower categories. The linkage of CPD to the renewal of the APC was not clarified. What the participants did not know was that accrual of 15 CPD points would lead to the renewal of the Annual Practicing Certificate. The lower nursing categories felt that the system was treating them unfairly.

> Tr1, PD
>
> "Some of the nurses do not really know about CPD; they have never ever been in serviced about this SANC CPD; they are confused and they do have a fear."

Participants stated that nurses should not be compared with other health practitioners affiliated with Health Professional Council of South Africa. They felt that other health

professionals were capable of CPD accrual every morning in their meetings, but owing to staff shortage, nurses cannot accrue the required number of CPD points.

> Tr3, PA
> "SANC should not compare what the Health Professional Council of South Africa (HPCSA) is doing, with what SANC or us as nurses are doing … my point here is that they are able to attend their meetings in the morning to acquire their CPD but … us at some point we might not acquire points because of shortage. They must not compare us with allied doctors and others. They must understand that at some point might not acquire CPD points …"

> Tr3, PA
> "… My recommendation is that how about the SANC to give… us an opportunity to write some sort of motivation if we could not acquire 15 CPD points a motivation of why we did not acquire those particular the points …"

Code 6: No consultation by SANC, No CPD activities attendance by nurses

Participants contend that owing to lack of consultation by SANC with the nurses, that lead to despondency on attending CPD activities. They further feel that presentations on CPD should be conducted by SANC so that nurses and midwives can be motivated to develop interest in CPD activities.

> Tr1, PD
> "As much as proper consultation was not done, I think people they lack interest because they were never consulted and there was no presentation. So, if presentation can be made from the SANC, people can be stimulated and develop interest in the matter."

Code 7: Lack of resources for CPD implementation

Participants reported that a small library and lack of Internet connection made it difficult for them to access online CPD activities or invitations to events.

Tr1, PD

(Hands in the air) "… here we don't have internet connection in the library It's very much important … the library is very small …. If it was broader structure, things would be simple."

Sub-theme 2: Positive attitudes towards CPD implementation

Code 1: Peer teaching embraced

Participants felt that it was imperative for nurses to attend CPD sessions in spite of the shortage of staff in order to avoid stereotypes of lack of knowledge. They further reiterated that it was better if they could teach each other in small groups in the wards and only attend to a larger CPD presentation on Wednesdays as it was the norm in the hospital under study.

Tr1, PE

"… those who understand CPD … it is best if you present it to a small group, like in the ward, … and then where you find that you know, this Wednesday of people coming out of the ward, going to a certain place being a large group to do a presentation to a large group, it works but maybe it's done weekly or monthly according to the … business of the ward by a certain person who understand what it is. All about CPD. Then gradually we'll get used to it at the end all understand."

Participants saw CPD initiative as motivating people to participate and anticipated more participation in future.

Tr1, PD

"… I think we share same sentiments, this is a nice thing; it's all about … people are stimulated by the initiative … (Pause) therefore participation will be more in due process, thank you …"

Code 2: Current knowledge in practice leads to improved patient outcomes

In spite of the shortage, participants felt that nurses should attend CPD presentations to stay current. Participants indicated that nurses should still learn when they are free because lack of knowledge leads to stereotypes and poor patient outcomes.

> Tr2, PB
> "… even though there is, yes … a shortage in your ward, if there is a shortage you can't do, if you can't go that time, you never go , but if time comes if you are free, you have to go and learn things, just because when you are in maternity, you only going to learn about women, something like that … 'ga ke tsebe' (I don't know) …and you as a nurse must know that you are here to help the patients, but … if you don't do CPD points, you will never gain knowledge."

4.4.4 Theme 3: Recommendations to enhance CPD implementation for nurses and midwives

Table 4.4 Theme 3: Recommendations to enhance CPD implementation for nurses and midwives

Theme	Codes
Theme 3: Recommendations to enhance CPD implementation for nurses and midwives	Code 1: SANC to conduct roadshows promoting CPD implementation Code 2: Employment of adequate staff at public healthcare institutions Code 3: Improved coordination of CPD presentations

Code 1: SANC to conduct roadshows promoting CPD implementation

The participants suggested that in order to enhance the implementation of CPD, SANC was to conduct roadshows in all health establishments and check for availability of relevant CPD resources such as Internet connection, availability of the libraries with eBooks, which were updated and recent. They reported that nurses needed full CPD presentation so that they can understand the full benefits of CPD. Participants felt that SANC should have proper consultation with nurses on CPD to prevent despondency on

CPD. They further stated that there were never any presentations on CPD by SANC to stimulate nurses to develop interest in CPD.

> Tr1, PD
> "Internet connection is very important … eBooks, resent books and internet connection (demonstrating with hands). Assessment of resources … I think the SANC should come and assess resources we are having before they are imposing on us this CPD. SANC, for example, they should come and look at our library, to check which books we have on our shelves, these are very old books!"

Participants felt that SANC was to ensure availability of resources for CPD before it made CPD compulsory for nurses. Participants suggested that the library and books on shelves to be checked for updated versions. They felt that this could be achieved if SANC was conducting roadshows. During roadshows, participants indicated that because they did not understand the CPD system, it would be appropriate for SANC to give a full presentation on the subject because people needed to understand the full benefits of CPD.

> Tr1, PD
> "… I think SANC should send a presenter to present the subject in full … people who do not understand the benefits of CPD points … can understand … benefits. I think the SANC should come and assess resources we are having before they are imposing on us this CPD. SANC, for example, they should come and look at our library, to check which books we have on our shelves.

Code 2: Employment of adequate staff at public healthcare institutions

They [participants] further cited that employers should recruit adequate staff in order to enhance the implementation of CPD. Moreover, nurses would be able to attend CPD sessions and accrue the required 15 CPD points that would enable them to renew their APCs to remain in practice. They recommended that night duty and sick leave to be considered carefully. Participants felt that adequate staff would enhance implementation of CPD. They were of the opinion that attendance at CPD would improve patient care.

Tr1, PH

"More staff!! If I have somebody, I will be able to attend, but if there is no one in the ward, I am not attending at all, I can't attend the CPD … because there is no one in the ward."

Code 3: Improved coordination of CPD presentations

Participants stated that improved coordination of CPD programming or scheduling would enhance the implementation of CPD. Participants aver that nurses should teach each other on CPD. Clinical instructors to facilitate CPD by presenting to small groups in the wards and to a large group only on Wednesdays.

They felt that the clinical instructors in the Clinical Teaching Department (CTD) could conduct CPD as it used to be done in hospitals in olden days. Such personnel, according to participants, could draw the CPD schedule and would own the project.

Tr1, PE

"We need to find somebody to facilitate that in the hospital who will present it (CPD) in the hospital; like in olden days we used to have somebody whom we called clinical what … (pause, thinking) … instructor, to be there every day, who will…maybe make a programme or schedule times when to attend ... Where I think it's best to have somebody who owns it"

They were of the opinion that if dates of attendance at CPD presentations are shared, ultimately everyone will get time to attend. It is impossible for everybody to attend CPD.

Tr2, PD

"I think with the small people that we have, we can share the dates, like a cycle I need to share with another one who did not attend if I attend this week, next week it will be somebody, so that at least everyone must attend maybe once a month."

Because of the shortage of staff, there were no ward rounds and operations over the weekends, therefore the participants felt that CPD presenters could take advantage of that time to conduct CPD activities.

Tr2, PD

"…there are no operations, no ward rounds on weekends, then CPD can be done."

4.5 OVERVIEW OF RESEARCH FINDINGS

In this study, the participants reported that it was important for nurses and midwives to attend CPD activities and events in order to develop knowledge, skills, improve attitudes, and add value to the profession. They further viewed CPD as very important because they were given presentations on new diseases and were able to gain knowledge on what was happening in other wards/units. The participants agreed that CPD assisted them to develop proficiencies in resuscitation of both paediatrics and adults. Skills in resuscitation change rapidly, but through CPD, they remained up-to-date.

The participants reported CPD reminded nurses and midwives of their obligations, which is quality patient care. CPD allowed nurses and midwives to gain knowledge and teach each other in the wards/units. They [participants] reported that CPD improved networking and team building; each time they met at the CPD workshops and presentations, interpersonal relationships were improved and their social issues resolved.

Participants expressed their feelings that patients could not be left alone over CPD attendance. The situation was worsened by the fact that attendance of CPD activities was conducted up to twice a week. Shortage of staff leads to despondency to attend CPD. They felt that it was not important to attend CPD. Too much night shifts lead to non-attendance of CPD. Some never attended CPD activities because they felt that it was a waste of time in that when you come back from CPD presentations, you find the work as you left it in the ward.

According to the participants, SANC should accept motivation for non-compliance requirements. Participants felt that SANC should not penalise nurses and midwives for non-accrual of 15 CPD points and non-compliance as per SANC CPD requirements. Moreover, they pleaded that nurses should not be coerced to attend CPD presentations because they only attended CPD to get signatures and did not learn anything. The

participants felt that nurses should attend CPD willingly without any threats from management.

This view by participants indicates that nurses do not understand CPD implementation and have a negative attitude towards its implementation. They already wanted to excuse themselves from participating in CPD activities and events. Participants stated that certain wards were busy throughout the year, 365 days; that was because doctors came every day in, especially in paediatric wards and casualty. Surgical wards were busy with admissions and operations daily. Participants failed to realise that the procedures that they cited above were actually part of CPD activities. They did not need to go to the boardroom for CPD when such activities were at their disposal.

4.6 SUMMARY OF THE RESEARCH PROCESS

The data yielded three (3) themes, nine (9) sub-themes and thirty-four (34) Codes. See Table 4.5 as depicted under 4.4 above.

4.7 CONCLUSION

This chapter presented the data analysis and interpretation of the results. This included the demographic data, content analysis themes, sub-themes, and codes that emerged from the data analysis. The themes, sub-themes and codes were supported by quotations from the participants so that the objectives of the study could be achieved. It also included overview of the research findings. The objective was to explore and describe the perceptions and attitudes of nurses and midwives towards the implementation of CPD and describe the recommendations to enhance the implementation of CPD for nurses and midwives in South Africa.

Chapter 5 presents the findings, limitations and recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 4 described the data analysis and interpretation of the results. This chapter addresses the research design and methods, summary and interpretations of the research findings, conclusions, recommendations, and contributions of the study findings, limitations, and conclusion remarks.

5.2 RESEARCH DESIGN AND METHOD

5.2.1 Research method

In this study, the researcher employed three focus group discussions of participants and recorded the discussions; the researcher transcribed and analysed data together with members of the research team. Refer to Chapter 3 for further information.

5.2.2 Purpose of the study

The purpose of this study was to develop understanding of nurses and midwives' perceptions and attitudes towards the implementation of CPD in a public regional hospital in the Limpopo Province, South Africa; and to make recommendations to enhance the attendance of CPD.

5.2.3 Objectives of the study

In order to achieve the purpose stated above, the objectives of the study that needed to be met were:

- To explore and describe the perceptions of nurses and midwives regarding CPD implementation at a public regional hospital in the Limpopo Province of South Africa.

- To explore and describe the attitudes of nurses and midwives regarding CPD implementation at a public regional hospital in the Limpopo Province of South Africa.
- To recommend how nurses and midwives could enhance the implementation of the CPD.

5.2.4 Research questions

Research questions are important because they help the researcher to set boundaries when conducting the literature review (Wilson 2014:58).

- What are the perceptions of nurses and midwives towards the implementation of CPD in a public regional hospital where the research was conducted?
- What attitudes do nurses and midwives have towards the implementation of CPD in a public regional hospital where the research was conducted?
- What recommendations can be made to nurses and midwives to enhance the implementation of the CPD?

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

Findings are discussed based on the questions that were posed to the participants on their views towards CPD in the public regional hospital where they are working; their attitudes towards CPD and the recommendations that they feel will enhance the implementation of CPD by SANC.

The researcher is of the view that the research objectives were met.

5.3.1 Objective 1: Views of nurses and midwives regarding CPD implementation at a public regional hospital in the Limpopo Province of South Africa

Nurses and midwives who participated in the study felt that CPD was important and had benefits for the nursing profession. This is in line with what several researchers had alluded to, namely, Casey et al (2016:661) in their study found that CPD has a key role in maintaining and demonstrating positive impact on service provision, patient experience and patient safety. Nsemo, John, Etifit, Mgbekem and Oyira (2013:330),

who in their study participants perceived that CPE is valuable and worthwhile for practice as nurses; helps them to meet diverse needs of patients; makes practitioners to keep up-to-date with current knowledge; develop new skills in nursing practice, and it promotes professional competence in practice.

There is a need for significant improvement in patient safety and quality care (Wakefield et al 2005; Smith et al 2007; Okuyama et al 2011c cited in Casey et al 2016:659). The current study supports these views in that participants stated that CPD was not stagnant, nursing is a developing profession and it is always teaching continuously. CPD had improved and changed attitudes of nurses and midwives and therefore it was very important for nurses to attend CPD workshops. Participants further cited that those practitioners who attended CPD presentations were knowledgeable and added value to those who remain in the units by giving them more information. They agreed that they could not all attend workshops as and when they wished. Participants indicated that such practitioners who attended CPD provided safe patient care and maintained good health which assisted them to manage patients. Moreover, Participants were particularly thrilled by presentations on new diseases, especially in casualty and orthopaedic units.

This is further confirmed by the study conducted by Chong et al (2014:4) that nurses and midwives preferred courses in specialised areas such as cardiothoracic nursing, wound care management and CPR as opposed to undertaking research, participation in degrees and diplomas. In the case of the Malaysian nurses and midwives, their constraints, according to the said authors, were financial constraints, family burden and work commitment. None of these barriers were mentioned by the participants in the study that the researcher conducted. Their main constraint was time and shortage of staff in the wards.

CPD, according to participants' view, has promoted interpersonal relationships and offered them team-building opportunities. Participants were motivated to participate in CPD activities because they saw the need to keep abreast. Nurses and midwives stated that they spent most of their time at work in hospital and with the advent of CPD they were able to deal with issues that they could not share with others before, and they also learned coping mechanisms to deal with difficult or burning issues. Attendance of CPD presentations broadened, developed and revived nurses and midwives. Uarije et al (2017:21) support this view in their study conducted on radiographers' attitudes

toward continuous professional development at state hospitals in Windhoek, Namibia. In this study, the respondents agreed to mandatory CPD and deemed CPD important because it was associated with improved practice, better patient care and increased confidence. The respondents in this study saw the need to keep abreast with current practices and knowledge because they felt motivated to participate in CPD activities.

In this study, participants reported that CPD builds confidence and proficiencies in nurses and midwives to deal with emergencies, especially in specialised units. Their skills in resuscitation were now developed. Through CPD, participants felt that they were able to learn paediatric and adult resuscitation; improved emergency updates, especially that the CPR changes rapidly. Currently, CPR starts with pulse, not airway and this makes CPD very important. They have also gained more knowledge in professional ethics, professional leadership and professional management in future. Macaden et al (2017:943) and Uarije et al (2017:21) support this view.

Nurses and midwives are reminded of their obligations, their purpose and how to take care of their patients when they attend CPD. Participants reported that usually nurses and midwives knew only what transpired in their units, but with CPD presentations, the stereotypes were removed. Furthermore, participants were of the view that nurses and midwives should not give excuses for not attending CPD. They argued that they lose out because correlation of theory and practice is very important. It is good to continue with CPD because it is very crucial and beneficial. Participants reported that CPD initiative motivated people to participate and that participation would continue in future. In addition to the benefits mentioned in this study, Macaden et al (2017:943) added that CPD programmes help professionals to retain their jobs and support nurses' professional status.

Macaden et al (2017:943) concur that CPD programmes promote patient safety; nurses in their study reported that they attended CPD training largely for their professional development needs and personal interest. They also cited CPD as an opportunity to socialise, especially those working in remote and rural areas who often feel isolated from fellow professionals. It is therefore imperative that those who develop CPD training opportunities should recognise this factor.

5.3.2 Objective 2: Attitudes of nurses and midwives regarding CPD implementation at a public regional hospital in the Limpopo Province of South Africa

In this study, participants felt that CPD had challenges such as lack of human and material resources for CPD implementation. Lack of Internet connectivity was cited as the main one because it limited access to CPD events or activities. They also reported that lack of recent books and the small library were a barrier to CPD implementation. They felt that if the library was broader, a different picture would be painted. The participants could not even mention the online CPD activities owing to lack of Internet connectivity. In this notion, the participants did not mention anything about lack of funding. This gives the impression that funding is not a challenge in the health establishment under study. In a similar study conducted by Ikenwilo and Skåtun (2014:200) on perceived need and barriers to CPD among doctors, respondents showed lack of time as the most identified barrier. The respondents further felt that policy makers should consider this perceived barrier in helping to design CPD activities. They propose that CPD planners should institute flexible working practices to allow doctors to engage and participate in available CPD activities (Ikenwilo & Skåtun 2014:200).

The participants' understanding of CPD activities and event attendance was limited to clinical procedures organised by the institution in a boardroom setting. None of them mentioned attendance of formal training such as at seminars, congresses and conferences. Not even the post-basic courses were mentioned as opposed to the study as depicted by the researchers on Malaysian nurses and midwives' current CPE practice who alluded to constraints that prevented them from undergoing degree courses and diplomas as stated above (Chong et al 2014:4).

Attendance at CPD presentations was not always possible with some participants due to shortage of staff. They also raised concerns about the shortage of training personnel at CPD. Currently, there was only one CPD Provider with no relief. When this provider was not available, either on sick or annual leave, the CPD activity was cancelled. The participants recommended that at least two or three dedicated CPD providers would be better to relieve each other. Mosol et al (2017:306) cited similar findings on staff

shortage, lack of time owing to heavy workload, and finances were major challenges facing nurses while participating in CPD.

There were times where participants in this study felt that it was challenging to attend CPD activities owing to shortage of staff. Nsemo et al (2013:330) found that continuing education programmes as currently organised in nursing in Nigeria do not seem to meet their expectations of such programmes. The reasons for this were that they seem fragmented, they do not earn CE points and there are no online options for those who cannot leave work to attend continuing education programmes outside their location of abode and work.

These findings are supported by the study that was conducted in Western Kenya by Mosol et al (2017:306). The latter study found that the majority of the nurses reported staff shortage, lack of time owing to heavy workload, night shift, lack of information on availability of CPD, family commitment, lack of interest, distance and lack of finance as challenges and barriers to CPD participation. Nsemo et al (2013:330) also observed the lack of interest in CPD attendance in their study where the majority of their participants felt that they have already acquired the necessary knowledge and skill to practice nursing and so do not require to participate in CPD for some time.

The respondents in the study conducted in Uarije et al (2017:21) on “Radiographers’ attitudes towards continuous professional development (CPD) at the State hospitals in Windhoek, Namibia”, indicate that they attend to a high patient load. If one radiographer is not available in the clinical area, this significantly increases the workload on the rest owing to staff shortages. Some respondents expressed feelings of guilt in such situations that they would forego participating in CPD activities. This supports the findings that the researcher reported from the research project conducted at the public regional hospital in Limpopo Province, South Africa, where the participants indicated that they would rather forfeit attendance of CPD than leave patients alone owing to shortage of staff. This shows that shortage of staff and non-attendance of CPD activities is across health professions and it is also experienced globally (Uarije et al 2017:21).

In spite of the challenges expressed above, the respondents of the study on radiographers still agreed that CPD should be mandatory in Namibia. This is comparable to other observed responses in UK, New Zealand, South Africa, and

Australia. In this study, CPD was deemed important because it is associated with improved practice, better patient care and increased confidence. The need to keep abreast with current practices and knowledge, motivates radiographers to participate in CPD activities (Uarije et al 2017:21).

In this study, the lower nursing categories felt that the system was treating them unfairly because they were not given chance to do CPD presentations. They reported that the practice disadvantaged them in the sense that they would never accrue more CPD points, but only a one for observing or attending a CPD event or activity. In contrast to this view, in their study when defining continuing professional competence, Casey et al (2016:659) recognise that the "individual nurse or midwife is aware of the boundaries of his/her scope of practice, patients' needs, workplace requirements and areas of specialisation". They further reiterate that similar to scope of practice frameworks, CPD should enable role expansion within the core functions and values of nursing and midwifery and the best interest of the patient. Unfortunately, in this study that the researcher conducted, the lower categories of nurses' lack understanding on how CPD programme works; this shows that they are not clear with the scopes of practice for different nursing categories, which specifies the parameters within which each category should function. The level of complexity differ according to categories of nurses functions (Casey et al 2016:659).

Apparently, the lower categories of nurses were confused by CPD point allocation system. They felt that they were not clarified on the linkage of CPD to payment of the Annual Practicing Certificate. What the participants did not know was that accrual of fifteen (15) CPD points would lead to the renewal of the Annual Practicing Certificate. According to Casey et al (2016:655), competence programmes are necessary for annual renewal of membership by the regulatory body of the country of concern. They further clarify that the CPD programme requires provision of details of clinical experience and the Portfolio of Evidence (PoE).

There were views of inequality in CPD provision**.** Participants stated that nurses and midwives with attitudes did not attend CPD because they did not see any value in it. The same people always attended all CPD presentations. In this study, the lower categories of nurses felt that they were segregated, undermined and treated unequally with other categories of healthcare professionals. According to participants, this

demotivated and demoralised them. They would feel better if they were allowed to teach other colleagues at CPD presentations. They also wanted to be given chance to express their views and intelligence (Nsemo et al 2013:332). They expressed that currently they were only allowed to attend CPD presentations and listen to other senior categories. They recommended that management should allocate them time to also teach so that they could accrue more CPD points. This view indicated lack of knowledge and understanding by the lower categories of nurses on how CPD programme works. Casey et al (2016:659) clarify that each category of nursing functions is in accordance with their role expectations and within the boundaries of their scopes of practice, patients' needs, workplace requirements, and areas of specialisation.

On contrary to the views of the participants in this study, Nsemo et al (2013:332) reported on finding where participants perceived that since nurses of different levels of career progression are brought together for the same content participants may not benefit from the CPE programme. They are of the opinion that the learning needs and opportunities of novice nurses should be differentiated from those of intermediate or expert practitioners when planning CPE programmes. There were "no CPE points earned from programmes". Participants perceived that because CPE programmes do not give CPE points and do not contribute towards promotion, nurses are not motivated to undertake CPE unless when they require re-licensure (Nsemo et al 2013:332).

There were some issues raised by the participants with the new nursing qualifications. They were not clear on how they were related to the CPD. According to their view, SANC should first ensure that CPD is rolled out and implemented throughout the country before introducing new qualifications. They felt that these two matters would overload the nurses. All these occur because of lack of knowledge. This finding is alarming because nurses lacking teaching and management skills would compromise the advocacy of health promotion, and poor utilisation of research among nurses may jeopardise quality of patient care (Chong et al 2014:4). The introduction of the new qualifications by SANC will address important topics as those cited above for improved patient care.

The reality is that CPD is meant for qualified practitioners (registered nurses, enrolled nurses and enrolled nursing auxiliaries) whereas the new qualifications will be introduced for students in the Nursing Education Institutions, which will be aligned with

the health needs of the South African community. In the study that was conducted by Chong et al (2014:4), it was discovered that nurses often preferred courses that they believed would enhance and advance nursing practices and clinical work. The study showed that nurses preferred courses that were usually held at workplace environment. Nurses in this study did not attend management, ICTs, degrees and diplomas, primarily because they were not covered in their basic training and therefore, did not value them.

Participants reported that in spite of the CPD presenter being available at the training venue, non-attendance of CPD would continue. They stated that non-attendance of CPD could even go beyond a month. Furthermore, participants felt that they could leave patients alone and attend CPD. This view is supported in Coventry, Maslin-Prothero and Smith (2015:5) that the quality and safety of patient care is highlighted as a priority over attending CPD. This notion is further supported by (Edwards et al 2001; Zimmer, 2004, Lee et al 2005, Brewer et al 2006, Gould et al 2007; Yfantis et al 2010; Muliira et al 2012). They cite shortage of staff as the main cause of non-attendance of CPD activities. The researcher believes that in an ideal world where there was adequate staff in the units, nurses would alternate at CPD attendance.

Certain wards/units were very busy. Practitioners reported that they could hardly attend CPD activities. They cited nursing workload as an obstacle, demanding or increased workload as significant factor in preventing participation in CPD. In the study conducted by Coventry et al (2015:5), nurses who worked additional hours or mandatory overtime experience fatigue and this factor also affects the quality and safety of nursing care. These authors observed that unpredictable workloads made it difficult to organise learning and release staff to attend programmes. This indicates that excessive workload is the biggest barrier to learning in a developing country context. In the studies conducted by the seven authors cited above, they described time as the main barrier to attending CPD, namely, limited time, lack of time and no time away from workplace (Coventry et al 2015: 5). Participants included finance, attitude of service managers and their leadership styles as barriers to CPE. It was emphasised by Davis (2011) cited in Nsemo et al (2013:333) that nurses work in shifts and that means that even if they are often keen to update their skills and knowledge, time constraints and costs can be an issue. These authors explained that it is not realistic to expect nurses who work shifts, who are employed full time and live in isolated areas to travel and pay for the expenses for CPE activities which are usually organised in urban centres (Nsemo et al 2013:333).

Uarije et al (2017:18) report that the respondents indicated factors such as lack of motivation by management, lack of time, financial constraints, family obligations, and engagement in private business as barriers limiting participation in CPD activities. Workload was also reported as a barrier in New Zealand and UK and with the pressure of work and owing to staff shortage, CPD was difficult to maintain and it is difficult to get time off for CPD. These findings are similar to those that the researcher reported from the participants during the focus group discussions in the said public regional hospital under study in Limpopo Province, South Africa. Similar findings are reported across health professions globally (Uarije 2017:22).

According to the SANC Nursing Act, 2005 (Act No. 33 of 2005), Sections 39 and 59, "the Council may determine conditions relating to CPD to be undergone by practitioners in order to retain such registration …" (SANC 2005:89). The Act gives the Council the mandate to develop relevant CPD documents such as the CPD Framework; Criteria and Guidelines for CPD Service Providers and CPD Rules that would direct the implementation of CPD for nurses and midwives in South Africa. For all the practitioners (nurses and midwives) to renew their APCs, they are required to accrue minimum of 15 CPD points per annum. This is in line with what Nsemo et al (2013:330) cited that the Mandatory CPD programmes were organised by the professional regulatory body for re-licensure, conferences, workshops, and department/ unit-based programmes.

There were concerns raised by the participants about the penalties that they face if they did not meet the 15 CPD points that the regulatory body, SANC, has prescribed. In spite of the roadshows that SANC has conducted throughout all provinces in South Africa, participants felt that they were not included in decision-making, hence their dissatisfaction with the 15 CPD points they are expected to accrue. Similar practices are observed from the study conducted by Chong et al (2014:3), which indicated that all registered nurses in Malaysia are required to show evidence that they participated in CPE and met the minimum requirements of 25 credit points annually before renewal of licensure is granted. This was to ensure that they are safe practitioners.

Failure to acquire the prescribed 25 credit points required to renew their licenses, led to 238 nurses being excluded from licensing. The study showed that the respondents'

attendance at CPE ranged from never, one or two, with few more than once. The study showed that activity attendance was below 50 % (Chong et al 2014:3).

Some participants felt that the shortage of staff made them feel that even if they attended the CPD, they would still find patients as they left them; nothing would have changed. The regulatory body links the renewal of the APC to accrual of 15 CPD points. Therefore, participants' fear for penalties that they face if they do not accrue the required 15 CPD points; it would be better if the SANC would listen to their motivations of non-attendance of CPD activities or events. This view indicates that nurses do not fully understand the value of CPD and are resistant to implementation of CPD (SANC 2018:10)

5.3.3 Objective 3: Recommendations by nurses and midwives to enhance CPD implementation

Internet connection to institution's library

In this study, participants stated that the importance of Internet connection in enhancing CPD implementation could not be overemphasised. Participants recommended that management should purchase updated books, get internet connection and broaden the library in their study on attitudes towards CPD and postgraduate education of Croatian students of physiotherapy, Sklempe, Schuster, Brumnic, Crnkovic and Znika (2016:132) found the Croatian physiotherapy students to have positive attitudes to CPD and plan to continue with postgraduate study. They are well aware of the importance of postgraduate education, but they lack in knowledge and interest to participate in research themselves, in spite of the sufficient IT competences they possess to enable them to use digital media to participate in CPD activities. This shows that availability of Internet connection alone cannot yield positive results on participation in CPD activities. Against this background, nurses and midwives in this study need to be motivated, encouraged and supported by management to participate in CPD activities.

Electronic recording of patient files

O'Mahony et al (2014:4) conducted a study in a Community Health Centre (CHC) in South Africa on "knowledge and attitudes of nurse in community health centres about

electronic medical records". In their findings, they identified many challenges associated with the current paper-based patient record system. There was a perceived high recording workload; entering data after the day's work was finished; duplication; difficulty in keeping track of patients, that is, data in different registers and lack of training. Poor handwriting also added to errors committed. The participants were therefore concerned with the amount of time that was spent on the above-mentioned issues to an extent that they had little if any time for patient care. This became so serious that one of the CHCs had to reduce antenatal bookings to allow time for paperwork. The willingness of the nurses to record data electronically helped to improve data completeness and accuracy and it is likely to lead to use of the resulting information in nursing practice. The benefit is a reduction in time spent in recording and retrieving patient data. This is one way of time management.

In South Africa, nurses are the main providers of primary healthcare and they are the largest professional group generating and recording healthcare information. The eHealth Strategy for South Africa (2012) postulates that all indicators derived from patient data should be captured electronically at the point of care. If the SANC can adopt this strategy as part of creating adequate time for nurses, midwives to attend CPD activities that will assist to enhance the implementation of CPD by the regulatory body for nurses, and midwives. This makes the use of Electronic Medical Records (EMR) very useful in saving the much-needed time for CPD and therefore, EMR should be one of the topics for CPD (O'Mahony et al 2014:5).

Proper scheduling of CPD activities and identification of learning needs

Participants in this study were of the opinion that if proper scheduling of CPD activities can be improved, that would make CPD system work well. They further suggested that if the management could give alternative dates for CPD attendance that could help a lot. In this study, participants are of the view that if they shared dates of CPD attendance, ultimately every nurse or midwife in the health establishment would get time to attend. Chong et al (2014:5) found that "the inventory of future learning need for CPE serves as a yard stick to provide relevant and timely courses planned for nurses". The authors further indicate that the CPD activities succeed where the focus is on learners' needs to ensure that they receive latest learning experience that they will be able to apply to improve their current practices.

In her study, Liphosa (2013:157) is of the opinion that to achieve quality patient care, health care institutions and other stakeholders need to invest intensively in the CPD of their employees. This study recommends that it can be achieved by developing CPD programmes that are based on the assessed learning needs of the employees; the educational needs of the employees should be taken into consideration when drawing CPD programmes, for example, the needs of the enrolled nurses as opposed to those of registered nurses. The study further suggests that clinical instructors should facilitate CPD scheduling and presentations so that there would always be somebody who owned the CPD programme.

In their study, Chong et al (2014:5) encourage the staff development and in-service training unit to consider providing a more structured programme based on nurses' learning needs in cooperated collaboration with education, practice and research. With the current set up, not everybody can be afforded time to attend CPD. In this research, it was found that without proper planning, mandatory CPD is unlikely to deliver the anticipated development of reflective practice and critical thinking that is considered to be crucial to improving patient care (Chong et al 2014:5). The study recommend that CPD providers should critically examine the existing education approach and explore more innovative teaching methods such as e-learning and self-directed learning, taking a problem-solving approach such as problem-based learning or evidence-based nursing.

These findings are in line with the findings in Priscah et al (2017:306), who reported that their informants indicated lack of proper policies, guidelines and coordination with CPD regulatory bodies as barriers to management of CPD. The informants cited lack of written policies for CPD, lack of available guidelines for CPD, lack of coordination with other CPD coordinators at county level or at national level, lack of appropriate evaluation tool/methods for CPD and challenges in time management by the nurses as challenges affecting participation at CPD (Mosol et al 2017:307).

These findings agree with what other authors alluded to in this research project who found lack of time dedicated for learning, staff shortages, lack of CPD policies, and health professionals being overwhelmed with patient care duties as barriers to CPD participants.

Effective management of staff shortages

Participants suggest that management should consider the staff that is sick, on annual leave or on night duty when they draw the CPD schedule. They believe that management should consider the above in case the presenters were affected, there should be alternate personnel to relieve them. Others suggest that CPD activities be conducted over the weekends when the units were less busy or alternatively one topic be handled in a month. Some of them were of the view that those who had an opportunity to attend the CPD activities or events should teach others in the units to enhance CPD implementation. Similar sentiments were shared by Mosol et al (2017:307), who recommend that hospital management should consider employing more nurses, formulate policies affecting CPD and coordinators should organise favourable time and space for CPD activities. The authors further assert that equal opportunities for all participants should be considered.

Non-attendance of CPD activities was alluded to shortage of staff by participants and felt that if employers recruit adequate staff that would enhance implementation of CPD. Participants further stated that attendance would improve patient care because practitioners would gain knowledge, skills and improve attitudes. Because of the shortage of staff, participants identified that because there were no ward rounds and operations over the weekends, CPD presenters could take advantage of that time to conduct CPD activities. Similar views were given by Mosol et al (2017:21) as stated in the previous paragraph.

Coventry et al (2015:5) concur with this study that when there is an inadequate supply of nurses in the clinical environment, participation in CPD does not occur. Moreover, inadequate staffing may occur when there is organisational reduction in numbers of staff, nurse absence, lateness, or sickness. Non-attendance at CPD occurs owing to the inability of nurses to leave the workplace because of inadequate staffing levels. According to the authors cited above, other four studies support their study, namely, (Brewer et al 2006; Gould et al 2007; Tame 2009; Jaradeh & Hamdeh 2010).

Mosol et al (2017:307) recommend that hospital management should consider employing more nurses, formulate policies affecting CPD, provide financial support, and

invite sponsors to help support CPD activities. Participants should be given equal opportunities for participating in CPD activities and coordinators should organise favourable time and space for CPD activities.

Consultation and involvement of nurses in the planning of CPD activities

Viljoen et al (2017:74) accentuate that nurses must be part of the collaboration throughout the decision-making process to ensure the success of a CPD programme, including the planning and implementation of the programme. They further indicate that using the top-down approach in which the clinical facilitator and unit managers decide on the content, time, and strategies to be used during the CPD programme may result in unsatisfactory attendance. That will result in a feeling of being pressured by managers to engage in a CPD programme to meet the organisational objectives. These findings concur with the findings reported by the researcher on the participants' responses during the focus group discussions conducted at a public regional hospital in Limpopo province, South Africa. Participants indicated that nurses preferred to be involved in matters affecting their work and future.

In this study, participants were of the view that owing to lack of consultation by SANC with the nurses, that lead to despondency on attending CPD activities. This is in line with what Casey et al (2016:661), who in their study reported on nurses and midwives in Ireland who expressed concerns through their representative organisations about quantum of the proposed increase in annual registration fee and the manner in which it was communicated. The nurses and midwives perceived that even if it may have raised awareness about the role and function of the Nursing and Midwifery Board of Ireland (NMBI), as it pertains to continuing registration, it may also account for the reduced levels of participation from the less paid and more vulnerable grades among the professions (Casey et al 2016:661).

Participants suggested that nurses and midwives needed to be trained in order to understand the full benefits of CPD. They further suggested that SANC should consult with nurses on how CPD should be conducted. Nurses and midwives felt that SANC should stimulate nurses to develop interest in CPD. Therefore, they suggested that this could be done by moving across provinces on roadshows on CPD. Participants felt that those who understood CPD should teach others in small groups in the units. They

stated that addressing a large group on Wednesday only, did not benefit nurses. They are of the opinion that by so doing, gradually everybody will understand CPD. Similar sentiments were expressed by Uarije et al (2017:21) in their study, where the respondents indicated factors such as lack of motivation by management as a barrier limiting participation in CPD activities.

CPD activities should be accessible and economical

Mosol et al (2017:306) indicate that participants' attitudes and funding were among the external barriers to CPD uptake by nurses. Other barriers as identified in literature concur with these findings that inflexible learning methods, limited time and resources, heavy workload and absence of colleagues to cover their work were reported as other barriers preventing uptake of CPD by nurses working in night shift (ibid). The findings further recognised the cost of attending CPD; family responsibilities; travel distance; understaffing and lack of quality or interesting topics; lack of benefit in attending CPD; lack of support from administration, and peer opinions and attitudes as deterrents to participation (ibid).

Contrary to the above findings, Macaden et al (2017:943) cite barriers to attending CPD training as personal reasons such as domestic responsibilities, distance, cost, and professional reasons such as work, commitment, staff shortage, and lack of information. Similar barriers to CPD attendance have been found elsewhere, including lack of time and finance, access to CD, difficulty in balancing work, continuing education and home life. The researchers further advice that in order to maximise participation in CPD, it is important that an environment is created for nurses to be able to participate interactively, taking into account nurses' professional, personal and social needs.

In a study conducted in New Zealand, Casey et al (2016:655) report that the requirements of the continuing competence framework was necessary for annual recertification of nurses and midwives and included evidence of practice hours, ongoing professional development and a self-declaration of competence collated in portfolios. Literature indicates that even in United Kingdom, Australia, Canada, and Ireland, the regulatory bodies ensure that competence programmes are necessary for annual renewal of membership for their nurses and midwives. In this study, participants suggested that SANC should accept the motivation on why they were not able to

comply with the CPD requirements of accrual of CPD points. Some of the reasons that they stated to be preventing them from accruing the CPD points were lack of resources and lack of staff

They were cognisant of the fact that there were SANC penalties that can be imposed for non-accrual of 15 CPD points. Casey et al (2016:653) note that the role of the employer should be to articulate the possible consequences for non-adherence with the CPD requirements. The participants suggested that management should not instil fear in cases where nurses were not compliant. Participants felt that SANC never in-serviced them on CPD and as such, they felt that they should not be penalised for CPD non-compliance. Contrary to how the participants felt in this study, Malaysian nurses who did not comply with the mandatory requirements of their regulatory body on CPD requirements were excluded from renewing their annual licensure (Chong 2014:2).

The participants in this study reported that management should consider different challenges experienced by wards and allow those who were able to attend, to do so. If as stated by Casey et al (2016:660) in their study, engagement in competence-related activities is to do the following:

- Maintain public trust
- To enhance the quality of patient care
- To meet professional obligations
- To meet personal and professional development goals

Should nurses and midwives not be monitored for adherence to the set standards, the public will receive suboptimal care with serious consequences for patients.

Participants in this study further stated that nurses and midwives should not attend CPD only to get signatures without learning anything. Nurses and midwives were of the view that SANC should encourage nurses to **a**ttend CPD willingly. The researcher believes that participants in this study did not view night shift as part of their calling but felt that they sacrificed to go on night duty because there was shortage of staff (Casey et al 2016:654).

Nursing management to effectively attend to CPD attendance barriers to prevent non compliance

Participants were of the opinion that SANC should not remove practitioners from registers for non-compliance. Moreover, they indicated that still wanted to continue to practice as nurses. According to the participants' thinking, CPD points should not be a deterrent for not practising as nurses. They stated that they wanted to learn but in a conducive, non-threatening environment. Literature indicates that where CPD for nurses and midwives is mandatory, failure to comply with the regulatory body requirements, leads to non-renewal of the practising licences (Chong et al 2014:2).

With regards to accrual of CPD points, participants stated that nurses should not be compared to doctors and allied health professionals. They stated that other professional health councils had ample time to accrue CPD points during the meetings that they held every morning; but nurses do not have that opportunity. Time and shortage of nurses were the ones that lead to non-attendance of CPD presentations. In contrary to this view by the participants, Ikenwilo and Skåtun (2014:200) in their study on perceived need and barriers to CPD among doctors, state "lack of time" as the most identified barrier to CPD. That was similar to what was reported among hospital-based prevocational doctors in Australia. Price et al in Ikenwilo et al (2014:200) reported barrier to implementing learning among a group of health care professionals in Colorado, was lack of time.

The lesson learned in this study is that the SANC should in terms of policy, as it relates to the rollout of CPD for nurses and midwives consider these perceived needs and barriers to CPD when formulating policy. The researchers further state that barriers could help in designing CPD activities and instituting flexible working practices to allow nurses and midwives time to engage and participate in available CPD activities (Ikenwilo et al 2014:200). There is evidence in other studies that strong organisational support, such as paid study time, strong leadership and a positive attitude to CPD from both management and peers facilitate effective learning (Macaden et al 2017:943).

Auditing of health care facilities to address the poor conditions of service

The participants in this study recommended that SANC should ensure availability of resources before making CPD compulsory for nurses. Participants needed SANC to look at the libraries and check books on shelves during roadshows on CPD. Moreover, participants indicated that they did not understand the CPD system and needed SANC to give a full presentation on the subject. People needed to understand the full benefits of CPD and suggested that SANC should have proper consultation with nurses on CPD. CPD has a key role in maintaining a positive impact on service provision, the patient experience and patient safety (Casey et al 2016:661).The researcher is of the opinion that this recommendation should be referred to the National Department of Health (NDoH) as the custodian of conditions of service in health care institutions in South Africa. The role of SANC is the protection of the public as indicated by the study by Casey et al (2016:661), who state that "the role of any professional nursing/midwifery regulatory body worldwide is to protect the health and safety of the public by setting standards and ensuring that nurses are competent practitioners".

The participants in this study further feel that presentations on CPD should be conducted by SANC so that nurses and midwives can be motivated to develop interest in CPD activities.

This view is supported by Chong et al (2014:4) who suggest that the lack of provision of nursing information, such as journal and books in clinical areas, and being discouraged from reading in the workplace has deterred nurses from engaging in CPD. They further reported disappointment with the Hong Kong nurses who were not interested in undertaking research, despite knowing the importance of evidence-based nursing. The purpose of CPE for Malaysian nurses, as in other countries, is to collect points to review their practice license (Chong et al 2014:4).

In her study conducted in Kisumu, Kenya, Onyango (2013:1) found that minimal involvement of nurses during the initial stages of designing CPD programmes may lead to incorrect identification of learning needs. Personal, organisational and professional factors were identified as barriers to nurses' participation in CPD. The author further established that preparation of nurses in advance and the use of teaching strategies

that recognise experience and adults as resources, were found to increase nurses' participation in CPD (Onyango 2013:1).

5.4 CONCLUSIONS

Much as challenges were experienced in the workplace, there were also benefits. CPD positively influenced quality patient care, staff morale improved, staff improved their knowledge, skills, and improved attitudes. CPD generated a team building opportunity and interpersonal relations at the workplace were promoted. Nurses and midwives became empowered by CPD and gained confidence and competent in executing their duties. Of importance was that CPD reminded them of their obligations towards patient care. Appropriate policy to regulate CPD and funding will enable practitioners to implement changes that will make it [CPD] sustainable.

5.5 RECOMMENDATIONS

In order to enhance the implementation of CPD in South Africa, the researcher recommends as follows:

5.5.1 Recommendations to nursing management

- Management should create an enabling environment for CPD activities to take place. Leadership should consult with nurses and midwives so that they can understand their learning needs and that challenges that they face so that they can ease the barriers.
- Management should ensure that there are adequate human and material resources to enhance the implementation of CPD. CPD can never be successful in the absence of Internet connections, up-to-date libraries and adequate staff to conduct the training. Dedicated personnel should be appointed to be in charge of the Clinical Teaching Department where nurses will be trained.

5.5.2 Recommendations to SANC

- SANC should contact practitioners who are found to be non-compliant, advising them of their status and to give reasons or motivate for their non-compliance

status, without instilling fear of removal from practicing nursing. Nurses should be made aware that removal from the register will be the last resort. SANC should give such non-compliant practitioners an extension of three months to accrue CPD points. If they fail, SANC can fine such practitioners for non-compliance before it reaches the last resort of removal from SANC register.

- SANC should ensure that the themes of CPD delivery are understood by practitioners as it is currently confusing. Nurses and midwives should also understand that CPD for nurses is flexible; it can be offered in their area of practice. Nurses should not worry that they have to attend only huge congresses, seminars and conferences only. Nurses should be encouraged to teach one another where they work.

5.5.3 Recommendations for research

The following topics are suggested for future research:

- Perceptions of nurses about accessibility and availability of CPD in rural health care facilities.
- The implications of mandatory CPD for nurses and midwives in South Africa.
- Barriers to attendance at CPD for nurses in South Africa.
- Nurses 'perceptions of the impact of CPD on the quality of nursing care.
- Correlation of attendance at CPD versus competencies gained from attending, and the quality of care of patient outcomes.

5.6 CONTRIBUTIONS OF THE STUDY

This study contributes valuable information to the current body of knowledge about CPD for nurses and midwives in South Africa. The knowledge obtained out of this study may assist the regulatory body, which is SANC, the Departments of Health in all the provinces, the nurse educators in the Nursing Education Institutions and the nurse managers in various health establishments, to formulating policies that can enhance sustainability of CPD into the future. The future CPD model in South Africa should be the one that will consider sustainable patient outcomes and that supports capacity

building to ensure that the nurses and midwives render quality patient care that is relevant and meets all the healthcare needs of the South African citizens.

The rich data that emerged during the focus group discussions represent and contribute important findings about CPD that can be helpful for developing countries that intend to initiate CPD programmes for their nurses and midwives. This study is a wake-up call for regulatory bodies such as the SANC, to conduct awareness campaigns to ensure that all the nurses and midwives are aware of the implications for registration and renewal of the APC and the implications of non-compliance; that would improve adherence to policy.

5.7 LIMITATIONS OF THE STUDY

The researcher conducted this study in one (1) public regional hospital, which is situated in one district in one province in South Africa out of nine provinces. It was challenging to access literature on CPD for nurses in South Africa since this is still new and it is not yet implemented. Out of the whole population of nurses in the said hospital, only 22 participated in the focus group discussions. Therefore, the results of this study cannot be generalised to the whole of South Africa.

5.8 CONCLUDING REMARKS

This chapter provided the findings of the study, limitations, recommendations, and future research topics. Participants viewed CPD as being beneficial for nurses because it improves quality patient care. Those who have a different view want it to be approached differently without instilling fear to nurses. The researcher hopes that these findings will benefit the health establishment that was under study, and other health establishments that would like to establish CPD programmes at their institutions to keep nurses up-to-date with the new professional developments and competencies. Generally, the nurses and midwives have a positive perception of CPD. The objective of this study was to explore and describe the perceptions and attitudes of nurses and midwives towards the implementation of CPD and describe the recommendations to enhance the implementation of CPD for nurses and midwives in South Africa. Chong et al (2014:5) cite that: “Collaboration among the nursing leaders in every area is vital to improve our practice, and most importantly, our nursing profession”.

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ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE FROM UNISA

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

7 February 2018

Dear Mmamooke Agnes Mnguni

Decision: Ethics Approval

HSHDC/833/2018
Mmamooke Agnes Mnguni
Student no:0511-255-9
Supervisor: Dr MG Makua
Qualification: D Litt et Phil
Joint Supervisor: -

Name Mmamooke Agnes Mnguni

Proposal: Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives

Qualification: **MPCHS94**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 7 February 2018 to 7 February 2020.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on7 February 2018.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

RECEIVED
2018 -02- 14
Executive Dean
College of Human Sciences

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

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

4) *[Stipulate any reporting requirements if applicable].*

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

Kind regards,

pp. Coetz

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Prof A Phillips
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ANNEXURE B: APPROVAL TO CONDUCT RESEARCH IN LIMPOPO PROVINCE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stander SS (015 293 6650) Ref:LP_

Mnguni AM
P.O. Box 658
Rooihuiskraal
0154

Greetings,

RE: Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
    - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
    - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
    - In the course of your study there should be no action that disrupts the services, or incur any cost on the Department.
    - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    - The above approval is valid for a 3 year period.
    - If the proposal has been amended, a new approval should be sought from the Department of Health.
    - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

04/04/2018
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!

ANNEXURE C: LETTER OF PERMISSION FROM THE INSTITUTION

Request for permission to conduct research at [redacted] Regional Hospital, Waterberg District, and Limpopo Province in South Africa

TOPIC:

"Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives"

DATE: 21 JULY 2017

Nursing Service Manager: Ms [redacted]

Institution: [redacted] Regional Hospital

Contact number: [redacted]

Email address: [redacted]@gmail.com

Dear Ms [redacted]

I, **Mmamoroke Agnes MNGUNI** am doing research with Dr MG Makua, a Senior Lecturer in the Department of Health Sciences, towards a Masters of Arts (MA in Nursing Science, at the University of South Africa. We have funding from UNISA for the Research Project. We are inviting you to participate in a study entitled:
"**Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives"**

The aim of the study is to explore and describe the nurses 'and midwives' perceptions and attitudes regarding implementation of CPD by the South African Nursing Council (SANC). It also aims to explore the strategies that can be implemented to enhance acceptance of CPD by nurses and midwives and ascertain the readiness of nurses to embrace CPD.

Your company has been selected because it has the potential to provide the researcher with appropriate information needed to assist SANC in its implementation of CPD Strategy, Your Organisation meets the set criteria for the study.

The study will entail Focus Group Discussion (focus group discussion) with the Professional Nurses; enrolled nurses and Enrolled Nursing Auxiliary in your workplace. You will be between 8 members in a group. You will be asked questions on CPD (CPD)

and notes will be taken during the discussions. All the proceedings will be audiotaped. Confidential forms will be signed by you with the help of the research assistant. The discussions will take place in a quiet room to avoid disturbances. Analysis will be conducted through coding to draw the prominent themes coming out of discussions.

The benefits of this study are that they will influence the formulation of policy in terms of the National CPD Framework to monitor and maintain CPD for nurses and midwives in order to protect the public by providing safe and quality care. There will be increased professional awareness of the role of the regulatory body in ensuring continuous competencies of nurses and midwives. The information will contribute to the body of knowledge on CPD especially in South Africa.

Potential risks are fear where you as a participant might be victimised for divulging information on workplace matters. Generally, you are not going to be exposed to any physical risks.

Feedback procedure will entail documenting the results in journals and articles accessible to nurses.

Yours sincerely

……

Researcher's signature

MS MA Mnguni
Contact number: 0829014009
Email address: Mnguni.agnes@gmail.com

Supervisor's office number: 012 429 6541
Email address:makuamg@unisa.ac.za

Chairperson of the Health Studies Research Ethics Committee: Prof Maritz

Email address: hsrec@unisa.ac.za

ANNEXURE D: INFORMATION LEAFLET TO PARTICIPANTS

TEMPLATE DOCUMENTS

PARTICIPANT INFORMATION SHEET

2017.06.27

TITLE: Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives

Dear Prospective Participant

My name is **Mmamoroke Agnes MNGUNI** and I am doing research towards a Master's Degree with **Dr MG Makua**, a senior lecturer, in the Department of Health Studies at the University of South Africa. We are inviting you to participate in a study entitled:
"**Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives"**

WHAT IS THE PURPOSE OF THE STUDY?

This study intends to explore the nurses' and midwives' perceptions and attitudes toward the implementation of Continuing Professional Development (CPD) by the South African Nursing Council (SANC).

WHY AM I BEING INVITED TO PARTICIPATE?

Why did you choose this particular person/group as participants?

You have been chosen because the researcher believes and hopes that you meet the criteria for this project and possess required information to take the project forward.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves the exploration or probing into the experiences and views (perceptions and attitudes) of the nurses and midwives with regard to the implementation of CPD by SANC

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

You are under no obligation to consent to participation and there is no penalty or loss of benefit for non-participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason except if such withdrawal intent is after you have submitted the non-identifiable completed scale.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

This study may not benefit you directly immediately but may have future implications on practice, since it will lead to development of a body of knowledge that will impact the community of South Africa and nurses in particular by improving knowledge, skills and attitudes.

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There are no foreseeable risks of harm or side-effects to the potential participants.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Anonymity will be ensured since your name will not be recorded anywhere and no one will be able to connect you to the answers you give. Their anonymous data may be used for other purposes, such as a research report, journal articles and/or conference proceedings. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. Confidentiality is assured since no

one apart from the researcher and identified members of the research team, will know about your involvement in this research. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet in the data storage strong room for future research or academic purposes. Electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. The stored hard copies of information will be destroyed by shredding, whilst electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software Programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

Your participation in this study is totally voluntary with no forms of compensation.

HAS THE STUDY RECEIVED ETHICS APPROVAL

This study has received written approval from the Ethics Review Committee of UNISA. The researcher will avail a copy of the approval letter if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Ms Mmamoroke Agnes MNGUNI, email address: mnguni.agnes@gmail.com. The findings

will be accessible from midyear 2019. Should you require any further information or want to contact the researcher about any aspect of this study, please contact the researcher at 082 901 4009

Should you have concerns about the way in which the research has been conducted, you may contact Dr M G Makua, +27124296524, e-mail address makuamg@unisa.ac.za. Or contact the Chairperson of the HSREC ethics committee, Professor Maritz, J. at hsrec@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

……..
Signature

Ms Agnes Mnguni

ANNEXURE E: CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the psychosocial scale.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……..Date……

Researcher's Name & Surname…… (please print)

Researcher's signature……..Date……

ANNEXURE F: CONFIDENTIALITY BINDING FORM

STUDENT NAME: MMAMOROKE AGNES MNGUNI

STUDNT NUMBER: 05112559

TOPIC: Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives

UNDERTAKING BETWEEN RESEARCHER AND PARTICIPANT

Binding Confidentiality agreement

I…….....(participant) for the study entitled**: CONTINUING PROFESSIONAL DEVELOPMENT IN SOUTH AFRICA: PERCEPTIONS AND ATTITUDES OF NURSES AND MIDWIVES**, conducted by …Mmamoroke Agnes Mnguni, Master student at University of South Africa, agree freely to participate to the Focus Group Discussion and to abide to the following:

- ✓ I will keep confidential all the information shared during the focus group discussion
- ✓ I will respect the opinion expressed by my group members
- ✓ I will not disclose any information outside the group discussion
- ✓ I will not link any information to any group member
- ✓ The researcher/facilitator agrees to take all reasonable steps to protect personal identity of the participants
- ✓ The researcher/facilitator agrees to take all reasonable steps to protect the privacy of the participants.

I fully understand the content of this entire agreement and undertake to freely participate to the group discussion.

The researcher The participant

Name: …….. Name:……..

Sign…… Sign: …….

Date……

ANNEXURE G: DATA COLLECTION INSTRUMENT

ESTIMATED TIME: 1Hour

Continuing professional development in South Africa: Perceptions and attitudes of nurses and midwives

FOCUS GROUP GUIDE

1. What are your views about CPD implementation by the regional hospital where you are working?
2. How do you feel about the implementation of CPD by the regional hospital where you are working?
3. What recommendations can you make to enhance the implementation of CPD?

ANNEXURE H: LANGUAGE EDITING CERTIFICATE

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

29 January 2019

TO WHOM IT MAY CONCERN

This certificate serves to confirm that I have edited and proofread Ms A Mnguni's dissertation entitled, **"CONTINUING PROFESSIONAL DEVELOPMENT IN SOUTH AFRICA: PERCEPTIONS AND ATTITUDES OF NURSES AND MIDWIVES".**

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:

Jack Chokwe (Mr)

Contact numbers: 072 214 5489

jackchokwe@gmail.com

Professional EDITORS Guild

ANNEXURE I: TURNITIN ORIGINALITY REPORT

Turnitin Originality Report
Dissertation by MNGUNI Agnes
From Complete dissertation/thesis submission for examination (CHS M&D Students 2019)

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