PERCEPTIONS OF REGISTERED NURSES WITH REGARD TO CONTINUING FORMAL EDUCATION

by

LYDIA ELIZABETH RICHARDS

submitted in part fulfilment of the requirements for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. E POTGIETER

JULY 2007

Student number: 3064-091-1

I declare that PERCEPTIONS OF REGISTERED NURSES WITH REGARD TO CONTINUING FORMAL EDUCATION 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.

....

SIGNATURE DATE
(MISS L E RICHARDS)

Acknowledgements

I am grateful to God for giving me the opportunity to complete this study, and give Him thanks and praise.

I would also like to give my thanks to the following persons for their invaluable support and encouragement:

- Prof. E Potgieter, my supervisor at Unisa, for her guidance, and patience and for all she taught me.
- The hospital directors for allowing their registered nurses to participate in the research.
- My registered nurse colleagues at the participating hospitals who participated in the research.
- My family and friends, who encouraged me, never gave up supporting and believing in me, particularly:
  - My sisters Ester Samuels and Bernice Versfeld who, together with their families, supported me physically and emotionally.
  - My friend Julia Davids for her inspiration.
- Florence Curtis for analysing the data and producing the statistics.
- Leverne Gething for editing of the dissertation.

To you all, my sincere thanks. I wish you all continued strength in your endeavours – may people be as caring and helpful to you as you have been to me.

Abstract

The purpose of this study was to explore and describe registered nurse's perceptions with regard to continuing formal education. A quantitative descriptive, explorative research design was used to study registered nurses views with regard to continuing formal education and to identify the barriers to continuing formal education as experienced by registered nurses. Convenience sampling was used to select the research sample of registered nurses working at four state health institutions in the Western Cape Province, South Africa. Descriptive statistics, based on calculations using the Microsoft (MS) Excel (for Windows 2000) programme, were used to summarise and describe the research results obtained from the questions completed by the registered nurses. The research results indicated that most registered nurses perceive continuing formal education as beneficial to their personal and professional growth and to improve the quality of patient/client care, but barriers exist which prevent or deter them from undertaking continuing formal education programmes. The main barriers were identified as structural barriers, including lack of funding, job and family responsibilities and lack of coherent staff development planning.

Key words: career development; continuing formal education; registered nurses; perceptions; motivation; physical barriers; structural barriers; attitudinal barriers.

TABLE OF CONTENTS **PAGE**

CHAPTER 1 INTRODUCTION AND OVERVIEW OF THE STUDY

TABLE OF CONTENTS **PAGE**

CHAPTER 2 LITERATURE REVIEW

TABLE OF CONTENTS **PAGE**

CHAPTER 3 RESEARCH METHODOLOGY

TABLE OF CONTENTS **PAGE**

TABLE OF CONTENTS **PAGE**

CHAPTER 5 SUMMARY OF FINDINGS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

LIST OF TABLES **PAGE**

LIST OF ANNEXURES

CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The World Health Organization *World Health Report* (WHO 2000:76) states that human resources are the most important of the health system's resource inputs. The performance of health care systems ultimately depends on the knowledge, skills and motivation of the people responsible for delivering services. Education and training are key investment tools as old skills become obsolete with the advent of new technologies. The *World Health Report* places emphasis on the need for strategic planning with regard to continuing education for health care providers. As an example, where education and training for junior nurses functions poorly, or where senior staff lack adequate time and resources to update their knowledge and skills, future shortfalls can be expected.

Nurses are required to be competent practitioners, have a scientific base for their practice, be sufficiently knowledgeable to communicate with increasingly informed patients and family members, be able to access relevant information from the Internet, and have a mastery of technology in the dynamic arena of patient care and patient conditions. Organisations which do not invest in the career development of their employees may discover that their organisation is characterised by unmotivated employees who are disinterested in career development and lack commitment to the organisation (WHO 2006:76).

Kenworthy and Nicklin (1993:84) say: “It is an indictment to the service that sustaining and developing nursing skills is dependent on the whim of the individual nurse or health district that employs her”. The continuing professional development of the registered nurse is not exclusively the responsibility of the individual or the employing authority but of both. The individual nurse has the right to expect the provision of training opportunities, and the employer should expect the nurse to maintain and develop the skills for which she is employed (Jooste 2005:53; Mackereth 1989:776).

The concept of employability is closely linked with continuing formal education. Employability means thinking not just in terms of the job skills needed to do the current job, but also about continuing professional development through continuing formal education, with the acquisition of new skills. Recommendations based on a study of career goals among post-basic nursing management students in Gauteng included the need for employers to encourage nurses to undergo further training to address the needs of the community they serve and to promote staff satisfaction. Employees expect to have a meaningful and secure job, authority and responsibility at work, a friendly working environment, equality in the work group, and to receive feedback relating to their work performance. Expectations are not static, but dynamic: a younger registered nurse’s current needs will not be the same in 20 years’ time. Initial expectations may focus on career prospects but later may focus on status and prestige. Meeting such expectations requires the acquisition of skills, and while opportunities for continuing formal education may not diminish with change, the employees’ expectations change - and this must be borne in mind by the nurse manager (Jooste 2003:140; Jooste 2005:47,52,53).

This study focuses on registered nurses' perceptions of and barriers to continuing formal education as a component of career development. Continuing formal education programmes are those which lead to the registration of an additional qualification with the South African Nursing Council or a higher degree in a health-related field. The registered nurses who form the research sample are drawn from those who currently work at selected state health institutions in the Western Cape Province, South Africa.

1.2 BACKGROUND TO THE PROBLEM

The researcher, a facilitator for a post-registration nursing course, has the opportunity to periodically conduct exit interviews with students who have not completed their course of study. Less positive comments have included: "managers and colleagues do not support us who are studying"; "work stress is making me miserable"; "I cannot manage the study and practice workload and dedicate quality time to my family" and "I hear constant complaints about the shortage of staff and it makes me feel guilty that I am studying". These comments contributed to arousing the researcher's interest in identifying the barriers to the continuing formal education of registered nurses.

In 2004 a strategic learning and research advisory group was consulted to evaluate post-registration nursing development in England, UK. Recommendations included the provision of a period of mentorship by employers for newly qualified nurses and employees. Employers should have workforce development and personal career planning programmes in place. Open communication between the health services practice areas, nursing registration bodies, and higher education institutions is regarded as vital to

maintain relevancy in career development and patient care. In the UK the context for learning beyond registration has changed significantly. The perceived value of professionally accredited and recognised awards by nursing registration bodies has been eroded as part of a more general shift towards award-bearing academic learning. Educators in the tertiary institutions must communicate these changes to nurse managers since these have implications for workforce planning and the granting of study leave (Strategic Learning and Research Advisory Group for Health, Social Care and Education Sectors at Central Government 2004:5-9).

Glass and Todd-Atkinson (1999:225-227) surveyed registered nurses and licensed practicing nurses across randomly selected facilities in North Carolina in the United States of America (USA), to ascertain their self-perceived learning needs. Findings included the need to be aware of readily available nurse education programmes, to have knowledge of how to access financial support for programmes, to have nurse managers who encourage continuing formal education and who are aware of factors that encourage or deter continuing education, and educators who ensure that learning is relevant to the current environment in which health care is delivered. It was acknowledged that failure to provide this constant assessment could result in patients/clients receiving suboptimal care. A study by White (2001:201-202) in the USA concluded that the health services manager faces the challenge of encouraging his or her own continuing education as well as that of the employees in the face of the cycle of a reduced pool of potential recruits into the profession, sicker patients, and a smaller workforce.

Fletcher (2001:327-329) surveyed 1780 registered nurses across ten hospitals located in Southern Michigan, USA, to ascertain hospital registered nurses' job satisfaction and dissatisfaction. Findings included the expectation that managers have their staff's best interest at heart as the number one concern. This could be proven by providing support and buffering stress, clearly communicating the manager's expectations, not being detached from the problem of staff shortages, and promoting professional development. Fulfilling the nurses' continuing education ideal requires managers who are interested in their employees and who will ensure that each employee gets their fair share of available learning opportunities (Jooste 2003:140; Kenworthy and Nicklin 1993:85).

1.2.1 The nurse's need to be cared for

Nurses themselves want to feel cared for. Caring involves being treated with dignity and respect. As people are the greatest asset of any organisation, it is the responsibility of the unit manager to create conditions for the personnel where they experience emotional support and administrative recognition. The working relationship between managers and employees must allow for open communication, the fostering of creativity, acknowledgement of accomplishments and trust. This inspires managers and employees to direct their efforts towards the common goal of providing quality care for the health service user (Jooste 2003:151). Nurses need job satisfaction and to feel that what they are doing is relevant. Learning to care skillfully and with understanding on the basis of knowledge and compassion is conducive to job satisfaction. To achieve relevance in nursing practice, the connection between knowing, learning, and doing must be maintained (Mellish and Brink 1996:84).

Mentorship is a contributory factor to the fulfilment of the less experienced nurse's need for educational support and recognition. Quinn (1997:188) defines mentorship as: "…an appropriately qualified and experienced ... nurse … who, by example and facilitation, guides, assists, and supports the student in learning new skills, adopting new behaviour and acquiring new attitudes". In Maslow's theory of human motivation, esteem needs are concerned with strength, achievement, mastery and competence, including reputation, prestige and dignity. Nurses who willingly seek lifelong professional education would be striving towards fulfilling their esteem needs on the way to achieving self-actualisation, the fulfilment of the individual's potential (Atkinson, Atkinson, Smith, Bem and Hilgard 1990:524). Adult learning theory includes the assumptions that they need to know the reason why they must learn something; take responsibility for their own learning; their readiness to learn relates to the things they need to know and do in real life; and that their motivation to learn is largely internal. Intrinsic motivation includes the need for self-esteem, quality of life and job satisfaction (Swansburg 1993:294; Quinn 1997:104). Therefore, opportunities must exist at both unit and organisational level for the registered nurse to pursue his or her desire for continuing formal education.

1.2.2 Barriers to continuing formal education

Nzimande (1987:22) suggests that continuing education depends entirely on the attitudes of the person who seeks it. She asserts that if the professional person accepts that continuing professional education is lifelong and self-directed, requires personal accountability and is willingly sought, nothing is impossible for them.

Several barriers have been identified to continuing formal education in nursing. Barriers refer to those aspects which prevent access or progress (*Collins English Dictionary* 1992). Reasons that nurses do not take the opportunity to continue their education may vary according to the availability of courses, the attitude of the nurse and the hours of duty. Nurses may feel that they have had many years of experience, in which they have perfected their nursing skills. Continuing their education has therefore little value for them (Nugent 1990:471). Barriers to post-registration continuing education in nursing are little different to the barriers to engaging adult learners. These barriers have been described as outlined below:

- *Physical barriers* include lack of time due to work, family and child care responsibilities; difficulties in paying course fees and fear of losing benefits; ill health; difficulty with reading and writing; difficulties with English if this is not the learner's first language; and difficulties with numeracy.
- *Attitudinal barriers* refer to being nervous about going back to the classroom and concern about not being able to keep up; skepticism about the value of continuing education; low self-esteem and lack of confidence both generally and in relation to learning; low aspirations and lack of role models; lack of trust in formal institutions; and a perception that they are too old to learn.
- *Structural barriers* include lack of transport; limited opportunities for learning near to place of residence; lack of the necessary entry requirements to post-registration programmes; and lack of knowledge about learning opportunities (Leading learning and skills [LSC] 2005:2-4).

Nursing services managers face the challenge of encouraging their own continuing education and that of their employees in the face of decreased resources, decreased clinical involvement, increased staff diversity, increased coordination across units, implementation of new regulatory requirements and being a spokesperson for the model of care being implemented. This frequently represents a major change in their professional role and can also lead to a great deal of frustration for the nursing unit manager who is trying to satisfy the demands of the organisation and the needs of the staff (Fletcher 2001:327-329; White 2001:201-202). According to Nicklin (1985), in Kenworthy and Nicklin (1993:85), the manager faces the dilemma of either releasing staff for training, which may result in staff shortages, or discouraging nursing skills development - and the manager is more likely to be criticised for being short of staff than for having nurses who are short of skills.

1.3 STATEMENT OF THE PROBLEM

Continuing professional development is extremely important in the nursing profession, especially because of rapid and continuous progress in medical science and specialisation. Nurses need to maintain competency and keep up to date with the most recent research and developments in patient care. The nursing profession is accountable to society for providing high-quality care for patients and families. Nurses need scientific knowledge to improve their decision-making skills regarding what care to provide to patients and how to implement that care (Burns and Grove 1999:5).

Practicing nurses need to be supported by their employers to enable them to pursue continuing formal education. It does, however, appear that a proportion of the post-registration course students with whom the researcher is in direct contact on a regular basis do not enjoy the support of their managers and colleagues towards their post-registration formal education programmes. Indicative of this lack of support are reports of being stripped of unit responsibilities they had before embarking on a programme of study; being excluded from ward level decision making because they are students; being overlooked for senior posts in spite of undertaking a relevant study programme; and difficulty in obtaining cooperation from the unit manager and colleagues to complete projects such as problem solving in the work place which require a team effort.

A proportion of students do not complete their studies. Reasons given have included the inability to meet deadlines set by the tertiary institution; work stress, which impacts on the time available to attend to studies; and family commitments.

It is against this background that this research study seeks to find answers to the following questions:

- How do registered nurses view continuing formal education?
- What are the barriers experienced by registered nurses with regard to continuing formal education?

1.4 PURPOSE OF THE STUDY

The purpose of the research is to explore and describe perceptions of registered nurses with regard to continuing formal education.

1.5 RESEARCH OBJECTIVES

The objectives of the study are to:

- Establish how registered nurses view continuing formal education.
- Identify barriers to continuing formal education experienced by registered nurses.

1.6 SIGNIFICANCE OF THE STUDY

It is important that both the employer and the employee have a responsibility towards career development of staff. Nurses have specific needs in their career that they state as their goals for the future. Nurses are more likely to have successful careers if organisations and individuals are involved in career planning. The research findings in terms of how registered nurses view continuing formal education and identification of the barriers to continuing formal education experienced by registered nurses, with the subsequent recommendations, could benefit the nursing profession and improve health care provision. The findings and recommendations of the research, when communicated to health care organisations, could benefit those organisations by providing insight into how registered nurses view continuing formal education and the barriers to continuing formal education that they experience. Additional support structures to overcome identified barriers to continuing formal education could then be put into place.

Organisations which do not invest in the career development of their employees may discover that their organisation is characterised by employees who lack commitment to the organisation, with high staff turnover rates and less than optimal commitment to a high standard of patient/client care (Orpen 1994:27; WHO 2000:76).

Nursing education allows the nurse to look at the wider issues around practice, and to meet the patients' needs more efficiently. The more health professionals learn, the more they will challenge the traditional practices, embrace change, and foster innovation. However, nursing education must be relevant, based on patient/client needs and the needs of the health care organisation. The research findings and subsequent recommendations could contribute to making education programmes more accessible where this is found to be prohibitive, and ensuring that relevance to clinical practice is maintained. Effective continuing education programmes in nursing have been credited with the ability to enhance the quality of nursing care by improving the knowledge base of staff with the consequence of raising standards and producing a more cost-effective service (Burns and Grove 1999:12; Hoban 2005:22; Mackereth 1989, in Smith and Topping 2001:342).

1.7 DEFINITION OF KEY CONCEPTS

Perceptions refer to the act of having knowledge and understanding of something (*Collins English Dictionary* 1992). In this study, perceptions refer to the knowledge and understanding that registered nurses have with regard to continuing formal education.

Barriers refer to those aspects which prevent access or progress (*Collins English Dictionary* 1992). In this study, barriers refer to those physical, attitudinal and structural aspects which prevent the registered nurse from engaging in continuing formal education.

Registered nurse refers to a person who has successfully completed the basic programme in nursing which leads to registration with the South African Nursing Council in terms of South African Nursing Council Regulation No. 425 (R425) of 22 February 1985 as amended (Mellish and Brink 1996:50). The term registered nurse in this study is used to denote this category of nurse.

Continuing formal education refers to a programme of study undertaken after registration as a general nurse leading to the registration of an additional qualification with the South African Nursing Council or a higher degree in a health-related field.

Continuing professional development/career development refers to the concept of a life-long process of becoming something better than the individual is at the present time, through the pursuit of skill enhancement. It is the individual's capacity to accurately assess developmental needs in relation to life and career goals (Simms, Price and Ervin 1994:169). Continuing professional development/career development embraces continuing formal education, continuing professional education, in-service education in nursing and education courses which do not necessarily lead to the registration of an additional qualification.

Tertiary institutions refer to education institutions approved by the nursing registration body that provide academic nursing education leading to the registration of additional qualifications such as diplomas in critical care nursing, child nursing, trauma nursing and advanced diplomas in health studies, and institutions which confer qualifications in health-related fields (Dumpe, Herman and Young 1998:174; Redman 2001:57; Unisa 2005:3).

Levels of service provision in South Africa as described in Coovadia and Wittenberg (2000:50):

Primary level services refer to the level of health care through which a patient makes first contact with the health care system, for example, a primary health care clinic or a general practitioners consulting room practice.

Secondary level services refer to health service facilities to which patients, seen at primary level, are referred for more sophisticated management such as non invasive diagnostic tests or general surgery.

Tertiary level services refer to health service facilities staffed by either specialists or super-specialists to which patients seen at the secondary level are referred for more sophisticated management, for example, cardio thoracic investigations and cardiothoracic surgery and organ transplantation.

1.8 RESEARCH DESIGN AND METHODOLOGY

A research design addresses the planning of a scientific enquiry. It focuses on the end product and the logic of the research. The research design is a plan of how the researcher intends to conduct the research. Babbie and Mouton (2002:72,78) and Mouton (2002:4,56) emphasise the importance that the researcher chooses a study design which will provide acceptable answers to the research problem or questions, considers what kind of evidence is required to address the research question adequately, and is aware of the possible challenges or limitations of the chosen design. The research methodology refers to the process and the steps in the research process (Babbie and Mouton 2002:56). Creswell (2003:14,21) suggests that if the problem to be investigated is to identify factors that influence an outcome or to understand the best predictors of outcomes, then a quantitative approach is best.

1.8.1 Research design

A quantitative, descriptive, exploratory research design is proposed for the study, using a self-administered questionnaire. A quantitative approach requires collection of information using instruments based on measures completed by the participants and recorded by the researcher. Descriptive research seeks to gain information about the characteristics of a phenomenon of interest. The purpose is to provide a picture of a situation (Burns and Grove 2005:232). In this study, registered nurses' perceptions about continuing formal education and what they regard as motivators and barriers will be investigated and described.

Exploratory research involves adopting an investigative stance and exploring all sources of information to gain new insights which might lead to a better understanding of a phenomenon. Utilising the survey for its exploratory purpose will allow the researcher to obtain information, especially through open-ended questions, as to the what and why pertaining to motivators and barriers to continuing formal education. Including open-ended questions in a questionnaire which contains largely close-ended questions, as in this research, will facilitate the exploratory purpose of the research in order to gain deeper insight and better understanding of the motivators and barriers to continuing formal education as experienced by the respondents (Babbie and Mouton 2002:80; Neuman 1997:19).

1.8.2 Population

The study population included registered nurses who currently work at four state health institutions in the Western Cape Province, South Africa. The researcher requested the participation of registered nurses at these health institutions after giving them information relating to the purpose of the study. The inclusion criterion was willingness to participate in the study. The exclusion criterion was self-exclusion through unwillingness to participate in the study

The following categories of registered nurses were included in the study:

- Registered nurses in charge of a nursing unit;
- Registered nurses currently enrolled for a post-registration programme;
- Registered nurses who have completed a post-registration programme; and

- Registered nurses who did not complete a post-registration programme.

1.8.3 Sample and sampling technique

Sampling is the process of selecting a portion of the population to represent the entire population. A sample is a subset of population elements, an element being the most basic unit about which information is collected. Random sampling usually provides a sample that is representative of a population, because each member of the population is selected independently and has an equal chance or probability of being included in the study. However, descriptive studies are often conducted with non-random or non-probability samples (Burns and Grove 1999:28; Polit and Beck 2004:291). In this study convenient sampling was used. There was no way to estimate the probability that each element had of being included in a non-probability sample as the research sample was drawn specifically from four state health institutions in a specific province, the Western Cape Province, South Africa. The sample size was seventy registered nurses.

1.8.4 Method of data collection

The quantitative approach employs strategies of data collection using predetermined instruments such as questionnaires that yield statistical data, with the intent of generalising from a sample to a population. Surveys using a self-administered questionnaire may be used for descriptive, exploratory and explanatory purposes. Surveys are chiefly used in studies that have individual people as the units of analysis, and are also appropriate for measuring attitudes and orientations in a large population. The questionnaire will facilitate determination of the extent to which respondents hold a

particular attitude or perspective. A questionnaire provides an unbiased approach in response to being asked to either support or refute beliefs with regard to continuing formal education for registered nurses (Babbie and Mouton 2002:230; Cresswell 2003:14,18,19; Burns and Grove 1999:794). Creswell (2003:23) places emphasis on the need for researchers to be sensitive to the audiences to whom they report their research. An unbiased set of questions would demonstrate sensitivity to the audience who will have access to the research report. The audience for this study is likely to include the respondents to the questionnaire and the participating health care institutions.

1.8.5 Measures to ensure reliability and validity

Researchers want their findings to reflect the truth. Research cannot contribute to evidence to guide clinical practice or evidence to inform nurse education if the findings are inaccurate, biased, fail to adequately represent the experiences of the target group or are based on misinterpretation of the data. Two of the most important criteria used to assess the quality of a study are reliability and validity (Polit and Beck 2004:35). The measuring tool proposed for this study is a self-administered questionnaire. The questionnaire will require testing for reliability and validity.

1.8.5.1 Reliability

The reliability of a research instrument is indicative of the degree of consistency with which it measures the attribute it is supposed to be measuring. Reliability refers to the accuracy and consistency of information obtained in a study. The term is most often associated with the methods used to measure research variables. Reliability is also

important in interpreting the results of statistical analyses referring to the probability that the results are an accurate reflection of a wider group than just the study participants, a measure to ensure that the same results would be obtained with a completely new sample of participants (Polit and Beck 2004:35). The reliability of the research instrument will be discussed in chapter 3.

1.8.5.2 Validity

Validity concerns the degree to which an instrument measures what it is intended to measure (Polit and Beck 2004:735). Content validity refers to the extent to which a specific measurement provides data that relate to commonly accepted meanings of a particular concept. Content validity concerns the degree to which an instrument has an appropriate sample of items for the construct being measured (Babbie and Mouton 2002:123; Polit and Beck 2004:714). To overcome errors in questionnaire construction, such as ambiguous or vague terms, double-barrelled questions, negatively phrased and leading questions, pre-testing of questionnaires is recommended (Mouton 2002:103). The questionnaire was pre-tested by one unit manager, one registered nurse currently engaged in formal continuing education, and one registered nurse not currently engaged in formal continuing education.

1.8.6 Method of data analysis

Polit and Beck (2004:451) say: “Statistical analysis helps researchers make sense of quantitative information. Without statistics, quantitative data would be a chaotic mass of numbers”. The data were analysed using quantitative data analysis methods.

1.8.7 Ethical considerations

Informed consent refers to the right to full disclosure about the research. Informed consent was ensured by obtaining written approval from the Directors of the participating state health institutions to obtain confidential information from registered nurses in their employ. The participants in the research also received a written explanation of what the research was about and the benefits of the research. The principles of confidentiality and anonymity were upheld. No indicators (such as numbers or lettering) by which a participant could be identified appeared on the data collection instrument. Secure storage of the completed questionnaires was ensured. The outcome of the study will be reported to the participating state health institutions, giving participants in the research access to the results in accordance with ethical research (Babbie and Mouton 2002:523; Mouton 2002:244). Ethical considerations will be discussed in detail in chapter 3.

1.9 TIME FRAME OF THE STUDY

The researcher completed the study in December 2006.

1.10 ORGANISATION OF THE CHAPTERS OF THE DISSERTATION

The dissertation is presented as follows:

CHAPTER 1: Describes the relevance of this research to the field of nursing, the research problem, objectives and definition of key concepts. An overview of the research methodology, design and ethical aspects is provided.

CHAPTER 2: Includes a review of previous research findings in the field of continuing formal education for registered nurses.

CHAPTER 3: Focuses on the methodology and design of the research, and includes the selection of the sample of participants, data collection methods and a plan to organise and analyse the data.

CHAPTER 4: Presents an analysis and interpretation of the findings.

CHAPTER 5: This final chapter focuses on further discussion of the findings of the research, and the conclusions, limitations and recommendations with regard to the continuing professional development of registered nurses.

1.11 CONCLUSION

In this chapter the researcher presented an introduction and the background to the research problem. The key concepts, research design and steps taken to answer the research question were formulated.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Today, health care users generally know more about health services, and governments are increasingly demanding that patients' views be sought and that equal partnerships be developed between health care users and health care professionals. Consequently, health care users have greater expectations, and at the same time they are more critical in their attitudes. Health care users have the right to openly air their views about whether or not health care providers deliver value for money. Consumers of health care are demanding that services become more service-oriented, thereby indicating that they want them to be more relationship-centred.

Health care users expect and are entitled to information regarding available services, and the level and quality of services they can expect. Health care users expect health care professionals to have up-to-date knowledge and skills appropriate to the specialist field in which they practice. Health care professionals need to be equipped to meet these challenges. Education beyond registration as a nurse provides for ongoing expansion of knowledge to meet these requirements and of skills to meet current challenges (Astedt-Kurki and Haggman-Laitila 1992:1192,1195; Jooste 2003:7,144,246,247; Department of Health 1999).

In this chapter the literature is reviewed and discussed. The purpose of a literature review is to demonstrate familiarity with a body of knowledge, to show the path of prior

research, to integrate and summarise what is known in a specified area, to learn from others and to stimulate new ideas with regard to the research problem (Neuman 1997:89). Literature was reviewed which relates to continuing formal education, continuing professional development, and continuous professional education. For the purposes of the study, the term continuing formal education refers to a programme of education that leads to the registration of an additional nursing qualification or a higher degree in a health-related field. While continuing professional development and continuing professional education may not necessarily culminate in the achievement of a professional qualification, the principles which underlie the pursuit of new knowledge are the same as for continuing formal education in nursing, hence their inclusion in discussion of the literature reviewed.

The literature is discussed under the following headings, which arose repeatedly during the course of the literature review:

- the importance of continuing professional development;
- the benefits of continuing professional development for the health care professional, the health care user, and the health care organisation;
- the motivation for continuing professional development;
- the barriers to undertaking continuing formal education; and
- the factors which facilitate pursuing a continuing formal education programme.

2.2 IMPORTANCE OF CONTINUING PROFESSIONAL DEVELOPMENT

Lahiff (1984:27) states: “Despite the lip service paid to post-basic education by the nursing profession, many nurses still have an anti-intellectual bias”. These sentiments, expressed twenty two years ago, were based on the assumptions that there is a need for high-quality nursing care; the nursing profession needs to improve its status; and in the foreseeable future continuing education will become a prerequisite for continuing registration and promotion. It is recognised that higher-level competencies and professional expertise result in part from years of clinical experience. This experience, however, is expected to be underpinned by advanced learning beyond initial registration as a nurse.

Anderson (2000) in Horton-Deutsch and Mohr (2001:124) criticised the anti-intellectual culture in the nursing profession in the USA, stating that it is one that values “doing” over knowing and as a result is “undereducated, aging and in a cycle of decline”. Horton-Deutsch and Mohr (2001) explored how nursing leadership was being influenced by an anti-intellectual stance among members of the profession. These authors claim that advocates of degree nursing have been chastised for attempting to obstruct less economically advantaged individuals from entry into the profession, an attack that reflects genuine concern for people who are not able to afford a university education, but also reflects the anti-intellectual bias of the greater culture. According to Christman (1998) in Horton-Deutsch and Mohr (2001:124), the weakest prepared nurses are the highest in number, and yet it is this group who vehemently object to criticism.

In South Africa, nurses carry the burden of a public health system battling to overcome staff shortages, a growing HIV/AIDS pandemic, and under-resourced public health facilities which result in stressful working conditions. It is difficult to see beyond these harsh conditions to how attaining a higher nursing qualification will ease the burden of care and attract increased monetary reward. Many experienced registered nurses who completed their basic nursing course at diploma level, and have acquired professional expertise from years of clinical experience, should not be criticised for expressing doubts about the value of advanced learning. Review of the literature will, however, show improved motivation and levels of retention as well as improved levels of clinical and managerial competence as a result of continuing education.

The United Kingdom Central Council for Nurses Midwives and Health Visitors (1992) emphasises the importance of continuing professional development when it states that: "Foundation education alone, cannot effectively meet the changing and complex demands of the range of modern health care. Post registration education equips practitioners with additional and more specialist skills necessary to meet the special needs of patients and clients" (Abruzzese 1996:31). There is a relationship between societal and technical change and subsequent pressures for reform on health care systems and nurses. Nurses face constantly increasing demands to remain both professionally up to date and personally capable of coping with the stresses of nursing and changes in their own lives (Yuen 1991:1233). A programme of continuing professional development can be viewed as having a range of functions, namely: the maintenance role that fosters the notions of life-long learning; the survival role that requires practitioners to demonstrate their

ongoing competence; and the mobility role that aims to increase a person's employability. As nursing becomes more complex requiring nurses to be more knowledgeable, and as the number of nurses with degrees grows, so will competition for posts (Lawton and Wimpenny 2003:41; Eustace 2001:134; Hoban 2005:22).

Kennie and Enemark (1996:1) aptly summarised the importance of continuing professional development when they stated that few professionals can remain unaffected by the rapid pace of change which has influenced the professions over the past decade. Professionalism relies increasingly on an ability to respond quickly to changing market conditions, to client requirements, and to the influences of government policies. Professionals are encouraged to embrace change and foster innovation. New skills, essential to professional and organisational success, are needed to adapt to these changes. The authors suggest that the concept of continuing professional development is not new, but that it is simply part of good professional practice. What *is* new, however, is the greater importance and relevance of continuing professional development to professional success. According to Welsh and Woodward (1989) in Kennie and Enemark (1996:3), the following reasons account for the growing importance of continuing professional development: competence; consumerism; litigation; standards; quality assurance; and competitiveness. These are outlined below.

Competence: According to Welsh and Woodward (1989) in Kennie and Enemark (1996:3), it has been estimated that the knowledge gained in a vocational degree course has an average useful life span of about four years. While this will vary according to the

discipline, it does nevertheless highlight the increasing need to maintain an active interest in keeping up to date with changing technology, legislation and operational procedures. If at the same time professionals have expectations of increased managerial responsibility, the need to acquire new skills and knowledge is even more acute. Tlholoe (2006:5) agrees with the need for a commitment to continual learning, stating that people who stop learning become less and less relevant as skills gained early in a career are insufficient to avoid costly mistakes made through ignorance.

Consumerism: According to Welsh and Woodward (1989) in Kennie and Enemark (1996:3), the development of a more affluent consumer society has also resulted in a better informed and more sophisticated public. One consequence of this trend is that the public expect a higher duty of care and level of service from their professional advisors than in the past. The skills acquired during an initial training period or during higher/further education may not equip new staff for this role. Continuing formal education has important implications for both professional nurses and for the general public. The public has a right to be safeguarded against malpractice, and they have an expectation that nurses will possess up-to-date knowledge and skills appropriate to the specialist field in which they practice. The aim of continuing formal education is to ensure that practitioners' skills and knowledge (including psychosocial aspects) remain current, optimising the safety and quality of those services, and giving assurance to the community in this regard (Abruzzese 1996:31).

Litigation: The professions are increasingly at much higher risk from claims of negligence than in the past. Health care professionals work in a very structured environment where regulation and accountability for practice are required. Nursing deals with complex human problems, and cannot limit itself to a circumscribed body of information. In order to respond to the array of problems that nurses confront, the profession as a whole and its members individually must be encouraged to profit from every source of knowledge (Davee and McHugh 1995:100; Eustace 2001:134).

Standards: One of the primary roles of professional bodies is to safeguard standards of competence. Continuing professional development has a key role to play in the communication of agreed standards and in ensuring that members comply with specified procedures (Welsh and Woodward 1989 in Kennie and Enemark 1996:3). The South African Nursing Council, which was established under the Nursing Act of 1978 (as amended), is the controlling and disciplinary body for nursing in South Africa and makes regulations relating to the scope of practice of persons registered in terms of the Act. The South African Nursing Council determines professional standards. In so doing, health care users are afforded the services of a competent professional nurse (Searle and Pera 1994:4). The South African Charter of Nursing Practice (2006) focuses on competencies, based on a scientific approach, that nurses have to demonstrate in the care of individuals, groups and communities at all levels of health care. The challenge for nurse education includes fostering the competence of the nurse to ensure that he/she can implement evidence-and research-based practice that guides the nurse in sound decision making (van Wyk 2006:45).

Quality assurance: According to Welsh and Woodward (1989) in Kennie and Enemark (1996:3), the increasing emphasis on quality management systems and the ethos of continuous improvement has also increased the relevance of continuing professional development. Quality management in health care refers to excellence described by means of standards and criteria in accordance with the expectations of the different role-players, the patient, service providers, and funders. Training and education are key elements to the maintenance of quality in health care provision (Jooste 2003:247,263).

Competitiveness: Whether in the private or the increasingly privatised public/state sector, the competitive market edge must be partly or totally focused on client care/service quality or technological innovation. All of these responses demand a high investment in developing people skills if they are to be effective (Welsh and Woodward 1989 in Kennie and Enemark 1996:3).

The studies referred to have a common thread, which is the benefit of continuing professional development for the individual (in this research the registered nurse as the health care provider) and for the health care user, of increased motivation and competence in the provision of health care. Health needs are not static. The health care user is dependent on the health care provider to receive appropriate care, based on sound knowledge of the patient/client as a unique individual. The studies reviewed show a strong correlation between continuing professional development and increased levels of motivation and clinical and managerial competency experienced by the registered nurse.

2.3 BENEFITS OF CONTINUING PROFESSIONAL DEVELOPMENT

Inherent in the benefits of continuing professional development for the health care professional is the benefit to the health care user and the employing organisation of an empowered health care provider. Negative environmental events are frequently (although sometimes unconsciously) initiated by the health system, creating barriers to patient care. The greatest barrier of all is disempowerment of staff (Gary 2002:33). Many nurses define themselves by the tasks they perform, rather than their actual role in the health care system, accepting the 'non-significance' of their input into the health care system, even though they form the largest single sector in the health care profession (Roberts 1997 in Gary 2002:33).

Empowerment relates to the sense of self worth and competence that comes from having the skills and abilities to carry out the required job, skills which are acquired through a process of continuing professional development. Empowered health care professionals can perform their jobs more confidently and more effectively than those who are not empowered. Registered nurses who have been delegated greater decision-making responsibilities provide safer, more cost-effective care than those who are not empowered, and they facilitate smoother work flow (Parsons 1998 in Gary 2002:33). According to Laschinger, Finegan and Shamian (2001) in Gary (2002:33), empowerment is the confidence to take control of a job and use the autonomous decision- making skills of a professional. The health care institution also benefits from empowered nurses. Patient care and productivity are improved, and lower levels of absenteeism and greater staff retention rates have been reported (Gary 2002:33). Indicative of empowered

individuals is the creation of an environment where personal growth is encouraged and conflict is managed collaboratively (Rocchiccoli and Tilbury 1998 in Gary 2002:33).

Smith and Topping (2001:341-349) examined the relationship between undertaking a post-registration nursing course and the perceived benefits to the nursing practitioners. The students perceived the benefits as improved knowledge, improved care delivery, and professional development. These perceived benefits are congruent with the findings of Mackereth (1989) in Smith and Topping (2001:342), who identified that effective continuing professional development has been linked with raised staff morale, increased motivation and staff retention. Effective continuing professional development has been credited with the ability to enhance the quality of nursing care by improving the knowledge base of staff with the consequence of raising standards and producing a more cost-effective service.

According to Ehrat (2001:36-42), in most circumstances continuing professional development in nursing and the accompanying acquisition of leadership skills positively correlates with demonstrated technical and general skills. The ability to inspire followers, theorise, master uncertainty, inspire confidence and shoulder criticism is enhanced. The acquired leadership skills are also demonstrated in appreciation of the accomplishments of others, and being able to view change with anticipation and to capitalise on mistakes.

In a discussion of mandatory continuing education in nursing, reasons given for undertaking continuing education which were viewed as beneficial were: to enhance

professional knowledge; advance professionally; provide relief from routine; improve social relations; and acquire credentials (Eustace 2001:134). According to Hoban (2005:22), nursing is not just about doing something anymore, but about being holistic. Education allows the nurse to look at the wider issues around practice and meet the patients' needs more efficiently. Life-long learning should be about improving patient care and service delivery and the enhancement of inter-professional working. Ultimately, it is the health care user, the health care profession, and the employing organisation that will benefit from health care professionals who are involved in continuing education, since the more health professionals learn the more they will challenge the traditional practices, embrace change and foster innovation.

As adults mature they have the potential to create a reservoir of experience that will cause them to become a rich source of learning. The working environment of the health care professional is dependent on their having the opportunity to engage in continuing professional development and relating this knowledge to practice.

It is surprising then, that while the literature points to the benefits of continuing professional development, there is an abundance of literature which points to barriers to the professional development of nurses. Neglect of personal and professional development will result in nursing lacking the credibility it has always been seeking (Hoban 2005:24). It becomes imperative to visit and re-visit the barriers to continuing professional development and to devise innovative means to facilitate and foster a culture of life-long learning.

2.4 MOTIVATION FOR CONTINUING PROFESSIONAL DEVELOPMENT

Having completed modules in leadership and health services management as part of her current MA Cur degree programme, the researcher has become acutely aware of the need for registered nurses to be motivated to become involved in continuing professional development. Motivation is a concept that describes both extrinsic conditions that stimulate certain behaviour and intrinsic responses which are those needs, wants or drives that demonstrate the behaviour in human beings. Deficiencies in needs stimulate people to seek and achieve goals to satisfy these (Hewitt 1994:116,127; Swansburg 1993:290). Within each individual, the motivating needs differ from time to time. Swansburg (1993:295) says the key lies in figuring out which is currently a "top-priority need".

The registered nurse who undertakes a programme of continuing formal education is self-motivated and eager to satisfy the desire for self esteem by achieving credentials such as registration of an additional qualification with the South African Nursing Council or a higher degree in a health-related field. A unit manager can contribute to maintaining the momentum of motivation through understanding his or her own and the employee's needs, motivators and job satisfiers; being aware of the stressors which make them frustrated and dissatisfied; and seeking out opportunities for achievement of career goals (Swansburg 1993:297).

In the absence of learner motivation, participation in continuing professional development is unlikely to secure improvements in patient and client care or changes in professional and personal growth (Barriball and While 1996:1000). Nolan, Owens and

Nolan (1995:553) state: “Change is easier to implement when the practitioner is highly motivated, the environmental infrastructure is supportive and the change initiative is widely accepted as relevant”. Furze and Pearcey (1999) in Lawton and Wimpenny (2003:41) are supportive of the view of Nolan *et al.* (1995:558), who suggest that one of the most significant factors identified as contributing to participation in continuing professional development is individual motivation.

Kersaitis (1997:135-139) conducted a study of the attitudes and participation of registered nurses in continuing professional education in New South Wales, Australia. The researchers found a positive attitude toward continuing professional education, but a strong opposition to the introduction of mandatory continuing professional education. A conclusion can be drawn that adults are self-motivated to learn what they perceive as being necessary to learn. Knowles (1980), in Abruzzese (1996:31), explains the concepts of adult learning in terms of the adults’ need to know the reason why they should learn something; adults have a need to be self-directed - they become ready to learn when they need to know or be able to do something in order to perform their tasks more effectively and satisfyingly. Adults enter into a learning experience with a task-centred, problem-centred or life-centred orientation to learning. Motivation can be enhanced if the individual practitioner works out a career path or is encouraged and assisted to do so, thereby ensuring that only the relevant skills are acquired (Hoban 2005:23).

Heck (1981), Cox and Baker (1981), in Ferguson (1994:644), make recommendations for the achievement of optimal benefits from continuing education. These recommendations

are that continuing education is based on demonstrated need, and that the identified education needs should be translated into specific measurable objectives. The length of the continuing education programme should be appropriate to the objectives to be achieved. The researchers suggest that continuing education participants should preferably be a homogenous group with similar practice goals and learning readiness. When education activities are planned, attention should be given to those potential variables which may limit or hinder the clinical application of goals. Steps can then be taken to minimise such hindrances. The researchers draw attention to the emphasis of these recommendations on self-directed learning - which may not take into account those who do not have any inclination to take up continuing education.

Lathlean (1986) in Ferguson (1994:644) draws attention to the role and needs of the unit manager regarding the professional development of nurses. There is a need to support and educate the ward manager regarding his/her role, since it is the manager who is the linchpin for development of nurses' skills and who makes or breaks the environment for learning on the ward. The nurse manager's task is to develop his or her team professionally, which requires the nurse manager and the team he/she leads to remain abreast of practices, procedures and policies, which are never static.

2.5 BARRIERS TO CONTINUING FORMAL EDUCATION

A study which focuses only on the importance and benefits of continuing professional development programmes would be unbalanced if the barriers to these programmes were not investigated. Many researchers have discussed barriers to continuing professional

development, producing lists of the identified barriers which can be categorised as physical barriers, attitudinal barriers and structural barriers (Leading learning and skills [LSC] 2005), or the similar categories of situational, institutional and dispositional barriers as described by Cross (1981) in Cullen (1998:229).

2.5.1 Physical barriers

Physical barriers (synonymous with situational barriers) are those factors in the individual's life circumstances at any given time. Numerous authors and researchers have identified physical barriers, which include: lack of time because of job responsibilities; family and child care responsibilities; difficulties in paying course fees and fear of losing benefits; difficulty with academic reading and writing; difficulty with English if this is not the learner's first language; and difficulty with numeracy (Ferguson 1994:645-646; Yuen 1991:1233; Nolan *et al.* 1995:552; Kersaitis 1997:138).

Research among medical practitioners identified that only a small number of professionals had poor motivation towards their own continuing education. However, many encountered difficulties in these endeavours as a result of lack of time and work and personal commitments (Eales 2001:2). The commitment that professional nurses have towards their family members has been reported as a significant factor that affects participation in continuing formal education. Nurses who are most likely to participate in continuing formal education programmes are those who have no children and those whose children are older than five years (Kersaitis 1997:137; Barriball and While 1996:1002). Nurses are increasingly working overtime. Mandatory overtime imposed by

the employer or voluntary overtime worked in addition to regular contracted hours have been used as a measure to reduce the impact of the critical shortage of nurses (International Council of Nurses 2001:1). The International Council of Nurses recognises that many nursing services must be accessible on a twenty-four hour basis, making shift work a necessity. Shift work may have a negative impact on an individual's health, ability to function, and access to continuing education (International Council of Nurses 2000:1).

Inadequate funding is a contentious issue as it relates to continuing formal education. "Funding remains limited. We cannot afford to send staff away for long periods of time – there is no point having highly trained nurses if there is no one left to care for patients" (Burley in Hoban 2005:23). The argument about who should finance staff development is demonstrated in the following exchanges recorded by Nolan *et a*l. (1995:557): "Why should we pay ... it's part of your job ... it's not as if we get paid a lot anyway … expecting nurses to pay or give up their own time to study would disadvantage those unable to afford such contributions" (registered nurse). In this exchange, the nurse manager's stance is to make employees aware of the organisation's numerous commitments and the need for employees to take financial responsibility for their own development, when the manager states that: "Individuals must accept that organisational objectives do exist".

2.5.2 Attitudinal barriers

Attitudinal barriers (synonymous with dispositional barriers) refer to attitude and self-perceptions about oneself as a learner. Authors and researchers have identified attitudinal barriers as: negativity due to unpleasant past experiences in academia; lack of emotional and physical energy; being nervous about going back to the classroom; and concern about not being able to keep up academically. The result is the nurse having low aspirations and doubts about the value of continuing professional development; low self-esteem; lack of confidence both generally and in relation to learning; and lack of trust in the formal institution (Ferguson 1994:645-646; Yuen 1991:1233; Nolan *et al* 1995:551; Xaba and Phillips 2001:2; Horton-Deutsch and Mohr 2001:121-126). Nurses who feel undervalued may progressively develop low self-esteem and attribute a lower sense of meaning to their work. Nurses who have low expectations are less likely to react negatively to unfair treatment, leading to a sense of powerlessness. To be empowered is to have access to the information, resources and support necessary for competent patient care, and to have the self-worth that comes from having the skills and the ability to carry out the required job (Roberts 1997 in Gary 2002:34).

A barrier to continuing professional and personal development exists when the nurse manager and the individual nurse are unable to recognise the barriers to their continuing professional development - the greatest barrier being a feeling of powerlessness. The inability to recognise ideas, problems and solutions leads to an inability to access the information, resources and support necessary for removing barriers to patient care and to

formal education, and for increasing the overall commitment to the institution and its function (Beaulieu, Shamian, Donner and Pringle 1997, in Gary 2002:35).

Lack of trust in the formal institution to afford opportunities for nurses to be equipped to perform their role as competent health care providers may contribute to questioning the value of continuing professional development. The responsibility to educate patients and families has broad implications for all who hold leadership and management positions in health care organisations. Organisations cannot afford for staff development to stand on the sidelines of patient education efforts. Improving the competencies of health care professionals to provide patient education in rapidly changing health care delivery systems relies on key roles for staff development. These roles are to identify and address barriers in the delivery of patient education, raise awareness of the need for innovation to address health promotion, risk factor education, patient safety, and disease management (Duffy 2006:1).

Nurses, who form the largest single sector in the health care profession, have for decades been used by the health care system, often without recognition of their clinical expertise (Roberts 1997 in Gary 2002:33). Horton-Deutsch and Mohr (2001:121-126) explored how nursing leadership is being influenced by the structure of health care institutions. Nursing is clearly a female profession, with 97% of all nurses being women who have been ordered to care in traditionally male organisational worlds. The authors explain that the nursing profession has been institutionally oppressed by medicine and hospital administration. This institutional oppression results in nurses spending most of their time

functioning as subordinate elements in an authority system. The nurses' professional work situation is defined to a large extent as one in which they are to do a job that is prescribed by someone else, and in which they are expected to demonstrate sufficient amounts of submission to harmoniously interact with their superiors. These research findings draw focus to the existence of the "weaker sex" perception, and the fact that women have historically worried about conflict in relationships and avoided it to maintain a calm environment. The possibility of the structure of the health care institution being a barrier to the continuing professional development of the health care professional, especially the female health care professional, is thus raised, since nurses may question whether continuing professional development can lead to autonomous functioning (Des Jardin 2001 in Gary 2002:33).

2.5.3 Structural barriers

Structural barriers to continuing formal education and continuing professional development can be regarded as being synonymous with institutional barriers. These are the practices, procedures and policies that place limits on opportunities for potential adult learners to participate. Structural barriers have been identified as lack of transport and limited opportunities for learning near to the potential learner's place of residence. Staff shortages may limit opportunities for learning. Lack of knowledge about learning opportunities, prohibitive entry requirements to post-registration programmes, lack of appropriate programmes, and late advertising of professional educational events are cited as barriers to continuing formal education and continuing professional development. The lack of coherent staff development plans, difficulty in obtaining study leave, a non-

inclusive style of nursing management, and lack of support from managers have been identified as structural barriers (Barriball and While 1996:1000; Yuen 1991:1235; Leading learning and skills [LSC] 2005; Nolan *et al.* 1995:558).

Yuen (1991:1235) quotes a study by Heath (1980) which offers a "typical" view of the problems arising in continuing nursing education. Problems include the inability to convince nursing managers that staff development is of vital importance for the services; failure to encourage qualified nurses to value their own continuing personal and professional development; lack of criteria for nurse managers to select staff for continuing nursing education programmes; and little systematic attention to identifying educational and training needs.

The lack of a supportive working environment and lack of opportunities for professional growth are cited as deterrents to continuing formal education and continuing professional development. Some nurses feel that there is little space for them to grow in their profession in South Africa, complaining about the lack of opportunities for promotion/ upward mobility, the difficulty in getting study leave, and nursing education not being subsidised, leading them to choose to emigrate (Xaba and Phillips 2001:1-7).

An Australian study among registered nurses identified lack of reward and recognition, lack of information, and available continuing professional education programmes inappropriate to needs, as barriers to continuing formal education (Kersaitis 1997:138). Further studies created or generated considerable enthusiasm among students, but some

described how their initial enthusiasm was dashed by a lukewarm or even frosty reception on their return to the clinical environment. Nolan *et al.* (1995:558) recorded a unit manager's opinion as: "If one were to quantify the time they're off the ward and put a cash value on it in this new market, I'd like to see what I'm getting back, but at the moment I can't really see, they're not coming back and implementing new ideas. They improve patient care in the short term, but it's forgotten when the next module is tackled". Nolan *et al*. (1995:553) say it is unfortunate that practitioners who pursue professional development activities do not always receive recognition and support from managers for their efforts. Research conducted into the self-perceived learning needs of nurses across fourteen nursing facilities in North Carolina, USA, revealed that lack of employer cooperation and peer opinions and attitudes were rated fifth and sixth as factors which deterred continuing education, preceded by responsibilities at work, lack of information about programmes and family responsibilities. The top deterring factor was tuition costs (Glass and Todd-Atkinson 1999:222-223).

Staff shortages inhibit release from the workplace for the purposes of further nursing education. The nurse manager often faces the dilemma of releasing staff to pursue a programme of continuing formal education, with the consequence of overloading slender staff resources or having staff that are short of skills. Nicklin (1985) in Kenworthy and Nicklin (1993:85) suggests that the nurse manager will face greater criticism for being short-staffed.

Research reports exist which demonstrate that the level of staffing has an impact on patient outcomes such as mortality. Although there is no consensus as to what safe staffing means, authors do recognise that there has to be an appropriate number of staff, with a suitable mix of skill level that is available at all times to ensure that patient care needs are met and that hazard-free working conditions are maintained. Sub-optimal levels of staff have been associated with medico-legal hazards and adverse law suits resulting from patients' falls (higher patient fall rates occurring at night), lower patient satisfaction levels with pain management, and drug errors. Where safe staffing levels and appropriately skilled nurses are not available, a high-risk and potentially dangerous environment exists, in which stress and burn-out are well documented. In the face of staff shortages, the International Council of Nurses encourages nurses to lobby for regular review of scopes of practice and competencies to deliver optimum nursing care (International Council of Nurses 2006:22,24,25). It would not be appropriate to draw conclusions with regard to which is the stronger call - for staff numbers or for skills development. The literature demonstrates the tension that exists between these two equally strong and necessary components of nursing.

Course scheduling has an influence on continuing formal education. According to Barriball and While (1996:1000), evidence suggests that enrolled nurses and those working part-time and on night duty consistently attend less continuing professional education than their more senior, full-time and day duty colleagues. Nurses with family commitments prefer to work part-time or night duty. Continuing professional education provided on an arbitrary and random basis does not afford maximum positive outcomes

for health care users, the health service and practitioners, and has the potential to increase levels of frustration among disadvantaged groups of nursing staff. Course schedules need to be formulated in consultation with the practice area and the best ways sought to accommodate potential learners. Health care services managers and educators should be aware of the need for a flexible work schedule, since inflexibility, resulting in not having access to professional growth opportunities, is a factor influencing nursing staff turnover (Shader, Broome, Broome, West and Nash 2001:211). During a survey addressing work-related stress, Fletcher (2001:329) recorded the response of a registered nurse to staffing issues: "While the hospital supports higher education, my unit manager does not help staff going back to school with a flexible work schedule". Distance education programmes have been shown to provide flexible learning (University of Botswana 2000:2). However, correspondence institutions, based on a model of teaching by the lecturers rather than on learning by the students, results in students learning to pass exams rather than to acquire competencies needed to be effective in their work (Bosman and Frost 1996:3).

2.6 STRATEGIES TO OVERCOME BARRIERS TO CONTINUING FORMAL EDUCATION

Undertaking a programme of continuing formal education in nursing in order to achieve higher levels of competence and professional expertise requires commitment and cooperation between the individual nurse, the employing organisation and the tertiary institution. Recognition of the barriers to continuing formal education demands a collective response from the organisation, the individual nurse and the nurse manager to

overcome these. Nolan *et al.* (1994) in Barriball and While (1996:1005) say: “Creating assertive, reflective and analytical nurses may be the vision of the future, but such individuals will only flourish if the correct support systems are in place”. It will not be sufficient to make broad suggestions that identified barriers to continuing formal education can be solved by implementing short-term plans. Health care structures are complex, yet they have to be responsive to a rapidly moving external environment. This environment demands fast responses in the form of continuous progress in medical science and specialisation, maintenance of competency, and health care professionals who keep up to date with the most recent research and developments in patient care.

2.6.1 The nursing manager’s role in overcoming barriers to continuing formal education

Nurse managers are expected to lead others to the vision and mission of the desired characteristics of flexibility, responsibility, innovation, efficiency and being customer-focused by transforming their own role identities and functional skills, promoting team-work and growth of the profession, and tolerating ambiguity, while managing their own personal growth. This frequently represents a major change in their professional role. It can also lead to a great deal of frustration for the nurse manager, who is trying to satisfy both the demands of the organisation and the needs of the staff. She/he faces the challenges of decreased resources, decreased clinical involvement, increased staff diversity, environmental and clinical issues, and being spokesperson for the model of care being implemented (Fletcher 2001:324-331).

Today's health care situation is complex. This requires that the unit manager move away from traditional leadership styles, characterised by centralisation of authority and emphasis on tasks with people considered secondarily, to a caring leadership style which creates a work environment that fosters autonomy and creativity. Employees' expectations include a meaningful job, opportunities for personal development, authority and responsibility at work, and equality in the workplace. The unit manager is required to be effective in influencing the nursing team towards the goal of quality health through the application of a comprehensive human resources strategy. The unit manager is required to create an empowering environment for the professional development of her team, in the face of sicker patients and a smaller workforce, and the expectation of achieving better expenditure control while also achieving greater productivity (Jooste 2003:7,49,134,152; Hoban 2005:22). Nurse managers may face the predicament of simultaneously satisfying organisational demands to limit expenditure on the nursing education budget while fulfilling individual nurses' demands for continuing professional development. Managers who succeed in gaining the loyalty of employees to themselves and the organisation will benefit from their remaining loyal even in adverse circumstances. Strategies to foster loyalty include giving positive recognition to employees for their accomplishments, communicating to employees that they are valued, and listening to concerns about understaffing and overwork (Levin 2001:17,19).

2.6.2 Using research as motivation for physical, attitudinal and structural change

Managers should keep themselves informed of research findings both locally and internationally with regard to factors which facilitate or deter the career development of

nurses. Research findings should be evaluated for their relevance to the current health care situation. The unit managers would be in a stronger position to bring about necessary changes which are within her/his scope of practice and to contribute to decision-making at top management level with regard to practices and policies such as those which relate to granting of study leave and the necessary staff replacement arrangements, tuition fees, and staff for mentorship programmes.

Conclusions of a qualitative study conducted among nursing students who were registered for the 1st, 2nd, and 3rd year of nursing management courses at a South African residential university were recorded as follows:

- nurses need to become empowered through strategies of self-development, self-motivation and developing their leadership abilities;
- nurses need to be promoted in a motivated environment through the availability of managerial positions, promotion opportunities and satisfactory working conditions;
- opportunities for educational and professional development should be known by nurses to take the responsibility to develop themselves continuously;
- employers should encourage nurses to undergo further training to address the needs of the community and promote staff satisfaction.

Recommendations which flow from these conclusions have implications for all levels of management in the health service who are committed to continuing professional development. These recommendations are the following:

- plan for and create new types of posts, moving from a hierarchy to a network structure, using motivational strategies effectively;
- plan and budget to provide opportunities for employees to attend courses and conferences on a continuous rotating basis;
- promote a philosophy of a productive, motivated, healthy and balanced workforce through a people management and wellness programme for nurses; and
- encourage nurses to use nursing informatics to facilitate their career development (Jooste 2005:47-53).

2.6.3 Impact of age and maturity on continuing professional development

Mackereth (1989) investigated the developmental influences on nurses' motivation for their continuing education. He concluded that the younger the nurse, the more idealistic she/he is, making reference to the student nurse. The more mature (older) the nurse, the more pragmatic he/she is, referring to the qualified nurse. Benner (1982) in Yuen (1991:1234) writes about developmental career changes, proposing that the professional needs and interests of nurses and other professionals appear to change as they move through career stages. Nurse career stage and adult developmental stage have significant influence on the needs-based approach to continuing professional development in nursing.

It is estimated that by the year 2010, 40% of registered nurses in the USA will be older than 50; therefore, there will be high numbers of registered nurses retiring in the next 10-15 years (White 2001:201). In South Africa, where the retirement age is generally 60, at least 22.5% of the registered nurses will be retiring within the next ten years. From 1996 to 2001 there was a decline in the numbers of students enrolled for training in South Africa. Although the intakes from 2001 have increased, a gap in the growth of the nursing profession will remain unfilled (*Nursing Update* 2006:42, 43).

Buerhaus, Staiger and Auerbach (2000) in White (2001:201) estimate that by the year 2020, the demand for nursing services in the USA will exceed supply by 20%, due to an increasingly elderly population, an increase in the numbers of hospitalised and acutely ill older persons, and advances in technology which require very highly skilled and educated registered nurses. The primary factor that has led to the ageing of the registered nurse workforce in the USA appears to be the decline in younger women choosing nursing as a career during the last two decades. Unless this trend is reversed, the registered nurse workforce will continue to age, and eventually shrink, and will not meet projected long-term workforce requirements. Potential accommodations such pension availability, adult dependent care and perceived desirable working conditions of persons over 55 years of age may need to be made in order to retain the experienced nurse. This is a factor that nursing and organisational management would do well to consider as they plan strategies to retain a younger, mobile workforce through a programme of continuing professional development, while ensuring that the older workforce maintains relevancy in their practice (Peterson 2001:7).

An ageing nursing workforce is a feature in many countries, including South Africa. Institutions have to invest in programmes such as the acquisition of and training in technology that will decrease the risk of injury to health care users and health care providers, consider reduced hours, and invest in the continuing professional development of nurses. The nurse manager has first-hand information of the stage of maturity of her/his nursing team members, a position which is favourable for advocating for individualised continuing professional development for nurses of all ages.

2.6.4 Factors which contribute to job satisfaction

The nurse manager should be knowledgeable regarding the positive impact of continuing professional development opportunities on levels of job satisfaction.

A motivational theory such as that developed by Hertzberg in the mid-1960s offers a framework for understanding job satisfaction and dissatisfaction. Hertzberg was of the opinion that followers are motivated by two distinct sets of needs: the need to avoid discomfort and the need to seek out pleasure (Jooste 2005:61). Hygiene or maintenance factors do little to promote job satisfaction - but if reduced or absent, produce dissatisfaction. These include organisational policies, practices, rules and related factors; style of supervision and management; scale of pay and related benefits; interpersonal and social relationships within the working environment and status; working conditions, equipment, environment and work arrangements (Hertzberg in Jooste 2005:61). A predictable work schedule is a factor that organisations can manipulate and provide for nurses. Work schedules are especially important to younger nurses, who place high value

on control over their own time. Many have young children, thus requiring a flexible approach to their work schedule. Constantly changing schedules that result in the need for changes in child care arrangements and disruption to family life are not likely to be tolerated by employees (Shader *et al* 2001:214). A study conducted in California, USA, to gain an understanding of leaders' perceptions of the value of their roles in the current health care setting concluded that when given opportunities for growth and advancement, their leadership effectiveness was enhanced. Providing clinical nurses with sufficient information to do their jobs encouraged the nurses to support the changes needing to be implemented in the health care organisation. Providing nurses with sufficient resources to carry out their job responsibilities, such as supplies, equipment, ancillary assistance and additional staffing, removed obstacles to the provision of patient care (Upenieks 2003:146).

Hertzberg describes motivating factors which, unlike the hygiene factors, have a positive and longer-lasting effect and play an important role in ensuring satisfaction. Motivating factors include: a sense of achievement from work well done; recognition of achievement by superiors, which adds to self-esteem; the work itself, which needs to be challenging and rewarding; and actual or promised promotion (Hertzberg in Jooste 2005:61). In order to ensure high levels of productivity in an organisation, it is essential to create a favourable atmosphere that is conducive to enabling employees to willingly channel their energy in the direction of organisational goals (Bester and Mouton 2006:50). The nurse leader has the potential to earn employee loyalty by matching employee needs with opportunities. A nurse who is enthusiastic about learning could be allocated the task of

conducting or facilitating an in-service education programme. Older nurses who continue to be confident in their abilities and capable of meeting demands, despite the stressors of intergenerational conflict with younger nurses and less respect from patients and families, should receive appropriate recognition such as long-service awards (Letvak 2003:1).

Employees must get sufficient opportunities to realise their full potential and to experience job satisfaction and job involvement. A match must be created between the needs of the individual and the needs of the organisation. Employees have a responsibility to acquire a clear picture about their occupational self-concepts, including their skills, abilities, interests, values and the requirements of specific jobs in terms of these attributes (Bester and Mouton 2006:51). If there is little potential for an applicant to achieve his or her goals within a department in an organisation, consideration should be given to referring the candidate to a department that can match the applicant's needs (Levin 2001:19).

Employee competence includes not only what the organisation can do to increase competence, but also how the organisation uses the person's knowledge to the fullest. A large part of the assessment of an organisation's employee competence is its ability to retain valued employees. People are the greatest asset of any organisation, and should be cared for, not manipulated (Jooste 2003:150). When people leave the organisation their knowledge leaves with them. Organisations pay a huge cost for the loss of this intelligence and trying to recreate the same level of intelligence in new people. The effective leader in nursing is the one who can create high levels of intellectual capital

among those who provide patient care, retain the best and also create the infrastructure for a learning organisation that is in synergy with the internal environment and the external community environment (Sveiby1997 in Kerfoot 2002:41).

2.6.5 The role of mentorship

The experienced registered nurse has adopted a process of gradual routinisation in order to meet the demands of complex interactions which occur at a rapid rate and where speed and accuracy must underpin situational demands. The registered nurse who has been in a post for a period of time and who has internalised the interactive work management role can work quickly from that routined base. However, the less experienced nurse coming into the post must first be made aware of the components and activities involved; this highlights the need for mentors (Ehraut 1999 in Edmond 2001:254). A mentor's goal should be to facilitate the development of a less experienced individual. A mentorship programme can significantly impact on the attrition of newly hired nurses. This process involves support and guidance for personal and professional development (Quinn 1997:188).

Nurses need to become empowered through strategies of self-development, self-motivation and development of their leadership abilities (Jooste 2005:48). Involving the more experienced nurse in a mentorship programme has benefit for the mentor: focus is on long-term personal/professional growth; it encourages self-actualisation; and seeks to preserve nursing as a career. Mentors function as an advocate and a coach. The mentoring relationship must be based on respect, affirmation and empowerment and deliver benefits

to both mentor and novice. Novice benefits include one-on-one guidance and counsel, increased professional growth and knowledge, improved self-confidence and self-esteem, recognition, and increased loyalty to both the profession and the organisation. Experiencing the benefits of a mentorship programme increases the nurse's job satisfaction, thereby decreasing turnover. As turnover decreases, not only does the novice benefit, but the mentor and the organisation do as well (Modic and Schloesser 2006:96).

However, registered nurse mentors carry unrealistically heavy clinical loads which leave them little time for teaching. Provision of appropriate structures and resources, to ensure that mentors have the time, the tools, and the training to provide quality practical education and experience is necessary. For example, a mentor should have a reduced workload. The unit manager should use her position to motivate for the appointment of mentors, which will have positive effects on the career development of nurses (Edmond 2001:252,256).

2.6.6 Collaboration between the organisation, educational and practice environments

Orpen (1994:27) suggests that nurses have specific needs in their career that they state as their goals for the future. To address career goals, both the organisation and the individual should share responsibility. Nurses are more likely to have more successful careers if organisations and individuals are involved in career planning and management. Organisational reform - rather than a reform of content aiming at creating a common framework for formal acknowledgement of a wide range of courses with transfer of credits between institutions - was found to facilitate access to continuing formal

education programmes in Norway (Clark, Sweet, Gruber, Lourtie, Santiago and Sohlman 2006:1).

Potential synergy can result from the collaboration between the educational and practice environments which would contribute to overcoming barriers to continuing professional development. Campbell, Prater, Schwartz and Ridenour (2001:37) say: “Current literature indicates a strong resurgence of need for collaboration in the areas of education, research and practice if the nursing profession is going to thrive in a chaotic health care environment”.

The conclusion of a study conducted at a nursing college in Gauteng, which aimed to describe strategies to improve the performance of learners, included the fact that lack of clinical role-models contributes to poor performance of learners. Learners and tutor participants in the study felt unsupported in the clinical area, in that there were no real role-models. Learners found the system of education in the wards to be different to the way tutors taught and evaluated, resulting in sub-optimal performance in clinical examinations. The need for collaboration between the educational and practice environments regarding the content and structure of the curriculum and practice needs was identified. The academic programme should continually seek increased understanding from practice about what kind of nursing is preferred. This understanding may lead to curricular changes designed to develop nurses who are able to meet the demands of the changing health care environment. This would counter comments such as those expressed by the learners in this study that: “The things you are taught here in the

college you never find in the hospital ...” (Waterson, Harms, Qupe, Maritz, Manning, Makobe and Chabeli 2006:63).

2.6.7 The nurse’s role in overcoming barriers to continuing formal education

Hoban (2005:24) offers guidelines on how to make continuing formal education pursuits work for the individual nurse. Courses should be carefully chosen, giving careful consideration to what will benefit patient care in the area of work, develop the nurse personally and professionally, and aid promotion. A career pathway should be worked out, and once a particular goal has been identified the nurse should talk to nurses already in these roles. The nurse should be assertive and ask about funding. The nurse should get support from his/her employer, family and friends, and prepare them and be prepared to make sacrifices regarding social activities. To facilitate proposed studies, study skills should be updated. Nurses are encouraged to use their appraisals, since managers are obliged to identify the nurses’ learning and interpersonal development needs, and plan how these needs will be met. Combining specific job-related skills training with an individualised continuing professional development programme, drawn up during the performance review process, has the dual advantage of showing staff how valued they are as individuals and of equipping them to move into new roles as the organisation’s needs develop.

2.7 CONCLUSION

The aim of the research is to identify barriers to the continuing formal education aspirations of registered nurses. Literature was reviewed to gain insight into the

importance of continuing professional development, and the benefits of this for the health professional, health care user, and organisation. Literature relating to motivation for continuing professional development was found to have a close correlation to the principles of adult learning, underpinned by the adults' need to know the reason why they should learn something, ensuring that only the relevant skills are acquired.

Barriers to continuing formal education and continuing professional development took on common themes in various literature sources. Categorising barriers according to physical, attitudinal and structural aspects, or situational, dispositional and institutional barriers initially appeared a relatively uncomplicated process. However, the literature revealed much overlap between categories. What was clear was that many of the South African and international articles reviewed reported barriers to continuing formal education and continuing professional development which were of a structural/institutional nature to a greater extent than physical or attitudinal barriers.

The process of identification of barriers to continuing formal education faced by registered nurses would be of little benefit to any health care professional or organisation if literature which focused on strategies to overcome barriers were omitted from the literature review process. The literature review therefore concludes with an overview of strategies which are recommended or which have been implemented in an attempt to overcome the identified barriers to continuing formal education and continuing professional development.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides detailed information on the research design and methodology. The methodological paradigm in which the research took place is described and the method of data collection, the research instrument, reliability and validity, selection of the sample, method of analysis and ethical considerations are discussed.

The purpose of the research was to explore and describe the perceptions of registered nurses at selected state health institutions in the Western Cape Province, South Africa, with regard to continuing formal education. The objectives of the research were to:

- Establish how registered nurses view continuing formal education.
- Identify the barriers to continuing formal education experienced by registered nurses.

Health care providers are expected to remain abreast of developments in health care. The public has a right to be safeguarded against malpractice, and they have an expectation that nurses possess up-to-date knowledge and skills appropriate to the specialist field in which they practice. The skills acquired during an initial training period or during higher/further education may not equip nursing staff for this role. Continuing formal education therefore has important implications for both professional nurses and the general public in ensuring that practitioners' skills and knowledge remain current,

therefore optimising the safety and quality of services and assuring the community in this regard (Abruzzese 1996:31; Kennie and Enemark 1996:3).

It is important that educators and health service providers, especially those in management positions, are aware of the perceptions that exist among registered nurses with regard to continuing formal education, and the attitudinal, physical and structural barriers which deter registered nurses from furthering their nursing education beyond initial registration.

In order to address the objectives of this research and find answers to the research question, a research methodology has to be employed. The terms “methodological paradigms” and “methodological approaches” are often used interchangeably. Methodological paradigms are more than a mere collection of research methods and techniques, and include both the actual methods and techniques used by researchers as well as the underlying principles and assumptions regarding their use (Babbie and Mouton 2002:49).

3.2 RESEARCH METHODOLOGY

Research methodology is what makes social science scientific (Babbie and Mouton 2002:16; Neumann 1997:60). Paradigms and the different approaches to research determine the direction that the researcher will take to find answers to the research problem. Scientists use a wide variety of methods and techniques in empirical research, which vary according to the task they perform. The selection of methods and their

application are always dependent on the aims and objectives of the study, the nature of the phenomenon being investigated, and the underlying theory or expectations of the investigator (Babbie and Mouton 2002:49; Brink 1996:28).

3.2.1 Methodological paradigm

A paradigm means a basic orientation to theory and research, a fundamental model or scheme that organises our view of something. A scientific paradigm is a whole system of thinking, an overall philosophical framework of how scientific knowledge is produced. The significance of paradigms is that they shape how we perceive the world. The beliefs that a researcher holds are reflected in the way the research is designed, how data are collected and analysed, and how the research results are presented. A methodological paradigm includes basic assumptions, the important questions to be answered, the research techniques to be used as well as the underlining principles and assumptions regarding their use, and examples of what good scientific research looks like (Babbie and Mouton 2002:xxv; Brink 1996:28; Neuman 1997:62).

Guba in Brink (1996:28) describes a paradigm as a patterned set of assumptions about reality (ontology), knowledge of that reality (epistemology), and the particular ways for knowing about that reality (methodology). Three paradigmatic questions therefore follow:

- Ontological question: What is the fundamental nature of (social) reality?
- Epistemological question: What is the nature of knowledge?
    - How is knowledge generated?

- When is knowledge valid or credible?
- What is the relationship between the researcher (knower) and what can be known?

- Methodological question: How can the knower go about obtaining the desired knowledge and understanding in a logical manner? (de Villiers and van der Wal 2006; Neuman 1997:75).

The dominant paradigms in social research are the positivist paradigm, which is linked to the quantitative approach; interpretivism, which is linked to the qualitative approach; and the critical science paradigm, which has been linked to participatory action research (Babbie and Mouton 2002:xxxiv,27,28,33). The researcher proposed to study the perceptions of registered nurses with regard to continuing formal education and aimed to identify barriers to continuing formal education of registered nurses within a positivist paradigm.

3.2.1.1 Positivist paradigm

Positivist researchers perceive the world as external and objective and science as value-free. Reality is seen as a whole, but by dividing it and studying its parts the positivist researcher is able to understand the whole. Positivist researchers use methods such as observation and experiment to collect facts, which enable them to study the relationship between the facts and to derive laws and theories from them. Positivists therefore have a quantitative approach to research, seeking to deduce cause and effect relationships and to predict patterns of behaviour (Babbie and Mouton 2002:21; Neuman 1997:62-67).

The ontological question: What is the nature of reality? The positivist researcher believes in an objective reality which can be explained, controlled and predicted by means of natural, cause-effect laws. The positivist researcher believes that reality exists out there and is governed by natural laws. The researcher's task is therefore to predict and control natural phenomena.

The epistemological question: What is the nature of knowledge and the relationship between the knower and the would-be knower? The positivist researcher sees him-or herself as detached from the object being studied. The objects are studied objectively, implying that the researcher does not influence the objects in the study nor is the researcher influenced by the study objects.

The methodological question: How can the knower go about obtaining the desired knowledge and understanding? In terms of the research method employed by positivist researchers the physical sciences are emulated, where questions or hypotheses are stated and subjected to empirical testing to verify them. The researcher remains detached, neutral and objective as he or she measures aspects of social life, examines evidence, and replicates the research of others. Anything that might influence the test should be controlled to prevent bias (Babbie and Mouton 2002:49, 53; Neuman 1997:62-67).

3.2.2 Approach to the research

Approaches to research are different ways of looking at the world, and ways to observe, measure and understand social reality. While researchers may look at reality from

different positions, they may also end up looking at the same thing or saying the same thing. The nature of the data to be collected and the research problem dictate the research methodology. Quantitative research methodology employed in this research deals with data that are principally numerical. Conducting this research within the positivist paradigm would enable the researcher to objectively study registered nurses in the health care institution in which they currently work.

3.2.2.1 Quantitative approach

The quantitative approach has been linked to positivism. The quantitative paradigm has a number of related themes:

- An emphasis on the quantification of constructs. The quantitative researcher believes that the best or only way of measuring the properties of phenomena is through quantitative measurement, that is, assigning numbers to the perceived qualities of things. A strand in the history of quantitative research was the emergence of the discipline of statistics;
- Variables occupy a central role in describing and analysing human behaviour;
- Control for sources of error is afforded a central role in the research process. The nature of control is either through experimental control as in experimental designs or through statistical controls (Babbie and Mouton 2002:49).

Quantitative data analysis and interpretation is primarily deductive, proving or disproving the hypotheses or an assertion developed from a general statement. When reporting the research results the findings should be discussed in such as way that it can be recognised

to what extent the data collected either confirm or refute the research question (Babbie and Mouton 2002:63).

3.3 RESEARCH DESIGN

The research design is synonymous with a road map. The research design addresses the planning of scientific enquiry, designing a strategy for finding out something. There are two major aspects to the research design. Firstly, it is to specify as clearly as possible what it is the researcher wants to find out, by stating the research goal and objectives. The second aspect is to determine the best way to reach the research goal and objectives, deciding on the data collection methods, data analysis methods and interpretation of the findings.

In this study a survey, a quantitative research design, will be used to collect the data. Surveys may be used for descriptive, explanatory and exploratory purposes. In this research the survey will be used for descriptive and exploratory purposes. At the end of the data collection process statistical analysis methods will be used to analyse the data. The data will then be interpreted (Babbie and Mouton 2002:70, 72).

Survey

The survey design will enable the researcher to ask registered nurses questions in a short period of time by means of a questionnaire. Surveys are chiefly used in studies which have individual people as the units of analysis. Although this method can be used for other units of analysis, such as groups or interactions, some individual persons must serve

as respondents or informants. Thus a survey could be undertaken in which perceptions of the registered nurse with regard to continuing formal education are identified, and the barriers to continuing formal education identified, but the questionnaire would need to be administered to participants who hold these perceptions and who may or may not experience barriers to continuing formal education.

Babbie and Mouton (2002:232) suggest that survey research is probably the best method available to the social scientist interested in collecting original data for describing a population too large to observe directly. Careful probability sampling provides a group of respondents whose characteristics may be taken to reflect those of a larger population. Carefully constructed standardised questionnaires provide data in the same form from all respondents.

The survey design allows for counting or measuring and analysing the collected data statistically, facilitating interpretation of the data.

Descriptive exploratory research

Descriptive research presents a picture of the specific details of a situation, social setting or relationship. In descriptive research the researcher begins with well-defined goals and conducts research to describe the results accurately. The outcome of a descriptive study is a detailed picture of the participants' views or engagement in specific behaviours stated in percentage or numerical terms, and the frequency with which a specific characteristic or variable occurs in a sample (Babbie and Mouton 2002:80). In this research, utilising

the survey for its descriptive purpose allowed the researcher to obtain demographic information relating to the respondents and the status of their involvement in continuing formal education, and to identify what the respondents perceived as barriers to continuing formal education in nursing.

Exploratory research involves adopting an investigative stance and exploring all sources of information. Exploratory research is appropriate when little is known about the phenomenon being studied. In this research, utilising the survey for its exploratory purpose allowed the researcher to obtain information relating to the perceptions held by registered nurses with regard to the importance of continuing formal education, and their motivation for undertaking continuing education programmes. Including open-ended questions in a questionnaire which contains largely close-ended questions (as in this research) could lead to deeper insight and better understanding of the possible barriers to continuing formal education as experienced by the respondents (Babbie and Mouton 2002:80; Neuman 1997:19).

3.3.1 Population and sample

Population

A population is the entire group of persons or objects that meet the criteria the researcher is interested in studying (Brink 1996:132). See 1.8.2 for specific detail.

Sample

A sample consists of a subset of the entities that make up the population selected by the researcher to participate in a research project (Brink 1996:133). The purpose of selecting a sample was to obtain descriptions that would accurately portray the characteristics of the total population of registered nurses working in state health institutions in the Western Cape Province, South Africa. In this research, a quantitative approach to sampling dominated.

Quantitative approach to sampling

The survey method used in this research enabled the researcher to ask registered nurses questions in a written questionnaire about their view of continuing formal education and perceived barriers to continuing formal education, followed by recording and analysis of the answers. The quantitative survey researcher often uses a sample or a smaller group of selected people, but generalises the results to the larger group from which the smaller group was selected. The results of this research would hopefully produce results that would be as accurate as if every registered nurse working in a state health institution in the Western Cape Province, South Africa was a participant in the research (Babbie and Mouton 2002:187; Neuman 1997:31).

Selecting the sample

Convenience sampling was the sampling method employed in this research. This entails the use of the most conveniently available people as subjects in a study (Polit and Hungler 1993:176). A total number of seventy registered nurses at four state health

institutions at primary, secondary and tertiary level was earmarked for participation in the research, but only forty completed and returned the questionnaires. These health institutions were chosen on the basis that the researcher had easy geographical access to them during periods of student supervision. The researcher was aware of a risk associated with convenience sampling, being a personal leaning towards sampling those known to the researcher. A concerted effort was made to request participation in the research from those registered nurses not personally known to the researcher. Permission was obtained from the management at these health care facilities for questionnaires to be distributed. Questionnaires were delivered to registered nurses who were on duty on the days that the researcher visited the health care institutions.

At one of the participating health care facilities, the researcher distributed batches of questionnaires to each department, except the operating theatres, personally asked every unit manager to participate in the research, and spent time with each recipient of the questionnaire to explain the guidelines for completion of the questionnaire. At two of the participating hospitals the Deputy Directors of Nursing requested that they personally distribute the questionnaires. At the primary health care facility the nurse manager requested that she distribute the questionnaires. The researcher explained that the respondents should be registered nurses who were unit managers, registered nurses currently undertaking continuing formal education, and registered nurses not currently undertaking continuing formal education.

3.3.2 The questionnaire as a data collection instrument

According to Babbie and Mouton (2002:233), the term “questionnaire” suggests a collection of questions. A typical questionnaire will probably reveal as many statements as questions. Often the researcher is interested in determining the extent to which respondents hold a particular attitude or perspective. If an attitude can be summarised in a fairly brief statement, that statement can be presented and respondents asked whether they agree or disagree with it. Rensis Likert formalised this procedure through the creation of the Likert Scale, a format in which respondents are asked, for example, to indicate on a four-point scale to: strongly agree / agree / disagree / strongly disagree. Using both questions and statements in the questionnaire gives the researcher more flexibility in the design of items, making the questionnaire more interesting.

The literature review was used to guide the researcher in the compilation of the questionnaire, rather than using a predetermined set of questions which may not be relevant to the working situation of the registered nurse in South Africa. Using the literature review contributed towards the validity of the data collection instrument. Pre-testing of the questionnaire was done to ensure the reliability and validity of the data collection instrument.

A questionnaire was considered the most appropriate data collection instrument for this research. This design enabled the researcher to ask registered nurses questions by means of a questionnaire in a short period. The cost of distributing the questionnaire was not envisaged to be excessive since the researcher was to personally deliver and collect the

questionnaires from the participating health care institutions at the same time as conducting student supervision.

Data were collected under the following sections:

- demographic information on the sample;
- demographic information relating to continuing formal education;
- views on continuing professional development;
- motivation to engage in continuing formal education; and
- barriers to the undertaking of continuing formal education.

The questionnaires were self-administered and anonymous. The registered nurses were asked to participate in the study voluntarily by completing the questionnaire. Instructions in the form of a letter were attached to the questionnaire and the researcher explained to the respondents how to complete every section of the questionnaire. The letter contained details of the purpose of the research and the process for delivering the completed questionnaires, assurance that their participation in this research would be treated with confidentiality, and written assurance that it would be impossible to identify the respondents. Boxes for the responses were placed in specified departments at the participating health care institutions. Stamped self-addressed envelopes were provided for responses from registered nurses who would be returning from leave after the due date for the return of the questionnaires.

The distribution of the questionnaires at the selected state health institutions was according to the established protocol at these institutions. The Deputy Director at each of the participating hospitals was contacted via email. Their guidance was followed regarding the distribution mechanisms they wanted to have in place. At one hospital the researcher personally distributed batches of questionnaires. At two other participating hospitals and the primary health care facility the Deputy Directors of Nursing requested that they personally distribute the questionnaires.

The researcher's programme of study, MA (Health Studies), and the name of the university endorsing the research were made known in a letter. The respondents were asked to return the questionnaires within two weeks of receipt or by 1 December 2006, whichever came first. A disadvantage of this method of returning the completed questionnaires is that respondents may ignore the deadline or choose not to respond. This was recognised by the researcher, but redistribution was not an option since the respondents were anonymous.

3.3.2.1 Constructing the questionnaire

The questionnaire contained instructions on how to complete the sixty five-item questionnaire. Sixty-four close-ended questions and a small number (four) of open-ended questions were included. Close-ended questions were used since it would be easier and quicker for the respondents to answer, and answers could be easily coded and analysed (see Annexure A). However, Babbie and Mouton (2002:233) states that a disadvantage of using close-ended questions is that it forces respondents to give simplistic answers to

complex issues relating to continuing formal education. Some respondents may also develop a response-set, assuming that all the statements and questions represent the same orientation, resulting in a misreading of the questions.

The four open-ended questions related to the preceding closed question regarding reasons for not completing a programme of study; the perceived lack of role-models in the workplace being a barrier to continuing formal education; a non-supportive working environment being a barrier to continuing formal education; and the perceived benefits of a completed post-registration study programme. The open-ended questions allowed for more in-depth and subjective responses (Babbie and Mouton 2002:233).

3.3.2.2 Format of the questions

Questions were constructed using a matrix format to use space efficiently and hopefully encourage a faster completion time than a questionnaire with largely open-ended questions. The questions in each sub-section were relevant to the content of that sub-section. Care was taken to adhere to the principles of questionnaire construction, which are to ensure that important responses are not overlooked, such as issues that respondents might have said were important, and ensuring that the answer categories are mutually exclusive. The respondent should not feel compelled to select more than one answer category (Babbie and Mouton 2002:234).

3.3.2.3 Pre-testing the questionnaire

The questionnaire was pre-tested in order to identify and correct ambiguous questions, questions that people could not answer, and grammatical and/or numbering errors. The people chosen to pre-test the questionnaire were not part of the sample but were representatives of three groups of registered nurses, namely a registered nurse currently undertaking a programme of study, a registered nurse not currently undertaking a programme of study, and a nursing unit manager. Babbie and Mouton (2002:245) suggest that pre-testers be asked to complete the questionnaire rather than reading through it looking for errors, as a questionnaire might seem to make sense when first looked at but later the respondent might find there are questions which cannot be answered.

The pre-testers were asked in writing to assist with ensuring that the questions were clear and unambiguous. They were asked to complete the questionnaire and make comments. The researcher met personally with each pre-tester to discuss their suggested changes and to ensure that the rationale for asking the questions and the suggested changes were understood by all parties. Where there was mutual agreement, the questionnaire was altered based on the principle that a questionnaire that could be interpreted differently by different people was unlikely to produce meaningful information.

Changes to the questionnaire were as follows:

- The heading of the section to appear on each page of the questionnaire to avoid having to refer to previous pages to be reminded of headings.

Section D:

- To add “scarce skills allowance as a motivator for studying further” Question (9).

Section E:

- “Barriers” was added to the heading of section E to read: “Reasons which are barriers to undertaking or delaying continuing formal education” rather than: “Reasons for undertaking or delaying....”
- Question E (6): the term “... learn again” replaced with “... study again”.
- Question E (14): To add, the wording in italics: “Lack of staff development plans *by the institution*”.
- Question E (17): “Lack of criteria to select staff for continuing education programmes” was re-phrased to read: “Prohibitive entry requirements to programmes”.

Section F: Main reasons for interrupting a programme of study:

- This section was removed as two of the three pre-testers felt the open-ended question overlapped with the close-ended questions in Section E.

3.3.3 Reliability and validity of the research instrument

The related themes in quantitative research include emphasis on the quantification of constructs, the central role of variables in describing and analysing human behaviour, and the central role afforded to control for sources of error in the research process. In quantitative research a study cannot be considered valid until it is reliable (Babbie and Mouton 2002: 49,233).

3.3.3.1 Reliability

In quantitative research reliability reflects an indicator's dependability. A reliable indicator will yield the same result each time the same thing is measured, as long as what is being measured is not changing. Reliability is concerned with the application of a particular technique which, when applied repeatedly to the same object, would yield the same result each time. Reliability is concerned with the consistency, stability, and repeatability of the research participants' responses as well as the researcher's ability to collect and record information accurately (Neuman 1997:138; Babbie and Mouton 2002:49,233). Pre-testing of the questionnaire contributed towards reliability of the data collection instrument, measured in terms of asking about things the respondents were likely to be able to answer, and clarity of the questions (Babbie 1998:132). The pre-testers were asked to complete the questionnaire and to comment on those aspects of the questionnaire they were unable to answer with regard to the construction of the questions or the relevancy of the questions to perceptions of registered nurses regarding continuing formal education. See 3.3.2.3 for specific detail.

3.3.3.2 Validity

In quantitative research validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration - the degree to which the instrument measures what it is supposed to measure. Establishing validity requires determination of the extent to which constructs devised by the researcher represent or measure the categories of human experience that occur. When asking how valid the measuring instrument is, face/content validity is one of the criteria regarding the

researcher's success in making appropriate measurements. Face/content validity asks whether there is agreement concerning the concepts in the data collection instrument (Babbie and Mouton 2002:123). In this research, review of the literature pertaining to the research question contributed towards ensuring the face/content validity of the data collection instrument. Presenting the data collection tool to the research supervisor for comment enhanced the face/content validity of the tool, since the supervisor is an experienced nurse educator at higher education institution level. The content/face validity was enhanced by requesting one of the respondents in the pre-test to assess the data collection instrument according to a provided assessment form (see Annexure B).

External validity pertains to the research design. External validity is defined as "the degree to which the results of a study can be generalised to settings or samples other than the ones being studied" (Brink 1996:124). One aspect of a study's external validity concerns the adequacy of the sampling design. Using convenience sampling with pre-determination of the categories of registered nurses who would participate in the research study, it was envisaged that results of this research could be generalised to the population of registered nurses working in state health institutions in the Western Cape Province, South Africa.

3.4 DATA ANALYSIS

The raw quantitative data were subjected to descriptive statistical analysis based on calculations using the Microsoft (MS) Excel (for Windows 2000) programme. Patterns in the data obtained in response to the open-ended questions were analysed, seeking to

identify emerging patterns from the responses obtained, then interpreting these responses in terms of the specific context in which the questions were asked. The data are presented in tables.

3.5 ETHICAL CONSIDERATIONS

Survey researchers can intrude into a respondent's privacy by asking about intimate actions and personal beliefs, but the respondent decides when and to whom to reveal personal information. Respondents are likely to provide such information when it is asked for in a comfortable context with mutual trust, when they believe serious answers are needed for legitimate research purposes, and when they believe answers will remain confidential. Researchers have a duty to treat all respondents with dignity and to reduce anxiety or discomfort. Researchers are also responsible for protecting the confidentiality of data (Neuman 1997:264).

3.5.1 Informed consent

Informed consent involves voluntary participation by respondents. Respondents agree to answer questions and can refuse to participate, or have the right to withdraw from the study at any time without being penalised. Researchers depend on respondents' voluntary cooperation, so researchers need to ask well-developed questions in a sensitive way, treat respondents with respect, and be very sensitive to confidentiality. It is not enough to get permission from subjects. They need to know what they are being asked to participate in so that they can make an informed decision (Neuman 2006:130,450). Permission to conduct the research was sought from the management of the participating health care

institutions and the ethics committee of the university endorsing the research. The name of the researcher and the reasons for undertaking the research were made known to the respondents. They were assured that responses would only be used for research purposes. The researcher used the mechanism of a written letter attached to each questionnaire as the means of upholding the principle of informed consent. The researcher acknowledged the rights of the registered nurses not to participate in the study, and no respondent was coerced into completing the questionnaire (see Annexure C).

3.5.2 Anonymity

Anonymity refers to the protection of the participant in a study, such that even the researcher cannot link the participant with the information provided (Babbie and Mouton 2002:526; Polit and Hungler 1993:431). The management of the participating health care institutions and the research participants were informed that their identities would not be made known in the release or in the publication of the research. The categories of the state health institutions were only stated as primary, secondary or tertiary. In this manner the anonymity and confidentiality of the participants and the health care facilities were guaranteed.

3.5.3 Confidentiality

Confidentiality means that information, even if it has names attached to it, is held in confidence and kept secret from the public. The information is not released in a way that permits linking individuals to specific responses (Neuman 1997:453). The respondents who were asked to participate in this research were given written assurance of

confidentiality which was coupled with the anonymity principle. The questionnaire did not require that the name of the health care institution nor of the respondent be stated.

3.6 LIMITATIONS OF THE RESEARCH PROCESS

Due to time and geographical constraints the research was limited to registered nurses working in selected state health institutions in the Western Cape Province, South Africa.

3.7 CONCLUSION

A quantitative descriptive and exploratory survey design, utilising a questionnaire to collect the data, was used to conduct this research study. The compilation of the research instrument, reliability, validity, and pre-testing were discussed. A convenient sample consisting of registered nurses was drawn from four health care institutions in the Western Cape Province. Ethical considerations pertaining to the study were discussed.

The next chapter will explain the presentation, analysis and interpretation of the research findings, and hopefully show how the responses to each question contribute to answering the overall research question.

CHAPTER 4

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

This chapter presents an analysis and interpretation of the findings of the research. The raw quantitative data obtained were subjected to descriptive statistical analysis using a Microsoft (MS) Excel (for Windows 2000) programme. Patterns in the data obtained in response to the open-ended questions were identified and interpreted in terms of the specific context in which the questions were asked. The results of this research are presented in tables. The objectives which were formulated to achieve the purposes of the study are outlined below.

Objective 1: To establish how registered nurses view continuing formal education

In order to achieve the objective of ascertaining how registered nurses view continuing formal education, the researcher sought to obtain information relating to the number of registered nurses currently involved in a programme of study; reasons for not embarking on a programme of continuing formal education; reasons for not completing a programme of study; reasons for engaging in continuing formal education; and motivation for engaging in continuing formal education. These findings are presented in sections 4.3 to 4.3.5.

Objective 2: To identify the barriers to continuing formal education experienced by registered nurses

In order to achieve the objective of identifying barriers to continuing formal education experienced by registered nurses, the researcher sought answers to questions relating to family and work responsibilities; funding for education programmes; anxiety with regard to studying and physical energy needed; perceptions about the value of further education in nursing in terms of remuneration and promotion; lack of a supportive work environment; lack of role-models in the workplace; and lack of institutions' staff development plans. These findings are presented in sections 4.4 to 4.4.3.

4.2 FINDINGS: DEMOGRAPHIC DATA

To obtain the required information, the questionnaire (the data collection tool) was divided into five main sections: demographic information; demographic information relating to continuing formal education; perceptions regarding continuing formal education; motivation to engage in continuing formal education; and barriers to the undertaking of continuing formal education.

A convenient sample of forty registered nurses currently working at state health institutions in the Western Cape, South Africa, participated in the research. Of the seventy questionnaires distributed, forty (57.1%) were returned completed and five were returned without having been completed. The rest were not returned at all.

Information gleaned from the literature review was used to compile the questionnaire. The questionnaire was constructed using close-ended questions in the matrix format, and a small number of open-ended questions (four out of sixty-five). The respondents did not

answer every question, resulting in a number of questions having a different response rate.

4.2.1 Demographic data

The demographic data reported here include age, gender, marital status, number of children, number of years qualified as a registered nurse, place of practice as a registered nurse, basis of employment, present rank, and number of years practicing as a professional nurse since registration as a nurse.

4.2.1.1 Age

The registered nurses were asked to indicate their age to enable the researcher to determine whether a link exists between age and preparedness to undertake a programme of continuing formal education, or whether a greater number of barriers to continuing formal education exist in a specific age category.

Table 4.1 shows that the age group 46-55 years was the largest group of registered nurses (47.5%) represented in this study. The age group older than 55 years had the lowest number of participants (7.5%). Erickson, a proponent of a staged theory of development, describes those in the age group 40-65 years as being in the “middle years” of adulthood (Atkinson, Atkinson, Smith, Bem and Hilgard 1990:110). It has been suggested that the middle years of adulthood are the most productive years. Men in their forties are usually at the peak of their careers. Women who are mothers have fewer responsibilities at home because the children are grown up, and they can devote more time to career activities.

Table 4.1 DEMOGRAPHIC INFORMATION: AGE, GENDER AND MARITAL STATUS *(N=40)*

Age in years	**25-35**	**36-45**	**46-55**	**> 55**	**Unanswered**
	12.5% *(N=5)*	32.5% *(N=13)*	47.5% *(N=19)*	7.5% *(N=3)*	0%
Gender	**Female**		**Male**		**Unanswered**
	92.5% *(N=37)*		2.5% *(N=1)*		5% *(N=2)*
Marital status	**Single (never married)**	**Married**	**Divorced/ separated**	**Widowed**	**Unanswered**
	42.5% *(N=17)*	47.5% *(N=19)*	10% *(N=4)*	0%	0%

Feelings of satisfaction in middle adulthood come from helping teenage children become adults and providing for others who need help. Feelings of despair may come from the realisation that the individual may not have achieved the goals that they set for him- or herself as a young adult. Feelings of despair may also come from the belief that what the individual is doing is not important (Bee 1994:390; Freiberg 1987:521).

In response to the question regarding the lack of a supportive work environment being a barrier to continuing professional development, and thus frustrating the individual's goals, 50% of the total respondents in this research agreed that the work environment was a barrier to the achievement of their professional development goals (see Table 4.11). This percentage rose to 58% when the researcher analysed the responses of those in the

46-55-year age group, who agreed that the lack of a supportive work environment was a barrier to continuing formal education.

4.2.1.2 Gender

The participants were asked to indicate their gender to determine the gender distribution of the registered nurses in this research. Table 4.1 shows that the majority of registered nurses in the study were female (92.5%), with 1 male participant (2.5%) and 2 non-responses (5%) to the gender question. The predominance of the female gender in nursing is a persistent trend. In 1988 only 3.4% of the registered nurse population in South Africa was male with a slight increase to 5.9% (5,959 of 101,295 registered nurses) in 2006 (Mellish and Brink 1990:54; South African Nursing Council 2006).

4.2.1.3 Marital status and children

The participants were asked to indicate their marital status and the number of their children to ascertain the number of participants with family responsibilities. According to Kersaitis (1997:138), registered nurses who are married and have young children view their responsibility to their family and children as more important than undertaking a programme of study. Table 4.2 shows that a significant number of the respondents had children. The researcher analysed each of the completed questionnaires received from those who had children but had not completed their programme of study. None of the respondents cited family responsibilities as the barrier to completion of the programme, but rather reference was made to ill health (2 respondents), work pressure (2 respondents), and course-related issues (3 respondents).

Table 4.2 DEMOGRAPHIC INFORMATION: CHILDREN PER NURSES' AGE CATEGORY *(N=40)*

Age in years	**25-35**	**36-45**	**46-55**	**≥ 55**	**Unanswered**
	12.5%	32.5%	47.5%	7.5%	0%
	(N=5)	*(N=13)*	*(N=19)*	*(N=3)*	
Children	40%	69%	63%	66%	0%
	(N=2)	*(N=9)*	*(N=12)*	*(N=2)*	

4.2.1.4 Number of years qualified as a nurse

The participants were asked to indicate how long they had been qualified as a nurse. The researcher used the measures of central tendency, the mean, median and mode, and applied them to the number of years the respondents in the study had been qualified. The purpose of using measures of central tendency is to summarise the information about one variable, in this research the number of years a nurse has been qualified, into a single number. The mean is the arithmetical average of all the scores in the distribution. The number of nurses in the study was *N*=40. The total number of years that the respondents had been qualified as a registered nurse was 846 years, with an average of 21.15 years. The median is the midpoint score or value in a group of data ranked from lowest to highest. The number of years a nurse was qualified ranged from 2 to 38 years, with the median being 21.5 years. The mode is the value or score that occurs most frequently in a distribution. The most frequently occurring number of years a nurse in the study was qualified was 26 years, occurring four times (Brink 1996: 184; Neuman 2006: 349).

The mean number of years that the registered nurses had been qualified was 21.15. This indicates that the registered nurses in this research were experienced nurses who, in order to maintain relevance in their practice, should have been exposed to continuing formal education in nursing.

4.2.1.5 Place of practice as a registered nurse

The researcher had easier access to tertiary hospitals. The response rate indicated that the largest proportion of the respondents (62.5%, *N*=25) were registered nurses practicing at tertiary-level health care facilities. Only 25% (*N*=10) of the respondents practiced at secondary-level health care facilities and 7.5% (*N*=3) at primary level; 5% did not respond to this question (Table 4.3).

4.2.1.6 Basis of employment and rank

The participants were asked to indicate the basis of their employment and their rank. Asking respondents to indicate their rank helped the researcher to determine how many of the registered nurses occupied positions of leadership and management. Table 4.3 shows that the majority of respondents (90%) were in full-time employment. The largest group occupied Chief Professional Nurse posts (37.5%), followed by Chief Professional Nurse-Unit Manager posts (32.5%). As indicated earlier, the average length of time that the registered nurses in the sample had been qualified was 21.15 years. It would be expected that progress would have been made to senior level posts during these years.

Table 4.3 DEMOGRAPHIC INFORMATION: PLACE OF PRACTICE, BASIS OF EMPLOYMENT AND RANK *(N=40)*

Place of practice	**Tertiary level hospital**	**Secondary level hospital**	**Primary level clinic**	**Unanswered**
	62.5%	25%	7.5%	5%
	(N=25)	*(N=10)*	*(N=3)*	*(N=2)*
Basis of employment	**Full time**	**Part time**	**Mostly day duty**	**Mostly night duty**
	90%	7.5%	2.5%	0%
	(N=36)	*(N=3)*	*(N=1)*	
Present rank	**Professional nurse**	**Senior professional nurse**	**Chief professional nurse**	**Chief professional nurse-unit manager**
	15%	12.5%	37.5%	32.5%
	(N=6)	*(N=5)*	*(N=15)*	*(N=13)*

Registered nurses who occupy the roles of manager and leader coordinate the activities of their nursing team and contribute to the establishment of a work environment that is conducive to goal achievement. In order to fulfill these roles effectively, they are required to seek new knowledge in numerous and diverse areas of nursing practice (Jooste 2003:43).

4.2.2 Demographic information: continuing formal education

Registered nurses have to attend a formal course in order to obtain an additional nursing qualification. This qualification is also referred to as a post-basic qualification (Searle and Pera 1994:45). The purpose of questions in this section was to ascertain the respondents' highest post-basic qualification, the number of years elapsed before achieving their first post-basic qualification, number of years since last undertaking a formal programme of study, whether they were currently undertaking a programme of study leading to an additional nursing qualification, and reasons for not completing a programme of study.

4.2.2.1 Highest post-basic qualification

Participants in the study were asked to indicate their highest post-registration qualification. Table 4.4 shows that a significant number of the registered nurses (85%) had undertaken further studies, 45% at diploma level, and 22.5% at degree level. Another 17.5% had obtained a qualification in a health-related field, with 15% not having undertaken a formal course since obtaining their initial nursing registration.

Table 4.4 CONTINUING FORMAL EDUCATION: HIGHEST POST-REGISTRATION QUALIFICATION *(N=40)*

None	Post-registration nursing diploma	Post-registration nursing degree	Post-registration health-related diploma/degree
15% *(N=6)*	45% *(N=18)*	22.5% *(N=9)*	17.5% *(N=7)*

4.2.2.2 Number of years elapsed before achieving first post-basic qualification

Participants in the study were asked to indicate how many years had elapsed before achieving a post-basic qualification. Table 4.5 shows that the majority of respondents (72.5%) obtained their first post-basic qualification within 5 years of being qualified as a nurse; 6-10 years elapsed before 7.5% of respondents obtained their first post-basic qualification; and 11-15 years elapsed before 5% obtained a post-basic qualification, with 1 respondent obtaining a post-basic qualification after 15 years. Unfortunately 12.5% of respondents did not answer this question. The researcher made the assumption that these respondents had not undertaken a post-basic study programme.

Table 4.5 YEARS ELAPSED BEFORE OBTAINING FIRST POST-BASIC QUALIFICATION ***(N=40)***

How many years elapsed before you undertook and obtained your first post-basic qualification?	**0-5 yrs**	**6-10 yrs**	**11-15 yrs**	**> 15 yrs**	**Unanswered**
	72.5%	7.5%	5%	2.5%	12.5%
	(N=29)	*(N=3)*	*(N=2)*	*(N=1)*	*(N=5)*

The average number of years the nurses in this study have been qualified is 21.15 years. Hence, the average nurse in this study would have qualified in accordance with the regulations published under Government Notices R2118 of 30 September 1983, obtaining a general nurse qualification and embarking on a programme to obtain an additional qualification following initial registration, prior to the promulgation of Regulation R425 of February 1985, which provides for registration in the capacity of registered nurse (general, psychiatric, community) and midwife (Searle and Pera 1994:42). In view of 72.5% of respondents obtaining their first post-basic qualification in the period 0-5 years from initial registration, the researcher makes the tentative assumption that the majority

of the respondents have answered this question in terms of the R2118 regulation. This may imply that the registered nurse who obtained her general nursing qualification and undertook an initial additional course of study may have regarded further study in a less than favourable light, since it would have required six years of continuous studying to obtain the equivalent qualifications obtained in four years in terms of Regulation R425 of February 1985.

4.2.2.3 Number of years since achieving the last post-basic qualification

The researcher discovered that a 12.5% non-response to this question could have meant that the question was problematic. The researcher and the questionnaire pre-testers had not considered that there might be registered nurses who had not undertaken any post-basic programme of study. Half of the respondents (50%) had not obtained a post-basic qualification in the past five years, while 17.5% had not undertaken any course of study in the past 6-10 years. A further 15% of the respondents had not undertaken a course of study in the past 11-15 years, while 2 respondents had taken up a course of study after a period of 15 years (Table 4.6).

With the advent of the staff performance management system which requires public service workers to motivate why they should be considered for promotion or remuneration based on merit, nurses can no longer ignore the requirement to remain abreast of developments in health service provision. The number of years which had elapsed since 50% of the respondents had undertaken a post-basic course of study may be indicative of a health system which previously practiced a system of promoting

individuals in the absence of criteria by which to measure staff performance and educational advancement.

Table 4.6 YEARS ELAPSED SINCE LAST OBTAINING A POST-BASIC QUALIFICATION *(N=40)*

Years elapsed since last undertaking and obtaining a post-basic qualification	**0-5 yrs**	**6-10 yrs**	**11-15 yrs**	**> 15 yrs**	**Unanswered**
	50% *(N=20)*	17.5% *(N=7)*	15% *(N=6)*	5% *(N=2)*	12.5% *(N=5)*

4.3 FINDINGS PERTAINING TO HOW REGISTERED NURSES VIEW CONTINUING FORMAL EDUCATION

In order to achieve the research objective of ascertaining how registered nurses view continuing formal education, the researcher sought to obtain information relating to the number of registered nurses currently involved in a programme of study; reasons for not embarking on a programme of continuing formal education; reasons for not completing a programme of study; reasons for engaging in continuing formal education; and motivation for engaging in continuing formal education.

4.3.1 Current involvement in a programme of study

Only 15% of the respondents were currently undertaking a programme of study; 82.5% were not currently undertaking a programme of study, and 2.5% of the respondents did not answer this question (Table 4.7).

Table 4.7 CURRENT STATUS OF INVOLVEMENT IN CONTINUING FORMAL EDUCATION *(N=40)*

Currently undertaking a programme of Study leading to a post-registration SANC qualification	**Yes**	**No**	**Unanswered**
	15% *(N=6)*	82.5% *(N=33)*	2.5% *(N=1)*

The researcher reflected on the phrasing of this question, and concluded that it was repetitive and may have caused the respondents a degree of confusion, since currently undertaking a programme of study and time elapsed since doing so (0-5 years) may have resulted in less than accurate responses. Considering that 50% of the respondents indicated that they had undertaken a programme of study in the past 5 years, some may have completed a programme as recently as one month ago.

4.3.2 Reasons for not embarking on a programme of continuing formal education

Respondents who had not undertaken a post-basic course of study at all, or not in the past five years gave a number of reasons, outlined below.

Lack of role-models in the workplace (5 respondents)

Respondents qualified their statements regarding the lack of role-models in the work-place, when they referred to the expectation that a role-model is required to motivate the employees and be willing to contribute to the creation of a positive working environment by sharing new knowledge gained through having undertaken a course of study relevant to the practice area. An empowering nurse leader is expected to display behaviours similar to what is expected from followers (Jooste 2003:231).

Failure on the part of management with regard to staff development and off-duty arrangements (3 respondents)

Respondents reported that managers and management were seemingly unprepared to accommodate those who were desirous of studying further, with regard to lecture time and the practical requirements of a course. Staff development was perceived by the respondents as not being a management priority, with management focusing solely on staffing the nursing unit.

Negative impact of staff shortages (3 respondents)

Respondents reported that they had previously felt or would feel guilty about leaving colleagues under more pressure in the workplace when attending classes, in the knowledge that there would be insufficient staff to manage the workload in the nursing unit.

4.3.3 Reasons for not completing a programme of study

Only 15% of the respondents had commenced a programme of study but not completed it. The questionnaire allowed these respondents to give their reasons for non-completion of a course. Most (80%) had completed their study programme, with 2.5% not answering the question. The researcher identified the reasons for not completing a programme of study as the emergence of barriers to continuing formal education. Reasons cited for not completing a programme of study were:

- work responsibilities and associated time constraints (3 respondents);
- ill health and consequent lack of motivation (2 respondents); and

- lack of communication from education department with regard to course schedules, course fees and financial support for studies (2 respondents).

The findings were similar to reasons for not completing a programme of study identified in previous research over a timespan of 16 years (Barriball and While 1996:1000; Xaba and Phillips 2001:1-7; Yuen 1991:1235).

4.3.4 Reasons for engaging in continuing formal education

The information sought by asking questions relating to the reasons for engaging in continuing formal education was to obtain an overview of the perceptions which exist among registered nurses with regard to their continuing professional development. Table 4.8 shows that a larger number of respondents disagreed/strongly disagreed (67.5%) than agreed/strongly agreed (27.5%) that they would engage in continuing formal education only for the purposes of obtaining an additional qualification. Most respondents (75%) strongly disagreed/disagreed that they engaged in continuing formal education to give them a break from work pressures.

Table 4.8 REASONS FOR ENGAGING IN CONTINUING FORMAL EDUCATION *(N=40)*

Reason for engaging in continuing formal education	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**	**Unanswered**
Only to obtain an additional qualification	42.5% *(N=17)*	25% *(N=10)*	15% *(N=6)*	12.5% *(N=5)*	5% *(N=2)*
To plan my career pathway	5% *(N=2)*	2.5% *(N=1)*	42.5% *(N=17)*	50% *(N=20)*	0%
To network with other nursing colleagues	7.5% *(N=3)*	20% *(N=8)*	45% *(N=18)*	22.5% *(N=9)*	5% *(N=5)*
To keep abreast with new developments in my area of specialty	0%	0%	30% *(N=12)*	70% *(N=28)*	0%
To improve my confidence	0%	5% *(N=2)*	40% *(N=16)*	52.5% *(N=21)*	2.5% *(N=1)*
To improve prospects of remuneration and promotion	5% *(N=2)*	2.5% *(N=1)*	50% *(N=20)*	42.5% *(N=17)*	0%
To be an effective mentor for newly qualified nurses/nursing students	0%	7.5% *(N=3)*	22.5% *(N=9)*	70% *(N=28)*	0%
To provide me with a break from the pressures of work	32.5% *(N=13)*	42.5% *(N=17)*	17.5% *(N=7)*	7.5% *(N=3)*	0%
To provide me with knowledge and skills not received during my basic training	0%	2.5% *(N=1)*	35% *(N=14)*	62.5% *(N=25)*	0%
To develop proficiency necessary to meet patients' expectations	0%	2.5% *(N=1)*	22.5% *(N=9)*	75% *(N=30)*	0%
To facilitate the development of nurse leadership capabilities	0%	2.5% *(N=1)*	33.3% *(N=13)*	65% *(N=26)*	0%

The research suggests that the registered nurse would rather undertake an educational programme to be able to cope with the pressures of work than as an escape from the pressures of work. Newspaper headlines such as such as “Disease (TB) on the way up in Cape” Collison (2007:4), “South Africa’s TB cure rate poor” Thom (2007:4), and “Increasing dementia sets South Africa’s alarm bells ringing” Caelers (2007:1), reinforce the challenges faced by health care professionals. Such health issues require the nurse to be appropriately equipped with the knowledge and skills to provide patient and family education and to offer support to help families and carers to manage and cope with health care needs. Empowerment relates to the sense of self-worth and competence that comes from having the skills and abilities to carry out the required job, skills which are acquired through a process of continuing professional development. Empowered health care professionals can perform their jobs more confidently and more effectively than those who are not (Parsons 1998 in Gary 2002:33).

All of the respondents agreed/strongly agreed that continuing formal education programmes would be or are being undertaken for the purposes of keeping abreast with new developments in the area of specialty, and 98.3% indicated that they would be or are being undertaken to facilitate the development of nurse leadership capabilities. A total of 97.5% agreed/strongly agreed that continuing formal education provided the registered nurses with knowledge and skills not obtained during the basic nursing training; 97.5% agreed/strongly agreed that it helped develop the proficiency necessary to meet patients’ expectations; 92.5% agreed/strongly agreed that it was part of career planning; 92.5% agreed/strongly agreed that it was to improve confidence; 92.5% agreed/strongly agreed

that it was to improve prospects of remuneration; and 92.5% agreed/strongly agreed that it was in order to be an effective mentor for newly qualified nurses. There was agreement/strong agreement, but to a lesser extent (67.5%), that networking with other nursing colleagues was a reason for engaging in a continuing formal education programme.

The finding in this research that 100% of the respondents agreed/strongly agreed that continuing formal education programmes would be or are being undertaken for the purposes of keeping abreast with new developments in the area of specialty, as shown in Table 4.8, indicates that there is recognition among registered nurses that continuing education in nursing has benefit. In spite of this awareness, only 15% of the respondents are currently engaged in a continuing formal education programme. It is the researcher's view that systems at unit level as well as at organisational level have to be evaluated for their effectiveness in encouraging more registered nurses to commit to and be involved in continuing formal education.

Reasons given by respondents in this research for engaging in a continuing formal education programme are congruent with the findings of Ehrat (2001:36-42), that in most circumstances, continuing professional development in nursing and the accompanying acquisition of leadership skills positively correlates with improved, demonstrated technical and general skills. The ability to inspire followers, theorise, master uncertainty, inspire confidence and shoulder criticism is enhanced. The acquired leadership skills are also demonstrated in the appreciation of the accomplishments of

others, being able to view change with anticipation and being able to capitalise on mistakes. According to Hoban (2005:22), nursing is not just about doing something anymore, but about being holistic. Education allows the nurse to look at the wider issues around practice, and meet the patients' needs more efficiently.

Life-long learning should be about improving patient care and service delivery and the enhancement of inter-professional practice. Ultimately it is the health care user, the health care profession and the employing organisation that will benefit from continuing education. The more health professionals learn, the more they will challenge the traditional practices, embrace change and foster innovation (Hoban 2005: 24).

4.3.5 Motivation for engaging in continuing formal education

The respondents were asked to indicate what would motivate them to engage in continuing formal education (Table 4.9). In order of priority, the respondents rated the following variables as strong/very strong motivating factors for engaging in continuing formal education: real prospects of promotion and remuneration (80%); assistance with working out a career pathway (75%); role-models who demonstrate the value of career development (72.5%); funding assistance (72.5%); and a recent (< 2 years) successful programme of study (70%).

Table 4.9 MOTIVATING FACTORS FOR ENGAGING IN CONTINUING FORMAL EDUCATION *(N=40)*

	Very weak motivating factor	**Weak motivating factor**	**Strong motivating factor**	**Very strong motivating factor**	**Unanswered**
Real prospects of promotion and remuneration	7.5% *(N=3)*	10% *(N=4)*	52.5% *(N=21)*	27.5% *(N=11)*	2.5% *(N=1)*
A recent (< 2 years) successful programme of study	7.5% *(N=3)*	17.5% *(N=7)*	55% *(N=22)*	15% *(N=6)*	5% *(N=2)*
Assistance with working out a career pathway	10% *(N=4)*	12.5% *(N=5)*	55% *(N=22)*	20% *(N=8)*	2.5% *(N=1)*
Role-model who demonstrate the value of career development	2.5% *(N=1)*	22.5% *(N=9)*	50% *(N=20)*	22.5% *(N=9)*	2.5% *(N=1)*
Peer encouragement	5% *(N=2)*	25% *(N=10)*	55% *(N=22)*	12.5% *(N=5)*	2.5% *(N=1)*
Encouragement from management	7.5% *(N=3)*	27.5% *(N=11)*	52.5% *(N=21)*	10% *(N=4)*	2.5% *(N=1)*
Funding assistance	7.5% *(N=3)*	17.5% *(N=7)*	55% *(N=22)*	17.5% *(N=7)*	2.5% *(N=1)*
Obtaining a SANC qualification with scarce skills allowance entitlement	15% *(N=6)*	20% *(N=8)*	40% *(N=16)*	22.5% *(N=9)*	2.5% *(N=1)*
A study skills course prior to commencement of a formal study programme	12.5% *(N=5)*	22.5% *(N=9)*	47.5% *(N=19)*	15% *(N=6)*	2.5% *(N=1)*

White and Ewan (1997:195) say that a potential pitfall to avoid is the tendency to concentrate on technical aspects of nursing and so miss the opportunity to foster the nurses' personal growth. These assertions are made in relation to clinical teaching roles, but the same principle applies with regard to the role of the nurse manager. According to Jooste (2003:140), employees expect to have a meaningful and secure job and to receive feedback relating to their work performance.

The registered nurse's skills should be constantly redefined and improved throughout professional life. Butterworth and Faugier (1995:12) caution against stagnation and complacency with regard to skills development, when registered nurses (including unit managers) reach a point in their professional lives where they no longer recognise challenges which necessitate different solutions. Gabriel (2004:30), writing about skills development and the transformation process, states that the enemies of transformation include apathy and a new comfort zone. There is congruency between what the literature suggests are factors which would motivate a nurse to engage in a continuing formal education programme or a programme of continuing professional development and the strong motivating factors identified among the respondents in this research.

Strong/very strong motivating factors for engaging in continuing formal education, but to a lesser degree, were peer encouragement (67.5%); encouragement from management (62.5%); obtaining a SANC qualification with scarce skills allowance entitlement (62.5%); and a study skills course prior to commencement of a formal study programme (62.5%). Jordaan says (Together we lead 2006:23) that nurses will generally care for

their patients at the same level as the care that they are afforded by their own nurse managers. The concept of magnet hospitals being the gold standard for nursing care in the USA is attributed to those hospitals which have created an environment characterised by staff satisfaction, staff retention and improved care outcomes for patients. Aiken says (Together we lead 2006:30) that essential to attaining the gold standard includes working with clinically competent nurses, supportive nurse managers, and support for education. The findings in this research related to the factors which motivated nurses to engage in continuing education programmes, as reported by national and international literature.

In spite of only 50% of respondents having engaged in continuing formal education in the past five years, the need for a study skills course prior to embarking on a programme of study was a strong motivating factor for only 62.5% of the respondents (Table 4.9). The profile of nursing can be raised through research. The nursing services manager who plans to establish a nursing research programme is faced with selling the concept to nursing staff. Simms, Price and Ervin (1994:271) and Quinn (1997:447) suggest that a common attitude exists that a nursing research programme is a nicety rather than an essential tool for data-based decision making. In view of 70% of the respondents in this study being in agreement that a recent (< 2 years) successful programme of study was a strong motivating factor for engaging in continuing formal education, a study skills course prior to embarking on a programme of study - particularly for those nurses who have not been involved in continuing education for at least two years - needs to be promoted.

4.4 FINDINGS PERTAINING TO BARRIERS TO UNDERTAKING CONTINUING FORMAL EDUCATION

The respondents were asked to indicate the reasons which would be a deterrent to their engaging in continuing formal education nursing programmes. There was less distance between agreement and disagreement as to what posed a barrier to engaging in continuing formal education, compared to what motivated or did not motivate a respondent to engage in an education programme.

4.4.1 Barriers to continuing formal education as perceived by over 50% of respondents

In only 6 out of 29 parameters measured (Table 4.10) was there an above 50% level of agreement that they were perceived as barriers to continuing formal education: lack of funding (70%); job responsibilities (67.5%); conditions attached to the granting of study leave (62.5%); lack of employer cooperation, for example for funding (60%); family and child care responsibilities (55%); and lack of coherent staff development plans by the institution (52.5%).

The main barriers to continuing formal education could be categorised as both physical and structural barriers. Ferguson (1994:645-646), Kersaitis (1997:138), Nolan *et al.* (1995:552) and Yuen (1991:1233) identified similar barriers to continuing professional development in nursing, such as lack of time because of job responsibilities; family and child care responsibilities; difficulties in paying course fees and fear of losing benefits.

Table 4.10 BARRIERS TO CONTINUING FORMAL EDUCATION AS PERCEIVED BY OVER 50% OF RESPONDENTS *(N=40)*

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**Unanswered**
Lack of funding	10% *(N=4)*	20% *(N=8)*	47.5% *(N=19)*	22.5% *(N=9)*	0%
Job responsibilities	5% *(N=2)*	27.5% *(N=11)*	32.5% *(N=13)*	35% *(N=14)*	0%
Conditions attached to the granting of study leave, eg repay the service a year for each year of study	2.5% *(N=1)*	32.5% *(N=13)*	40% *(N=16)*	22.5% *(N=9)*	2.5% *(N=1)*
Lack of employer co-operation (e.g. for funding)	2.5% *(N=1)*	35% *(N=14)*	47.5% *(N=19)*	12.5% *(N=5)*	2.5% *(N=1)*
Family and child care responsibilities	12.5% *(N=5)*	32.5% *(N=13)*	32.5% *(N=13)*	22.5% *(N=9)*	0%
Lack of coherent staff development plans by the institution	2.5% *(N=1)*	45% *(N=18)*	45% *(N=18)*	7.5% *(N=3)*	0%

4.4.2 Barriers to continuing formal education as perceived 40-50% of respondents

Table 4.11 shows that 50% of respondents agreed that the lack of a supportive environment is a barrier to continuing formal education. The respondents who agreed were given an opportunity to elaborate on their answer. The researcher identified themes arising from the responses relating to the lack of a supportive environment as a barrier to continuing formal education, as follows: the impact of staff shortages; lack of

encouragement from management and colleagues; and the challenges of studying and working simultaneously not being appreciated.

Staff shortage (7 respondents)

Respondents qualified their statements regarding staff shortage as a barrier to continuing formal education by referring to those embarking on a continuing formal education programme being made to feel responsible for the resultant dependency on uncommitted agency nursing staff. Respondents who referred to the shortage of experienced staff expressed the lack of confidence displayed by medical staff in the nurses' abilities, as non-regular agency nurses were often a greater presence than experienced nurses.

Lack of encouragement from management and colleagues (11 respondents)

These respondents made reference to the lack of interest shown by management and colleagues, evidenced by the lack of discussion with regard to nurses' learning needs. Respondents who had acquired new clinical skills reported that they were not given the opportunity to display these new skills, and were not encouraged to mentor less experienced nurses. Reference was made to a lack of willingness by those who had completed post-registration courses to share their new-found knowledge.

The challenges of simultaneous work/study not addressed (3 respondents)

Respondents reported that where continuing education was encouraged, the reality of the challenge of working and studying simultaneously was not recognised, since full-time study leave was seldom granted. This resulted in prospective students having to evaluate

their willingness to use their much-needed annual leave for study purposes. Respondents expressed their concern that their studies would not receive the required attention due to the demands of the clinical arena.

Table 4.11 BARRIERS TO CONTINUING FORMAL EDUCATION AS PERCEIVED BY 40-50% OF RESPONDENTS *(N=40)*

	Strongly disagree	**Disagree**	**Agree**	**Strongly Agree**	**Unanswered**
Lack of a supportive work environment	2.5% *(N=1)*	47.5% *(N=19)*	30% *(N=12)*	20% *(N=8)*	0%
Lack of opportunities for promotion/upward mobility	2.5% *(N=1)*	47.5% *(N=19)*	30% *(N=12)*	20% *(N=8)*	0%
Lack of motivation to study again	15% *(N=6)*	40% *(N=16)*	35% *(N=14)*	10% *(N=4)*	0%
Lack of information about the structure of education programmes	7.5% *(N=3)*	47.5% *(N=19)*	35% *(N=14)*	7.5% *(N=3)*	2.5% *(N=1)*
Difficulty with English if this is not first language but is the medium of instruction	25% *(N=10)*	35% *(N=14)*	32.5% *(N=13)*	7.5% *(N=3)*	0%
Lack of role-models in the workplace	17.5% *(N=7)*	42.5% *(N=17)*	30% *(N=12)*	10% *(N=4)*	0%

Table 4.11 shows that 40-50% of the respondents agreed that the following were barriers to continuing formal education: lack of opportunities for promotion/upward mobility (50%); lack of motivation to study again (45%); lack of information about the structure of education programmes (42.5%); difficulty with English if this was not the respondent's

first language but was the medium of instruction (40%); and lack of role-models in the workplace (40%).

The respondents who agreed that the lack of role-models in the workplace was a barrier to their engagement in a continuing education programme were given the opportunity to elaborate on their answer. The researcher has identified themes within the responses here as: nurses' expectations of the unit manager; perceptions of the unit manager's style of management; structures (staffing/promotion) not conducive to professional development; and the reluctance of experienced nurses to share their knowledge.

Nurses' expectations of the unit manager role (8 respondents)

Respondents qualified their statements regarding their expectations of the unit manager being the role-model for the nurses' continuing formal education, in terms of unit managers not being motivators for academic and professional development, and not being competent in resolving conflict in the nursing unit.

Perceptions of the unit manager's style of management (2 respondents)

Respondents reported that the autocratic, non-participative style of management in the nursing unit was indicative of a unit manager being unable to be a spokesperson for nurses' concerns.

Structures (staffing/promotion) not conducive to professional development (3 respondents)

Respondents reported that they had first-hand knowledge and experience of not being remunerated for post-registration and postgraduate qualifications obtained, creating negativity with regard to the value of continuing formal education programmes.

Reluctance of experienced nurses to share their knowledge (3 respondents)

It was suggested that nurses known to the respondents, who had obtained a post-basic qualification, did so to obtain the scarce skills allowance or to be able to work overseas, rather than to contribute positively to the work environment through sharing their knowledge or to participate in training programmes.

Structural barriers, also referred to as institutional barriers, have been described by various authors as lack of transport; limited opportunities for learning near to place of residence; limited opportunities for learning due to staff shortages; lack of necessary programmes; entry requirements to post-registration programmes; lack of knowledge about learning opportunities; lack of coherent staff development plans; bureaucracy; a non-inclusive style of nursing management; difficulty in obtaining study leave; lack of support from managers; and late advertising of continuing professional educational events (Barriball and While 1996:1000; Yuen 1991:1235). In this research, areas of congruency were identified with such barriers to continuing formal education as reported in the literature reviewed.

4.4.3 Barriers to continuing formal education as perceived by 30-40% of respondents

The following barriers to continuing formal education, as perceived by 30-40% of respondents, were identified (Table 4.12): lack of learning facilities near to place of residence (37.5%); negativity due to unpleasant past experiences in academia (35%); anxiety about not being able to “keep up” academically (35%); nursing not viewed as a profession for life (35%); lack of physical energy (35%); available programmes inappropriate to clinical practice needs (35%); lack of opportunity to utilise new skills in the workplace (35%); managers not convinced that staff development is of vital importance for the services (35%); skepticism about the value of formal continuing education (32.5%); not coping well with academic studies (32.5%); and prohibitive entry requirements to programmes (30%).

Table 4.12 BARRIERS TO CONTINUING FORMAL EDUCATION AS PERCEIVED BY 30-40% OF RESPONDENTS *(N=40)*

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**Unanswered**
Lack of learning facilities near to place of residence	7.5% *(N=3)*	55% *(N=22)*	27.5% *(N=11)*	10% *(N=4)*	0%
Negativity due to unpleasant past experiences in academia	20% *(N=8)*	45% *(N=18)*	25% *(N=10)*	10% *(N=4)*	0%
Anxiety about not being able to "keep up" academically.	20% *(N=8)*	45% *(N=18)*	25% *(N=10)*	10% *(N=4)*	0%
Nursing not viewed as a profession for life	20% *(N=8)*	45% *(N=18)*	20% *(N=8)*	15% *(N=6)*	0%
Lack of physical energy	7.5% *(N=3)*	57.5% *(N=23)*	22.5% *(N=9)*	12.5% *(N=5)*	0%
Available programmes are inappropriate to clinical practice needs	10% *(N=4)*	52.5% *(N=21)*	30% *(N=12)*	5% *(N=2)*	2.5% *(N=1)*
Lack of opportunity to utilise new skills in the workplace	10% *(N=4)*	52.5% *(N=21)*	27.5% *(N=11)*	7.5% *(N=3)*	2.5% *(N=1)*
Managers not convinced that staff development is vitally important for services	15% *(N=6)*	47.5% *(N=19)*	27.5% *(N=11)*	7.5% *(N=3)*	2.5% *(N=1)*
Skepticism about the value of formal continuing education	20% *(N=8)*	47.5% *(N=19)*	20% *(N=8)*	12.5% *(N=5)*	0%
Not coping well with academic studies	15% *(N=6)*	50% *(N=20)*	27.5% *(N=11)*	5% *(N=2)*	2.5% *(N=1)*
Prohibitive entry requirements to programmes	7.5% *(N=3)*	57.5% *(N=23)*	22.5% *(N=9)*	7.5% *(N=3)*	5% *(N=2)*

Many of the described barriers can be clustered as attitudinal barriers, which refer to attitude and self-perceptions about oneself as a learner. Authors and researchers have identified attitudinal barriers as negativity due to unpleasant past experiences in academia; lack of emotional and physical energy; being nervous about going back to the classroom; and concern about not being able to keep up, resulting in having low aspirations (Ferguson 1994:645-646; Nolan *et al*. 1995:551; Yuen 1991:1233). Skepticism about the value of continuing professional development, low self-esteem, lack of confidence both generally and in relation to learning, lack of role-models and lack of trust in the formal institution were found to be common in this research and in the literature reviewed (Horton-Deutsch and Mohr 2001:121-126; Xaba and Phillips 2001:2). Nurses who feel undervalued may progressively develop low self-esteem and attribute a lower sense of meaning to their work. Nurses who have low expectations are less likely to react negatively to unfair treatment, leading to a sense of powerlessness. To be empowered is to have access to the information, resources and support necessary for competent patient care, and to have the self-worth that comes from having the skills and ability to carry out the required job (Roberts 1997 in Gary 2002:34).

It would be more encouraging if considerably less than the 30% of registered nurses in this research viewed attitudinal barriers as having a deterrent effect on the pursuit of continuing formal education. However, it is encouraging that, conversely, there is over 50% disagreement about aspects such as learning facilities are inaccessible, programmes inappropriate to clinical practice needs are barriers to continuing formal education, and acquired skills are not being recognised or utilised in the workplace.

4.4.4 Factors conducive to the pursuit of continuing formal education, and benefit gained

Table 4.13 shows that only 27.5% of the respondents in this research perceived lack of transport to and from education centres as a barrier to continuing formal education. However, the respondents in this research were based at health care facilities in urban areas. The picture regarding transportation to facilities of learning in rural areas might be different, but this was not investigated. A significant number of respondents (72.5%) seemed to indicate a familiarity with the selection criteria for being granted study leave.

Table 4.13 FACTORS CONDUCIVE TO THE PURSUIT OF CONTINUING FORMAL EDUCATION, AND BENEFIT GAINED *(N=40)*

Barrier to continuing formal education	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**	**Unanswered**
Lack of transport to and from education centres	10% *(N=4)*	62.5% *(N=25)*	17.5% *(N=7)*	10% *(N=4)*	0%
Not knowing the selection criteria for being granted study leave	17.5% *(N=7)*	55% *(N=22)*	22.5% *(N=9)*	2.5% *(N=1)*	2.5% *(N=1)*
Benefit after having completed a post-registration programme	**Yes** 57.5% *(N=23)*		**No** 20% *(N=8)*		**Unanswered** 22.5% *(N=9)*

Respondents were asked if they had benefited from undertaking a continuing formal education programme. Table 4.13 shows that 57.5% answered in the affirmative, while 20% felt that they had not benefited. However, 22.5% of participants in the research chose not to answer this question. With 15% of respondents not having gained a post-

basic qualification, therefore 7.5% would be the actual percentage of respondents who chose not to comment. Respondents who had apparently not benefited were not asked to comment. The researcher would (rightly or wrongly) make inferences from comments made relating to the lack of a supportive work environment. Comments from those who had benefited from a continuing formal education programme were clustered under the themes development of leadership skills; financial benefits; development of the mentorship role; and an enhanced knowledge base.

Development of leadership skills (4 respondents)

Respondents reported having grown in confidence with regard to being a leader and role-model in the workplace, especially where the choice of course undertaken was relevant to the clinical area. It was recognised that management and leadership skills gained were transferable to different situations such as managing resources and managing people.

Financial and promotion opportunities (8 respondents)

Respondents commented on the promotion opportunities as a result of having attained and additional nursing qualification.

Development of the mentorship role (2 respondents)

Respondents commented on confidence gained to be knowledgeable mentors to less experienced nurses.

Enhanced knowledge base (7 respondents)

The overarching comment was awareness gained of how the respondents' current field and place of practice fitted into the larger health care picture, and of the importance of collaboration across different sectors of health care.

4.5 CONCLUSION

Research findings relating to the perceptions with regard to continuing formal education of registered nurses were presented, analysed and interpreted.

The findings indicated that the age group 46-55 years contained the largest group of registered nurses (47.5%) represented in this study. The lowest number of participants (7.5%) were in the age group older than 55 years. The mean number of years that the registered nurses had been qualified was 21.15. This would indicate that the registered nurses in this research are experienced nurses who should have been exposed to continuing formal education in nursing in order to maintain relevance in their practice.

The research findings showed that only 15% of the respondents were currently involved in a programme of continuing formal education. The main reasons cited for non-involvement in a study programme were the lack of role-models in the workplace, failure on the part of nursing management to support continuing professional and academic development, and the negative impact of staff shortages. Positive comments received from the respondents were that they would undertake a programme of study mainly to be

able to cope with the pressures of work, keep abreast of new developments, and to gain knowledge and skills not obtained during basic nursing training.

The barriers to continuing professional development were categorised as physical, structural and attitudinal. Responses in this research as to what constituted a barrier did not fit into these neat categories; however, the structural barriers to continuing formal education could be identified as being the greatest of these barriers. Lack of funding, job responsibilities, conditions attached to study leave, and lack of employer cooperation were cited as barriers to continuing formal education by over 50% of the respondents. Half of the respondents indicated that the lack of a supportive work environment, staff shortages, lack of encouragement from management and colleagues, and the challenges of simultaneous work and study were barriers to continuing formal education. The lack of role-models in the workplace was described in terms of nurse managers practicing an autocratic style of management, and experienced nurses not being willing to share their knowledge with those less experienced.

Encouragingly, there were positive comments from nurses who had undertaken a programme of study. Positive statements included the development of leadership skills, enhancement of financial and promotion opportunities, development of the mentorship role, and a widened knowledge base.

The next and final chapter will summarise the research findings, recommendations, limitations and conclusions reached with regard to the perceptions of registered nurses on continuing formal education.

CHAPTER 5

SUMMARY OF FINDINGS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

In this chapter the research findings are summarised chronologically from the analysed data reported on in Chapter 4. Recommendations which follow on from the research findings will be offered with reference to nursing education, nursing practice and further research. The limitations of the study will be discussed, followed by the conclusion.

The purpose of the research was to explore and describe the perceptions of registered nurses with regard to continuing formal education. The research objectives were to:

- establish how registered nurses view continuing formal education; and
- identify the barriers to continuing formal education experienced by registered nurses.

A quantitative explorative and descriptive design was used to conduct the research. The data collection tool was a questionnaire. The questionnaire was designed based on the themes which arose repeatedly during a review of the literature. These themes were: the importance of continuing professional development; the benefits of continuing professional development for the health care professional, health care user, and health care organisation; the motivation for continuing professional development; the barriers to continuing formal education; and the factors which facilitate pursuing a continuing formal education programme.

Utilising the survey for its descriptive purpose allowed the researcher to obtain information regarding the demographics relating to the respondents and the status of their involvement in continuing formal education, and to identify what the respondents perceived as barriers to continuing formal education in nursing. Utilising the survey for its exploratory purpose allowed the researcher to obtain information relating to the perceptions held by registered nurses with regard to the importance of continuing formal education, and their motivation for undertaking continuing education programmes. Convenience sampling was used to obtain a sample of seventy registered nurses at four state health institutions at primary, secondary, and tertiary level in the Western Cape Province, South Africa. Only forty of the seventy in the sample returned completed questionnaires.

5.2 SUMMARY OF RESEARCH FINDINGS

5.2.1 Demographic information

The demographic variables discussed in this section are age, gender, number of years that the respondents had been qualified as a nurse, basis of employment, and professional rank.

5.2.1.1 Age

The age group 46-55 years was the largest group (47.5%) of registered nurses represented in this study (see 4.2.1.1). The finding was congruent with literature consulted, which showed that in the USA it is estimated that by the year 2010, 40% of registered nurses will be older than 50 years of age. Therefore, there will be high numbers of registered

nurses retiring in the next 10-15 years. The primary factor that has led to the ageing of the registered nurse workforce in the USA appears to be the decline in younger women choosing nursing as a career during the last two decades (White 2001:201). In South Africa, where the retirement age is generally 60 years of age, at least 22.5% of the registered nurses will be retiring within the next ten years. From 1996 to 2001 there was a decline in the numbers of students enrolled for training in South Africa. Although the intakes from 2001 have increased, a gap in the growth of the nursing profession will remain unfilled (Where are the nurses? 2006:42,43).

5.2.1.2 Gender

The gender distribution in this study (see 4.2.1.2) showed that the majority of registered nurses are female (92.5%), with 1 male participant (2.5%) and 2 non-responses (5%) to the gender question. From the literature, the dominance of females in nursing found support in a USA research report by Des Jardin (2001) in Gary (2002:33), which focused on the empowerment of nurses. The gender distribution in their sample was 97% female nurses.

5.2.1.3 Number of years qualified as a nurse

The mean number of years that the registered nurses in this study had been qualified was 21.15 (see 4.2.1.4). This would indicate that the registered nurses in this research are experienced nurses who should have been exposed to formal education to maintain relevance in their practice and willingly undertake the mentorship role. However, the research showed that senior nurses and nursing managers were criticised for not being

motivators and role- models for less experienced nurses who wished to embark on a programme of continuing formal education (see 4.4.2).

5.2.1.4 Basis of employment and professional rank

The majority of the respondents (90%) were in full-time employment (see Table 4.3). The largest group occupied the post of Chief Professional Nurse (37.5%), followed by Chief Professional Nurse-Unit Manager (32.5%) (see 4.2.1.6). As the average length of time that the registered nurses in the sample had been qualified was 21.15 years (see 4.2.1.4), it would be expected that progress would be made to senior-level posts during these years, with the responsibilities of leadership and management and coordinating the activities of the nursing team.

5.2.2 Demographic information: continuing formal education

The demographic details discussed in this section refer to the time period that had elapsed since obtaining a post-basic qualification.

5.2.2.1 Time lapse with regard to obtaining a post-basic qualification

The data showed that a significant number of registered nurses (85%) had undertaken further studies, 45% at diploma level and 22.5% at degree level. Another 17.5% obtained a qualification in a health-related field, with 15% not having undertaken a formal course since obtaining their initial nursing registration (see 4.2.2.1). While a significant number of respondents (85%) had undertaken a post-basic course, it became less significant when it was shown that only 50% of respondents had availed themselves of a study programme

in the last 5 years. A further 17.5% of the respondents had not undertaken any course of study in the past 6-10 years; 15% of respondents had not undertaken a course of study in the 11-15 years, while 2 respondents had taken up a course of study after a period of 15 years (Table 4.6). According to Welsh and Woodward (1989) in Kennie and Enemark (1996:3), it has been estimated that the knowledge gained in a vocational degree course has an average useful life span of about four years. If professionals have expectations of increased managerial responsibility (as in the case of senior registered nurses), the need to acquire new skills and knowledge is even more acute.

5.2.3 Findings pertaining to how registered nurses view continuing professional development

For the purpose of gaining insight into how registered nurses view continuing formal education, the following findings are discussed: respondents' current involvement in a programme of study; reasons for not embarking on a programme of study; reasons for not completing a programme of study; reasons for engaging in continuing formal education; and motivation for engaging in continuing formal education

5.2.3.1 Current involvement in a programme of study

Only 15% of the respondents were currently undertaking a programme of study, 82.5% were not currently undertaking a programme of study, and 2.5% of the respondents did not answer this question (see 4.3.1). Tlholoe (2006:5) says there is a need for a commitment to continual professional development since people who stop learning become less and less relevant as skills gained early in a career are insufficient to avoid costly mistakes made through ignorance.

5.2.3.2 Reasons for not embarking on a programme of study

Respondents who had not undertaken a post-basic course of study at all or not in the past five years gave their reasons as: lack of role-models in the workplace (five respondents); failure on the part of management with regard to staff development and off-duty arrangements (three respondents); and the negative impact of staff shortages (three respondents) (see 4.3.2).

According to the International Council of Nurses (2006:22,24,25), there has been much research demonstrating that the level of staffing has an impact on patient outcomes such as mortality. Although there is no consensus as to what safe staffing means, researchers do recognise that there has to be an appropriate number of staff, with a suitable mix of skill levels that are available at all times to ensure that patient care needs are met and hazard-free working conditions are maintained. Where safe staffing levels and appropriately skilled nurses are not available, a high-risk and potentially dangerous environment exists, in which stress and burn-out are well documented.

5.2.3.3 Reasons for not completing a programme of study

Respondents cited reasons for not completing a programme of study as: work responsibilities and associated time constraints (three respondents); ill health and consequent lack of motivation (two respondents); and lack of communication from education department with regard to course schedules, course fees and financial support for studies (two respondents) (see 4.3.3).

5.2.3.4 Reasons for engaging in continuing formal education

In order of priority, the respondents gave their top five reasons for engaging in continuing formal education as: to keep abreast with new developments in the area of specialty (100%); to facilitate the development of nurse leadership capabilities (98.3%); to provide knowledge and skills not obtained during the basic nursing training (97.5%); and to develop proficiency necessary to meet patients' needs and expectations (97.5%). Respondents strongly agreed that continuing formal education would improve confidence in the mentoring role (92.5%), and an equal number would undertake a continuing formal education programme to improve prospects of remuneration (92.5%) (see 4.3.4). The health care professional becomes empowered through continuing professional development, with resultant improvement in patient care and productivity. Empowerment relates to the sense of self-worth and competence that comes from having the skills and abilities to carry out the required job (Gary 2002:33).

5.2.3.5 Motivation for engaging in continuing formal education

Reviewing the responses in terms of the reasons for engaging in continuing formal education and the motivation for continuing education, the researcher was beginning to identify those factors which, if absent, would result in reluctance to embark on a programme of continuing formal education. In order of priority, the five most important motivators were: real prospects of promotion and remuneration (80%); assistance with working out a career pathway (75%); role-models who demonstrate the value of career development (72.5%); funding assistance (72.5%); and recent success in a programme of study (70%) (see 4.3.5).

5.2.3.5.1 Common denominators between motivation for and involvement in continuing formal education

The researcher identified reasons for engaging in continuing formal education which were also motivators for engaging in continuing formal education. With regard to career planning, 92.5% of the respondents would engage in continuing formal education and 75% of respondents would be motivated if given assistance with working out a career pathway. Improved leadership capabilities were cited by 98.3% of respondents as a reason for engaging in continuing formal education, with 72.5% of respondents being motivated by a role-model who demonstrated the value of continuing formal education. For 92.5% of the respondents, improved remuneration prospects were a reason they would engage in continuing formal education, with prospects of promotion being a motivator for 80%. The development of proficiencies necessary to meet patients' needs and expectations was a reason why 97.5% of respondents would engage in continuing formal education, with 70% being motivated to engage in further learning opportunities by a recent successful programme of study and improvement in their practice (see 4.3.4, 4.3.5 and 4.4.4). Motivation can be enhanced if the individual practitioner works out a career path or is encouraged and assisted to do so, thereby ensuring that only the relevant skills are acquired (Hoban 2005:23). In the absence of learner motivation, participation in continuing formal education is unlikely to secure improvements in patient and client care or changes in professional and personal growth (Barriball and While 1996:1000).

5.2.4 Findings pertaining to barriers to undertaking continuing formal education

The design of the questionnaire and the use of descriptive statistics using the Microsoft (MS) Excel (for Windows 2000) programme made it possible for the researcher to catergorise the barriers to continuing formal education in terms of percentage clusters. These percentage clusters were presented as: barriers to continuing formal education as perceived by over 50% of respondents (see 4.4.1); barriers to continuing formal education as perceived by 40-50% of respondents (see 4.4.2); and barriers to continuing formal education as perceived by 30-40% of respondents (see 4.4.3).

In summary, the main barriers the respondents had encountered or envisaged in the pursuit of continuing formal education were, in order of priority: lack of funding (70%); job responsibilities (67.5%); conditions attached to the granting of study leave (62.5%); lack of employer cooperation - for example, for funding (60%); family and child care responsibilities (55%); and lack of coherent staff development plans by the institution (52.5%) (see 4.4.1). In a study on nurse emigration by Xaba and Phillips (2001:1-7), it was reported that some nurses feel that there is little space for them to grow in their profession in South Africa, citing the lack of opportunities for promotion/upward mobility, the difficulty in getting study leave, and nursing education not being subsidised as reasons leading them to emigrate.

The significant barriers perceived by over 50% of the respondents in the current research (see 4.4.1) found commonalities with structural barriers - those practices, procedures and policies that place limits on opportunities for potential adult learners to participate in

continuing education, as described by various researchers and authors (see 2.5.3). The common barriers were lack of coherent staff development plans and bureaucracy, described by respondents in this study as lack of funding for education programmes, and conditions attached to the granting of study leave. Lack of financial support was also cited by two respondents as a reason for not completing a programme of study (see 4.3.3). Limited opportunities for learning due to staff shortages were described by respondents in this research in terms job responsibilities being a barrier to involvement in an education programme. Work responsibilities were also cited as a reason for not completing a programme of study (see 5.2.3.3). Family and child care responsibilities, cited by 55% of the respondents in this study, together with financial constraints found common ground with physical barriers to continuing adult education described in the literature (see 2.5.1).

Having analysed the data pertaining to the barriers to undertaking a programme of continuing formal education in nursing, the focus is drawn to the mainly structural barriers - those practices, procedures and policies of the employing institution that place limits on opportunities for formal learning.

5.2.4.1 The lack of role-models in nursing as a barrier to continuing formal education

Of significance in the research findings was the attention afforded the role-model function of the registered nurse. Lack of role-models as a barrier to career development has been described by various authors as an attitudinal barrier. Attitudinal barriers,

synonymous with dispositional barriers, were those self-perceptions about the individual characterised by but not limited to lack of emotional and physical energy, and lack of confidence - both generally and in relation to learning (Yuen 1991:1233).

The 40% of respondents who agreed that the lack of role-models in the workplace was a barrier to their engagement in a continuing education programme were given the opportunity to elaborate on their answers (see 4.4.2). The lack of role-models was the most important reason for respondents not embarking on a programme of continuing formal education (see 4.3.2). A role-model was one who demonstrated the value of career development in the workplace, in so doing motivating the nurse to embark on a programme of continuing formal education (see 4.3.5; 5.2.3.5). Lack of role-models was cited as a factor contributing to 50% of the respondents agreeing that the lack of a supportive environment was a barrier to continuing formal education (see Table 4.11).

5.2.5 Factors conducive to the pursuit of continuing formal education and benefit gained

A relatively small percentage of the respondents (15%, see Table 4.7) were currently involved in a programme of continuing formal education, although overall 85% of respondents had attained a post-basic qualification (see Table 4.4). Comments from those who had benefited from a continuing formal education programme were clustered under the following themes: development of leadership skills; financial benefits; development of the mentorship role; and an enhanced knowledge base (see 4.4.4). These positive comments are not dissimilar to the factors which were identified as being both a

motivator and the reason for engaging in continuing formal education: positive role models; improved remuneration; and enhanced proficiencies.

5.3 RECOMMENDATIONS

These recommendations are offered as pertaining to nursing education, nursing practice and further research.

5.3.1 Nursing education

- **Mentorship:** Post basic nursing education programmes should include a module on mentorship, and what it means in practice. Negative comments have been expressed by respondents with regard to the reluctance of registered nurses to share information gained following a course of study and to and demonstrate support for the less experienced nurse. As adults mature, they have the potential to create a reservoir of experience that will cause them to become a rich source of learning. A mentorship program can significantly impact the attrition of newly hired nurses (Modic and Schloesser 2006:96). The working environment of the health care professional is dependent on the health care professional relating his or her knowledge to practice (see 4.4.2).

- **Course scheduling:** Course schedules need to be formulated in consultation with the practice area and the best ways sought to accommodate potential learners. Health care services managers and educators should be aware of the need for adjustable, flexible work and course schedules to accommodate potential learners.

- **Collaboration:** The academic programme should continually seek increased understanding from practice about what kind of nursing is preferred. This understanding may lead to curricular changes designed to develop nurses who are able to meet the demands of the changing health care environment.

5.3.2 Nursing practice

- **Age implications:** The majority of registered nurses in this study were in the 46-55 year age range. The average age the nurse in this study was qualified was 21.15 years. The aging nursing work force is a factor that nursing and organisational management would do well to consider as they plan strategies to retain a younger mobile workforce through a programme of continuing professional development while ensuring the older work force maintains relevancy in their practice. Institutions have to invest in programmes such as the acquisition and training in technology that will decrease the risk of injury to health care users and health care providers, consider reduced hours, and invest in the continuing professional development of nurses.

- **Collaboration:** To address the nurse's career goals, both organisations and individuals should share responsibility for the careers of employees. Nurses are more likely to have more successful careers if organisations and individuals are involved in career planning and management.

- **Value of the appraisal system:** Nurses should be encouraged to use their appraisals as managers are obliged to identify the nurses learning needs, interpersonal development needs, and plan how these needs will be met. Combining specific job-related skills training with an individualised continuing professional development programme, drawn up during the performance review process, has the dual advantage of showing staff how valued they are as individuals and of equipping them to move into new roles as the organisation's needs develop Hoban (2005:24).

- **Career planning:** Plans have to be put in place by nurse unit managers and organisational management for budget provision to provide opportunities for employees to attend courses and conferences on a continuous rotating basis. Opportunities for educational and professional development should be known by nurses via the health care institution's communication channels. Nurses should be encouraged to use nursing informatics to facilitate their career development. Nurses need to be promoted in a motivated environment through the availability of managerial positions, promotion opportunities and satisfactory working conditions.

5.3.3 Further research

- **Impact of nurses' rank on career development:** The largest group of respondents in this study occupied the post of Chief Professional Nurse. In order to fulfill their roles of leadership and management they are required to seek new

knowledge in numerous and diverse areas of nursing practice. A comparative study between registered nurses who do not occupy management posts and those who do could conclude which rank of nurse faces more barriers to continuing formal education. Appropriate career development plans could then be put in place by the health care institution's.

- **Career development structures:** An investigation into the career development needs of employees compared to the appropriateness and accessibility of an institutions development plans may reveal the improbability of employees accessing the opportunities for continued learning provided by the health care institution.

- **Mentorship:** The researcher perceives as valuable a study of the impact of mentorship on attrition rates and job satisfaction of newly qualified employees and employees reverting to be novices through deployment to unfamiliar areas of practice.

- **Work experience abroad:** Obtaining feedback from those nurses who have returned to South Africa after working abroad with regard to career development and accessing continuing formal education programmes may serve as a guide for managers responsible for the career development of nurses.

5.4 LIMITATIONS

The researcher identified the limitations in the study in terms of a response rate of 57%. The data collection process was guaranteed to be anonymous, so there was no way of knowing who had not returned a questionnaire. In spite of making numerous personal requests, the overall response rate improved by just three responses.

In terms of responses to the questions on current involvement in a study programme and time lapse since undertaking a course of study, the researcher concluded that asking a respondent to indicate a response in a 0-5-year box might have resulted in less than accurate findings, since some of the respondents may have completed a programme as recently as one month previously (see 4.3.1 and Table 4.7).

When it came to assessing the impact of family responsibilities, the respondents were not asked to indicate the age of their children. Most of the respondents were married with children, and family responsibility was identified as a barrier to continuing formal education. The literature review also cited family responsibility as a significant barrier to career development (Kersaitis 1997:137; Barriball and While 1996:1002). Asking whether or not the respondents had children served only as demographic information. The researcher was not able to conclude congruency or otherwise of the findings in this study with the conclusions in the relevant literature.

5.5 CONCLUSION

The findings of this research indicated that registered nurses working at the participating health care institutions are aware of the benefits of a continuing formal education programme in nursing, and of the need to remain updated. However, at the time the study was conducted (December 2006), only 15% of the registered nurses in the sample were involved in continuing formal education programmes. The researcher concludes that numerous barriers exist, which are largely of a structural nature. These prevent nurses from embarking on a programme of continuing formal education. Structural barriers - those practices, procedures and policies that placed the most severe limits on access to continuing formal education programmes by registered nurses in this study - included the lack of funding; job and family responsibilities; conditions attached to the granting of study leave; lack of coherent staff development plans by the institution; and lack of opportunities for promotion. Other constraining factors were the lack of role models and mentors and staff who are reluctant to share newly acquired knowledge. The emphasis in this study on the lack of funding for study programmes, shows that nurses remain reluctant to take financial responsibility for their own learning; they also regard conditions attached to the granting of study leave as a deterrent to embarking on a programme of study.

The major reasons for which registered nurses in this study would undertake or had undertaken continuing formal education programmes were to keep abreast with new developments in the area of specialty, to facilitate the development of nurse leadership capabilities, and to acquire knowledge and skills not obtained during the basic nursing

training (see Table 4.8). It is encouraging to realise that registered nurses engage in continuing formal education programmes for the right reasons, which are to enhance professional development and improve patient care.

In spite of this awareness, only 15% of the respondents are currently engaged in a continuing formal education programme (see Table 4.7). It is the researcher's view that systems at unit level as well as at organisational level have to be evaluated for their effectiveness in encouraging more registered nurses to commit to and be involved in continuing formal education.

The message has to be conveyed - repeatedly - that continuing professional development has been credited with enhancing the quality of nursing care, through improving the knowledge base of staff with the consequence of raising standards and producing a more cost-effective service.

Recognition of the barriers to continuing formal education demands a collective response from the health care institution, the individual nurse and the nurse manager in order to overcome these barriers.

LIST OF REFERENCES

Abruzzese, RS. 1996. *Nursing staff development: strategies for success.* St Louis: Mosby Year Book.

Astedt-Kurki, P & Haggman-Laitila, A. 1992. Good nursing practice as perceived by clients: A starting point for the development of professional nursing. *Journal of Advanced Nursing*, October, **17**(10)**:**1195-1199.

Atkinson, RL, Atkinson CA, Smith EE, Bem DJ & Hilgard ER 1990. *Introduction to psychology*. 10th edition. Fort Worth: Harcourt Brace Jovanovich College Publishers.

Babbie, E. 1998. *The practice of social research.* 8th edition. Belmont, CA: Wadsworth.

Babbie, E & Mouton, J. 2002. *The practice of social research.* Cape Town: Oxford University Press Southern Africa.

Barriball, KL & While, AE. 1996. Participation in continuing professional education: Findings of an interview study. *Journal of Advanced Nursing*, **23**:999-1007.

Bee, H. 1994. *Lifespan development.* New York: Harper Collins College Publishers.

Bester, CL & Mouton, T. 2006. Differences regarding job satisfaction and job involvement of psychologists with different dominant career anchors. *Curationis,* August, **29**(3):50-55.

Bosman, W & Frost, D. 1996. *Policing and distance education in South Africa*: A process in transformation. www.ncjrs.gov/policing/pol615.htm (accessed 30/10/06).

Brink, HL. 1996. *Fundamentals of research methodology for health care professionals.* Kenwyn: Juta.

Burns, N & Grove, SK. 1999. *Understanding nursing research.* 2nd edition. Philadelphia: W.B. Saunders.

Burns, N & Grove, SK. 2005. *The practice of nursing research: conduct, critique and utilization.* St Louis: Mosby Elsevier/Saunders.

Butterworth, T & Faugier, J (eds). 1995. *Clinical supervision and mentorship in nursing*. London: Chapman & Hall.

Caelers, D. 2007. Increasing dementia sets SA's alarm bells ringing. *Weekend Argus,* 17 March:1.

Campbell, SL, Prater, M, Schwartz C & Ridenour, N. 2001. Building an empowering academic and practice partnership model. *Nursing Administration Quarterly*, **26**(1):35-44.

Chamberlain Dunn Associates Ltd. *Employing Nurses and Midwives: 100 ways to recruit and retain professional staff- a special report 1997-1998*. Surrey, UK.

Clark, T, Sweet, R, Gruber, KH, Lourtie, P, Santiago, P & Sohlman, A. 2006. *Thematic review of tertiary education: Norway country note.* www.odin.asap-asp.com/filarliv/290997/OECD_tertiary_education (accessed 30/10/06).

Collins English Dictionary. 1992. Glasgow: Harper Collins Publishers.

Collison, L. 2007. Disease on the way up in Cape. *Cape Argus,* 23 March:4.

Coovadia, HM & Wittenberg, DF. 2000. *Paediatrics and child health: A manual for health professionals in the third world.* 4th edition. Cape Town: Oxford University Press.

Creswell, JW. 2003. *Research design. Qualitative, quantitative and mixed methods approaches.* 2nd edition. California: Sage Publications.

Cullen, PD.1998. Delaware registered nurse's reasons for non participation in continuing education. *The Journal of Continuing Education in Nursing,* September/October, **29**(5): 229-233.

Davee, P & McHugh, J. 1995. Mandatory continuing education relevancy for nurses with advanced preparation. *The Journal of Continuing Education in Nursing*, May/June, **26**(3): 100-103.

Department of Health. 1999. *National Patients Rights Charter*. Pretoria: Government Printer.

De Villiers, L & van der Wal, DM. 2006. *Research seminar notes.* Pretoria: Unisa.

Duffy, K. 2006. (World Research Group). *Redesigning and improving patient education. Innovative strategies to maximize patient knowledge retention, significantly increase effectiveness and provide optimal care.* http://www.world rg.com/showconference.workshop (accessed 30/10/06).

Dumpe, ML, Herman, J & Young, SW. 1998. Forecasting the nursing workforce in a dynamic health care market. *Nursing economics.* **3**(4). July/August:170-188.

Eales, CJ. 2001. Lifelong learning. *South African Journal of Physiotherapy,* **57**(3):2.

Edmond, CB. 2001. A new paradigm for practice education. *Nurse Education Today*, **21**: 251-259.

Ehrat, S. 2001. Executive nurse career progression: Skills, wisdom and realities. *Nursing Administration Quarterly*, **25**(4):36-42.

Eustace, LW. 2001. Mandatory continuing education: Past, present, and future trends and issues. *The Journal of Continuing Education in Nursing*, May/June, **32**(3):133-137.

Ferguson, A.1994. Evaluating the purpose and benefits of continuing education in nursing and the implications for the provision of continuing education for cancer nurses. *Journal of Advanced Nursing*, **19**:640-646.

Fletcher, CE. 2001. Hospital RN's job satisfactions and dissatisfactions. *JONA*, **31**(6):324-331.

Forum for professional nurse leaders 2006. Together we lead - Nursing Conference. *Professional Nursing Today*. May/June 2006, **10**(3):23-30.

Freiberg, KL. 1987. *Human development. A life-span approach.* 3rd edition. Boston: Jones and Bartlett Publishers.

Gabriel, J. 2004. Skills development: transformation in process. *HR Future*, June:30-31.

Gary, DL. 2002. Invest in yourself. The why and wherefore of empowerment: The key to job satisfaction and professional advancement. *Nursing Forum*, July/Sept, **37**(3):33-36.

Glass, JC & Todd-Atkinson, S. 1999. Continuing education needs of nurses employed in nursing facilities. *The Journal of Continuing Education in Nursing*, Sept/Oct, **30**(5): 219-228.

Hewitt, JP. 1994. *Self and society. A symbolic interactionist social psychology*. 6th edition. Boston: Allyn & Bacon.

Hoban, V. 2005. The continuing professional development challenge. *Nursing Times*, February, **101**(8): 22-24.

Horton-Deutsch SL & Mohr, WK. 2001. The fading of nursing leadership. *Nursing Outlook*, May/June, **49**(3): 121-126.

International Council of Nurses. 2006. Safe staffing saves lives. *Nursing Update*, May, **30**(4): 22-25.

International Council of Nurses. 2001. *ICN Fact Sheet* - nurses and overtime. http://www.icn.ch/matters_overtime.htm (accessed 30/10/06).

International Council of Nurses [a] 2000. *ICN Position Statements* - nurses and shift work. http://www.icn.ch/psshiftwork00.htm (accessed 30/10/06).

International Council of Nurses [b]. 2001 *ICN Position Statements* - career development in nursing. http://www.icn.ch/pscardev.htm (accessed 30/10/06).

Jooste, K. (ed). 2003. *Leadership in health services management.* Paarl: Juta.

Jooste, K. 2005. The career goals of nurses in some health care settings in Gauteng. *Curationis,* August, **28**(3):47-53.

Kennie, T & Enemark, S. 1996. CPD-Continuing professional development and its future promotion within FIG (International Federation of Surveyors). *FIG publication (15).* http://www.fig.net/pub/figpub/pub15/figpub (accessed 20/08/06).

Kenworthy, N & Nicklin, K. 1993. *Teaching and assessing in clinical practice. An experiential approach.* London: Scutari Press.

Kerfoot, K. 2002. On leadership. The leader as chief knowledge officer. *Nursing Economics,* **20** (1):40-43, January / February.

Kersaitis, C.1997. Attitudes and participation of registered nurses in continuing professional education in New South Wales, Australia. *The Journal of Continuing Education in Nursing,* May/June, **28**(3): 135-139.

Khoza, LB & Ehlers, VJ. 2000. The competencies of newly qualified psychiatric nurses. *Health SA Gesondheid,* **5**(2):50-59.

Lahiff, M. 1984. Attitudes to continuing education. *Nursing Times,* **80**(2): 27-30, January, 11-17.

Lawton, S & Wimpenny, P. 2003. Continuing professional development: A review. *Nursing Standard,* **17**(24):41-44.

Leading learning and skills [LSC] 2005. *What are the barriers to engaging adult learners?* Skills and education network. http://senet.lsc.gov.uk (accessed 08/06).

Letvak, S. 2003. The experience of being an older staff nurse. *Western Journal of Nursing Research,* **25**(1):45-56.

Levin, PM. 2001. The loyal treatment: How dedicated employees benefit you and your organization. *Nursing Management,* January, pp: 17-20.

Mackereth, P.1989. An investigation of the developmental influences on nurses' motivation for their continuing education. *Journal of Advanced Nursing,***14**:776-787.

Mellish, JM & Brink, H. 1996. *Teaching the practice of nursing. A test in didactics.* 3rd edition. Johannesburg: Heinemann.

Modic, MB & Schloesser, M. 2006. *Preceptorship.* Lippincott Williams & Wilkins, **22**(2), March/April, pp 96-97.

Mouton, J. 2002. *How to succeed in your master's and doctoral studies. A South African guide and resource book.* Pretoria: Van Schaik Publishers.

Neuman, WL. 1997. *Social research methods. Qualitative and quantitative approaches.* 3rd edition. Boston: Allyn and Bacon.

Nolan, M, Owens RG & Nolan, J. 1995. Continuing professional education: Identifying the characteristics of an effective system. *Journal of Advanced Nursing,* **(21):**551-560.

Nugent, AB. 1990. The need for continuing professional education for nurses. *Journal of Advanced Nursing,***15**: 471-477.

Nzimande, PN. 1987. Professionalism and continuing education. An imperative for nurses. *Nursing RSA Verpleging,* **2**(11-12): 20-22.

Orpen, C. 1994. The effects of organizational and individual career management on career success. *International Journal of Manpower*, **15**(1): 27-37.

Peterson, CA. 2001. Nursing shortage: Not a simple problem-no easy answers. *Online Journal of Issues in Nursing,* **6**(1):1-9, 31 January.

Polit, DF & Hungler BP. 1993. *Essentials of nursing research. Methods, appraisal, and utilization.* 3rd edition. Philadelphia: JB Lippincott Company.

Polit, DF & Beck, CT. 2004. *Nursing research. Principles and methods.* 7th edition. Philadelphia: Lippincott Williams & Wilkins.

Quinn, FM.1997. *The principles and practice of nurse educaton.* 3rd edition. Cheltenham: Stanley Thornes Publishers Ltd.

Redman, BK. 2001. The dean of nursing as arbiter, antagonist and advocate. *Nursing administration quarterly.* **25**(14): 57-63.

Searle, C and Pera, S. 1994. *Professional practice. A South African nursing perspective.* 2nd edition. Durban: Butterworths.

Shader, K, Broome, ME, Broome, CD, West, ME & Nash, M. 2001. Factors influencing satisfaction and anticipated turnover for nurses in an academic medical center. *JONA,* April, **91**(4): 210-216.

Simms, LM, Price, SA & Ervin, NE. 1994. *The professional practice of nursing administration.* 2nd edition. New York: Delmar Publishers Inc.

Smith, J & Topping, A. 2001. Unpacking the "value added" impact of continuing professional education: A multi-method case study approach. *Nurse Education Today,* **(21):**341-349.

South African Nursing Council. 2006. *Geographical distribution of the population of South Africa versus nursing manpower as at 2006/12/31*. http://www.sanc.co.za/stats.htm.

Strategic Learning and Research Advisory Group for Health, Social Care and Education Sectors at Central Government. 2004. *Post registration development – a framework for planning, commissioning and delivering learning beyond registration for nurses and midwives*. UK.

Swansburg, RC.1993. *Introductory management and leadership for clinical nurses.* Boston: Jones and Bartlett Publishers.

Thom, A. 2007. South Africa's TB cure rate poor: Struggle to stem tide. *Cape Argus,* 23 March: 4.

Tlholoe, MM. 2006. Role of nurse managers as executives. *Nursing Update,* August, **30**(8):5.

Together we lead. 2006. *Professional Nursing Today*. **10(3):**23-30, May/June.

University of Botswana. 2000. *Distance education mainstreaming policy.* www.ub./about/documents/Distance_Education_Mainstreaming_Policy (accessed 30/10/06).

Upenieks, V. 2003. Nurse leaders' perceptions of what compromises successful leadership in today's acute inpatient environment. *Nursing Administration Quarterly,* **27**(2): 140-152.

Van Wyk, NC. 2006. Nursing by degrees. *Nursing Update,* August: 45-47.

Verdejo, T. 2003. Mentorship as a key retention strategy. *Health Care News and Views That Matter To You.* [On Line], April 20, 2006.

Waterson, E, Harms, E, Qupe, L, Maritz, J, Manning, M, Makobe, K, & Chabeli M. 2006. Strategies to improve the performance of learners in a nursing college. Part 1: Issues pertaining to nursing education. *Curationis*, **29**(2):56-65).

Where are the nurses? 2006. *Nursing Update.* **30**(4):42-45, May.

White, R & Ewan, C. 1997. *Clinical teaching in nursing*. Cheltenham: Stanley Thornes Publishers Ltd.

White, KM. 2001. A new and very real nursing shortage. *Policy, Politics and Nursing Practice*, August, **2**(3): 200-205.

World Health Organization. 2000. *The World Health Report. Health systems: Improving performance*. Geneva: World Health Organization.

Xaba, J & Phillips, G. 2001. Understanding nurse emigration: Final report. *Trade Union Research Report*, 19 June 2001:1-7.

Yuen, F. 1991. Continuing nursing education: Some issues. *Journal of Advanced Nursing*, **16**:1233-1237.

Annexure A: Questionnaire

Section A: Demographic Information. Questions A (1) to A (3): Mark your response with an X in the appropriate box					For office use
A (1) Your age?	25-35 yrs 1	36-45 yrs 2	46-55 yrs 3	> 55yrs 4	
A (2) Your gender?	Male 1		Female 2		
A (3) Your marital status?	Single (Never married) 1	Married 2	Divorced/ Separated 3	Widowed 4	
Questions A (4) and A (5): Fill in the number.					
A (4) How many children do you have?					
A (5) How many years have you been qualified as a nurse?					
Questions A (6) to A (8): Mark your response with an X in the appropriate box on each question.					
A (6) Where are you practicing as a professional nurse?	A Tertiary level hospital 1	A Secondary level hospital 2	A Primary level clinic 3	Other: State the institution 4	
A (7) On what basis are you employed?	Full time 1	Part-time (state the hours per week) 2	Mostly day duty (> 6 months per year) 3	Mostly night duty (> 6 months per year) 4	
A (8) Your present rank?	Professional nurse 1	Senior professional nurse 2	Chief professional nurse 3	Chief professional nurse-Unit manager 4	
Question A (9): Fill in the number of years and months					
A (9) How long have you been practicing nursing since registration as a nurse?		years	months		

Section B: Demographic information: Continuing formal education. A post registration course refers to a course that leads to a qualification obtained in addition to your basic nursing qualification. Mark your response with an X in the appropriate box on each question.					For office use
B (1) Your highest post registration qualification? (underline health related field diploma or degree)	None 1	Post registration nursing diploma 2	Post registration nursing degree 3	Post registration health related diploma/ degree 4	
B (2) How many years elapsed before you undertook and obtained your first post basic qualification?	0-5 yrs 1	6-10 yrs 2	11-15 yrs 3	> 15 yrs 4	
B (3) How many years have elapsed since you last undertook and obtained a post basic qualification?	0-5 yrs 1	6-10 yrs 2	11-15 yrs 3	> 15 yrs 4	
B (4) Are you currently undertaking a programme of study leading to a post registration SANC qualification?	Yes		No		
B (5) In the past 5 years did you commence a programme of study but did not complete it?	Yes		No		
B (6) What were the reasons for not completing the programme?					

Section C: Perceptions regarding continuing professional development: What are or would your reasons be for engaging in continuing formal education? Mark your response with an X in the appropriate box on each question.					For office use
Reason	Strongly disagree	Disagree	Agree	Strongly agree	
C (1) Only to obtain an additional qualification.	1	2	3	4	
C (2) To plan my career pathway.	1	2	3	4	

C (3) To network with other nursing colleagues.	1	2	3	4	
C (4) To keep abreast with new developments in my area of specialty.	1	2	3	4	
C (5) To improve my confidence.	1	2	3	4	
C (6) To improve prospects of remuneration and promotion.	1	2	3	4	
C (7) To be an effective mentor for newly qualified nurses/ nursing students.	1	2	3	4	
C (8) To provide me with a break from the pressures of work.	1	2	3	4	
C (9) To provide me with knowledge and skills not received during my basic training.	1	2	3	4	
C (10) To develop proficiency necessary to meet patients' expectations.	1	2	3	4	
C (11) To facilitate the development of nurse leadership capabilities.	1	2	3	4	
Section D: What would motivate you to engage in continuing formal education? Mark your response with an X in the appropriate box on each question.					For office use
Reason	Very weak motivating factor	Weak motivating factor	Strong motivating factor	Very strong motivating factor	
D (1) Real prospects of promotion and remuneration.	1	2	3	4	
D (3) A recent (< 2 years) successful programme of study.	1	2	3	4	
D (4) Assistance with working out a career pathway.	1	2	3	4	
D (5) Role models who demonstrate the value of career development.	1	2	3	4	
D (6) Peer encouragement.	1	2	3	4	
D (7) Encouragement from management.	1	2	3	4	
D (8) Funding assistance.	1	2	3	4	
D (9) Obtaining a SANC qualification with scarce skills allowance entitlement.	1	2	3	4	

D (10) A study skills course prior to commencement of a formal study programme.	1	2	3	4	
Section E: Indicate the reasons which are barriers to undertaking or delaying continuing formal education. Mark your response with an X in the appropriate box on each question.					For office use
Reason	Strongly disagree	Disagree	Agree	Strongly agree	
E (1) Job responsibilities.	1	2	3	4	
E (2) Family and child care responsibilities.	1	2	3	4	
Section E cont'd: Indicate the reasons which are barriers to undertaking or delaying continuing formal education. Mark your response with an X in the appropriate box on each question.					For office use
Reason	Strongly disagree	Disagree	Agree	Strongly agree	
E (3) Lack of funding.	1	2	3	4	
E (4) Not coping well with academic studies.	1	2	3	4	
E (5) Difficulty with English if this is not my first language but is the medium of instruction.	1	2	3	4	
E (6) Lack of motivation to study again.	1	2	3	4	
E (7) Negativity due to unpleasant past experiences in academia.	1	2	3	4	
E (8) Anxiety about not being able to "keep up" academically.	1	2	3	4	
E (9) Skepticism about the value of formal continuing education.	1	2	3	4	
E (10) Nursing not viewed as a profession for life.	1	2	3	4	
E (11) Lack of role models in the workplace.	1	2	3	4	
E (12) If you agree / strongly agree that the lack of role models in the workplace is a barrier, give your reasons.					

Section E cont'd: Indicate the reasons which are barriers to undertaking or delaying continuing formal education. Mark your response with an X in the appropriate box on each question.					For office use
Reason	Strongly disagree	Disagree	Agree	Strongly agree	
E (13) Lack of physical energy.	1	2	3	4	
E (14) Lack of coherent staff development plans by the institution.	1	2	3	4	
E (15) Not knowing the selection criteria for being granted study leave.	1	2	3	4	
E (16) Lack of information about the structure of education programmes.	1	2	3	4	
E (17) Prohibitive entry requirements to programmes.	1	2	3	4	
E (18) Available programmes are inappropriate to clinical practice needs.	1	2	3	4	
E (19) Lack of learning facilities near to the place of residence.	1	2	3	4	
E (20) Lack of transport to and from education centres.	1	2	3	4	
E (21) Lack of opportunities for promotion/upward mobility.	1	2	3	4	
E (22) Lack of a supportive work environment.	1	2	3	4	
E (23) If you agree / strongly agree that the lack of a supportive work environment is a barrier, give your reasons.					
E (24) Did you benefit after having completed a previous post registration programme?	Yes		No		For office use

E (25) If you answered Yes to E (24), how did you benefit after having completed a post registration programme?					
Section E cont'd: Indicate the reasons which are barriers to undertaking or delaying continuing formal education. Mark your response with an X in the appropriate box on each question.					
Reason	Strongly disagree	Disagree	Agree	Strongly agree	
E (26) Lack of employer co-operation (e.g. for funding).	1	2	3	4	
E (27) Lack of opportunity to utilize new skills in the work place.	1	2	3	4	
E (28) Managers not convinced that staff development is of vital importance for the services.	1	2	3	4	
E (29) Conditions are attached to the granting of study leave e.g. repay the service a year for each year of study.	1	2	3	4	

Thank you for completing the questionnaire.

Lydia Richards

Annexure B: Assessment of data collection instrument

ANNEXURE B

UNISA university of south africa

ASSESSMENT OF THE DATA COLLECTION INSTRUMENT

Please indicate your view about the data collection instrument by circling the appropriate number option

	Excel -lent					Poor
Clarity of covering letter	(6)	5	4	3	2	1
Overall appearance	(6)	5	4	3	2	1
Page layout	6	(5)	4	3	2	1
Clarity of instructions	(6)	5	4	3	2	1
Legibility	(6)	5	4	3	2	1
Realistic completion time	(6)	5	4	3	2	1
Assurance of anonymity	(6)	5	4	3	2	1
Relevance of items to the literature review on continuing formal education for nurses	6	(5)	4	3	2	1
Information required not too revealing	6	(5)	4	3	2	1

Please write any comments or suggestions below

A good covering letter makes it easy for respondents to complete the questionnaire within the specified completion time. Anonimity is ensured. The topic of research is quite relevant to all nurses who perceive barriers to post basic studies.

Stain
J.E. STAIN.
12/06/07.

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

Annexure C: Letter of request to participate in the study and instructions to complete the questionnaire

5 Riversands
Abington Road
Fish Hoek
7975.
16th October 2006.

Dear Nursing Colleague,

Research project: Lydia Richards

Thank you for participating in this research project. The objectives of this research project are:

- To establish how registered nurse view continuing professional development
- To identify barriers to continuing formal education

Before you complete this questionnaire would you please note the following instructions:

- Treat this questionnaire and your responses as private and confidential.
- Your responses will only be used for research purposes. It will be impossible to identify the respondents, hence the self addressed envelope to be sealed after completion of the questionnaire. The processed questionnaires will be re-sealed.
- Answer all the questions frankly and objectively using your own opinion and experiences.
- Complete each question by marking your response with (X) in the appropriate space provided.
- Please return this questionnaire in the SAE by the 1st December 2006.

Thank you for your assistance

Lydia Richards

Lydia Richards (Masters student at the University of South Africa, Department of Health Studies)

Annexure D: Letters of permission from the participating health care institutions to conduct the research

"lydia richards" <lydiaricha@telkomsa.net> 2006/10/26 08:18 PM >>>
Dear Miss Nieuwoudt

Attached, a request for data collection for my masters thesis

Yours sincerely,

Lydia Richards

Good morning Lydia,
I don't think there will be a problem. However, I do need a copy of the questionaire before I can give the final OK. You can e-mail it to me and then we can take it from there.

Willemien Nieuwoudt.

"lydia richards" <lydiaricha@telkomsa.net> 10/26/06 8:14 PM >>>

Dear Mrs Basson,

Attached is a request regarding my masters thesis

Lydia Richards

Lydia,
Please send/submit the ethical approval and the questionnaire. Best wishes, RMB

From: E Potgieter [mailto:POTGIE@unisa.ac.za]
Sent: Wednesday, November 08, 2006 2:12 PM

Good day Ms Richards,

I mailed the (approval of your research instrument) ethical clearance certificate to you today 8/11/06.

Regards,

Prof. Eugené Potgieter
Associate Professor
Department of Health Studies
PO Box 392
Unisa 0003

"lydia richards" <lydiaricha@telkomsa.net> 2006/11/14 10:41 PM >>>
Dear Ms Nieuwoudt,

I have received confirmation that my data collection tool has ethical clearance (email forwarded). May I go ahead and distribute approximately 10 questionnaires amongst registered nurses at Karl Bremer.

I needed to make slight (grammatical) modifications to the questionnaire so I am attaching the copy which awaits distribution approval

Thank you for your assistance.

Lydia Richards

Hallo Lydia,
It is OK, I have cleared it with my M/S. I must just inform the staff. How are you planning to do it?

Ms. Nieuwoudt

---

5 Riversands
Abington Road
Fish Hoek
7975.
10th October 2006.

The Deputy Director of Nursing
Red Cross War Memorial Children's Hospital
Rondebosch
Cape Province
South Africa.

Dear Mrs Roodt,

Re: Data for Masters Thesis.

I am currently completing my Masters Degree at the University of South Africa. The focus of my thesis is *Barriers to career development as perceived by registered nurses.* In view of my thesis being of limited scope, I require a small sample of registered nurses (100 in total) to assist me by providing the necessary data. I have decided, permission permitting, to sample from Red Cross Hospital and Tygerberg Hospital.

I hereby request your assistance with this project, the motivation for which has been the feedback from registered nurses undertaking the children's nursing programmes at UCT which I currently facilitate. Would you grant me the permission to distribute the questionnaire amongst members of the nursing staff at Red Cross Hospital please?

The responses to the questionnaire will be treated as confidential. It will be impossible to identify the respondents. The completed questionnaires will be submitted in sealed envelopes. The results of the research will be made known to all relevant parties including the participating hospitals following submission of the completed thesis to Unisa, Department of Health Studies.

Yours sincerely,
Miss Lydia Richards

Dear Lydia Richards,

From the Nursing Division we have no objections to your research project.

I would like to request the following:

Please indicate how many Professional Nurses will be surveyed, which areas and when.

This request must also be channelled through the Hospital Management so I would like to suggest that you also write to the CEO.

Good luck with your research!

Regards,

Mrs Sandra Roodt

Mrs S.E. Roodt
Deputy Director : Nursing
Red Cross War Memorial Children's Hospital

Tel : (021) 658-5008

---

5 Riversands
Abington Road
Fish Hoek
7975.
30th October 2006.

The Chief Executive Officer
Red Cross War Memorial Children's Hospital
Private Bag
Rondebosch, 7701

Dear Dr Erasmus,

Re: Data for Masters Thesis.

I am currently completing my Masters Degree at the University of South Africa. The focus of my thesis is *Barriers to career development as perceived by registered nurses*. In view of my thesis being of limited scope, I require a small sample of registered nurses (100 in total) to assist me by providing the necessary data. I have decided, permission permitting, to sample from Red Cross Hospital, Tygerberg Hospital, and Karl Bremer Hospital

I hereby request your assistance with this project, the motivation for which has been the feedback from registered nurses undertaking the children's nursing programmes at UCT which I currently facilitate. Would you grant me the permission to distribute the questionnaire amongst members of the nursing staff at Red Cross Hospital please? You may want a hard copy of the questionnaire for scrutiny before you make a decision regarding my request. I will attach a copy. I have communicated with Mrs Roodt who has seen the data collection tool.

The responses to the questionnaire will be treated as confidential. It will be impossible to identify the respondents. The completed questionnaires will be submitted in sealed envelopes. The results of the research will be made known to all relevant parties including the participating hospitals following submission of the completed thesis to Unisa, Department of Health Studies.

Yours sincerely,
Miss Lydia Richards

Annexure E: University of South Africa: Ethics clearance certificate

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences
CLEARANCE CERTIFICATE

Date of meeting: **7 November 2006** Project No: **30640911**

Project Title: **Perceptions of registered nurses with regard to career development**

Researcher: **Ms LE Richards**

Supervisor/Promoter: **Prof E Potgieter**

Joint Supervisor/Joint Promoter:

Department: **Health Studies**

Degree: **MA (Health Studies)**

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Date: **7 November 2006**

Prof TR Mavundla
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

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