

University of the Western Cape
Faculty of Community and Health Sciences
Full PhD Thesis

Title: The development of a model for continuing professional development for professional nurses in South Africa

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A thesis submitted in fulfilment of the requirements for the degree of Doctor Philosophiae in the School of Nursing, University of the Western Cape.

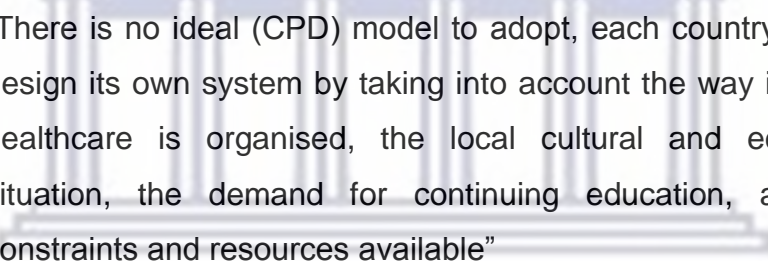
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Keywords: Academic Education, Competence, Continuing Education, Continuing Professional Development, Lifelong Learning, Model, Outcomes Based Education, Professional nurse, Staff Development and System.

The logo of the University of the Western Cape, featuring a classical building with a pediment and columns, is faintly visible in the background.

“There is no ideal (CPD) model to adopt, each country should design its own system by taking into account the way in which healthcare is organised, the local cultural and economic situation, the demand for continuing education, and the constraints and resources available”

(World Health Organisation, 1988, p.1).

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Abstract

The development of a model for continuing professional development for professional nurses in South Africa.

Introduction

Continuing professional development (CPD) is an essential characteristic of a profession and lasts throughout the individual's personal and professional career, thereby embracing the concept of lifelong learning. In the Republic of South Africa (RSA) there is a CPD system for most health professionals such as medical practitioners and dentists, but no CPD system is currently available for professional nurses.

CPD is known to improve the quality of nursing care to clients as well as to promote job satisfaction of the professional nurse. Pre-registration education prepares a nurse for practice at the point of registration but CPD is involved with a lifelong career development and should be linked to a registration renewal process.

Aim and Objectives

The overall aim of this project was to develop an evidence based model for CPD for professional nurses in South Africa.

The objectives of this study were to:

- Conduct an analysis of current international CPD systems for nurses as well as the current CPD system of the Health Professions Council of South Africa (HPCSA).
- Conduct a situational analysis of relevant South African government legislation and policies that may influence CPD for professional nurses.
- Assess the community's health needs in order to determine the health priorities.

- Conduct a survey to assess the continuing professional development needs of professional nurses in South Africa.
- Develop guidelines and a model for CPD for professional nurses in South Africa.

Methodology

A combination of qualitative and quantitative research methods was used. A non-experimental design, using exploratory, descriptive, and contextual analytic strategies were utilised. Permission was obtained from the participants who completed the survey as well as from the Senate Higher Degrees Committee of the University of the Western Cape.

Conclusion

Comparative analysis of the CPD systems internationally and nationally revealed that CPD is mandatory for some whilst for other countries it is compulsory, but not mandatory for licensing purposes. Licensing occurs on a yearly basis, but CPD recognition is accredited over a time period with expiry deadlines and minimum requirements. A portfolio was a common method of recording and proof of evidence for CPD, and a continuous theme was that CPD is needed to ensure competency.

The Nursing Act 33 of 2005 makes provision for CPD for nurses but to date the South African Nursing Council has not yet decided on a model of CPD for implementation for SA nurses.

Priority of health needs showed that the disease profile of a country can change over time and the practicing nurses need to undergo CPD to ensure that they are competent to practise evidence based nursing care. Health statistics showed that illnesses with the highest prevalence rate were HIV, Tuberculosis and cancer amongst others. More time should thus be set aside to update professional nurses to enable them to contribute significantly to the

community needs. The national survey showed that nurses felt there is a need for CPD and there is a consensus that CPD should be mandatory and be implemented. The professional nurses felt that they will be willing to fund their own CPD, but also expected some financial contribution from the employer.

The researcher concluded by presenting guidelines and a proposed Model for CPD for professional nurse in South Africa.

Keywords for electronic searches: Academic Education, Competence, Continuing Education, Continuing Professional Development, Lifelong Learning, Model, Outcomes Based Education, Professional nurse, Staff Development and System.



Declaration

I declare that **The Development of a Model for Continuing Professional Development for professional nurses in South Africa** is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Sathasivan Arunachallam

November 2009

Signed:.....

Dedication

I hereby dedicate this thesis to all health personnel who appreciate the importance of undertaking Continuing Professional Development throughout their working life, thereby subscribing to a philosophy of Lifelong Learning.

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Above all, I would like to thank the Lord for His grace upon me.

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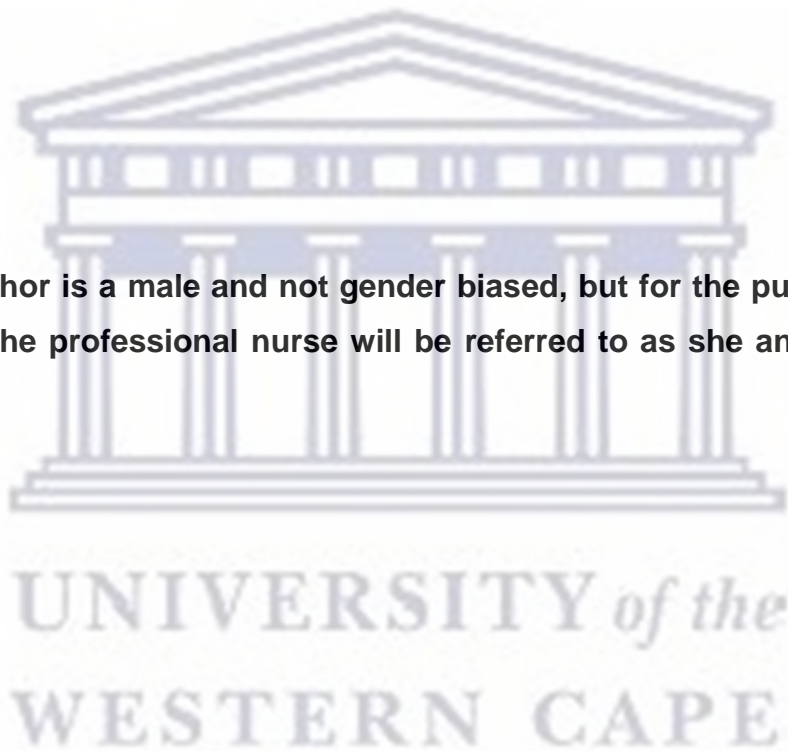
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The author is a male and not gender biased, but for the purpose of this thesis the professional nurse will be referred to as she and not she or he.



Acronyms

ARVs	Anti-retrovirals
ANA	American nursing association
CNO	College of nurses of Ontario
CE	Continuing education
CEU	Continuing Education Units
CPD	Continuing professional development
DOTS	Directly observed treatment short course
DPSA	Department of public service administration
ECPDSA	Electronic continuing professional development
ETQA	Education and training quality assurance
HPCSA	Health Professions Council of South Africa
HWSETA	Health and welfare sector education and training authority
MDR	Multi-drug resistance
NCSS	Number cruncher statistical software
NHRH	National human resources for health
NHS	National Health Service
NMC	Nursing and midwifery council
PMTCT	Prevention of mother to child transmission
RHPA	Regulated health professions act
SA	South Africa
SANC	South African Nursing Council
SETA	Sector education and training authority
UKCC	United Kingdom Central Council
UNAID	United Nations Aid
VCT	Voluntary counselling and testing
WHO	World Health Organisation
XDR	Extreme-drug resistance

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Chapter one

Introduction

1.1 Introduction

The introduction of evidence-based care, new techniques and equipment, as well as changes taking place in the health needs of the community and the health care policies necessitate Continuing Professional Development (CPD) for nurses and midwives (Dienemann, 1998; Nursing Act, 2005). Professional development can be described as a lifelong process of active participation by nurses in activities that assist in developing and maintaining their continuing competence, enhance their professional practice and support achievement of their career goals (ANA, 2000). The South African Nursing Council (SANC) is the legislative body that controls the registration and is the Education and Training Quality Assurance body (ETQA) for nurses and midwives in South Africa (SANC, 2007). Professional nurses often attend in-service education and other educational courses, but these courses do not carry any credits towards their CPD. The reason is that the SANC currently does not have a CPD system in place although the Nursing Act (33 of 2005 section 39) makes provision for the implementation of CPD. The only requirement for a professional nurse to be on the registration roll is to pay the annual registration fee, irrespective whether the person qualified 20 years ago, and is still practising as a nurse or not. Currently the SANC requires no proof of CPD to re-register a professional nurse to practice. The researcher has identified the need to establish whether CPD should be a requirement for re-registration and if so, how it should be implemented. Chapter one introduces the reader to an overview of the study that included several phases which enabled the researcher to develop a model that could be used by SANC to implement CPD.

1.2 Rationale

The responsibility for CPD is essentially that of the individual professional nurse and is a characteristic of the nursing profession. It lasts throughout the individual's personal and professional career, thereby embracing the concept of lifelong learning (Quinn, 1998). The aim of CPD is to enable the professional nurse to obtain competency in knowledge, skills, attitudes, and ethical values. CPD embraces the gaining of knowledge regarding new techniques, new evidence, and new health trends (Booyens, 2000). Nursing as a profession in South Africa, needs to subscribe to the philosophy of lifelong learning, which is CPD. Professional nurses and midwives practice in an environment of constant change. This involves new and expanding roles for health professionals, increasing technological advances in treatment and care, new equipment, reorganization and the redirection of resources (Dienemann, 1998; WHO, 1988).

It is vital for the professional nurse to develop professional knowledge and competence to cope with these demands and complexities of modern professional practice (NMC, 2002). The premise is that CPD will improve the quality of nursing care to clients as well as to promote job satisfaction of the professional nurse and midwife (Tomey, 1996). A very important aspect that needs to be considered regarding CPD for nurses is that nurses make up the bulk of the health manpower in the country whilst every other health professional such as pharmacists and those belonging the Health Professions Council such as doctors, dentists, occupational therapists and physiotherapists all have a CPD system whereas nurses do not have a CPD system. Inclusion of a compulsory CPD system has shown better patient care and improves public health as well as being abreast of changes that affect the health of the population (Martin, Labadarios, Marais, Wentzel-Viljoen;2008;27; French and Dowds, 2007:190). One can deduce that for a professional to be recognised as such, should have updated knowledge and skills in compliance with a professions CPD system requirements.

There is direct evidence that CPD can improve knowledge and care, interpersonal skills, facilitate change and enhance the status of nursing, ethical attitudes and values. The lack of a CPD system for professional nurses in S A could allude to the short coming of knowledge, skills, ethical attitudes, and values of professional nurses (Du Boulay (1999). There is no formalised structure within the nursing profession in SA to state that CPD indeed does take place in a particular format. This is unlike the HPCSA's CPD committee that is made up of representatives from each professional board and works with professional boards to develop policy proposals for CPD. The committee is accountable to the HPCSA (HPSCA, 2005). A further implication could be that the professional nurses opinion could be disregarded when inputs are made in meetings as her information could be regarded as outdated by others.

1.3 Significance of the study

This study is unique because CPD for South African nurses is not well researched. One previous PhD thesis has been located where the student addressed the possibility of implementing a CPD system in South Africa. This is the first study that involves the professional nurse's view regarding a CPD model and the integration of current CPD practices related to health indicators and legislation issues.

1.4 Research problem

The major problem identified is that there is no formal system of CPD for professional nurses in South Africa. Most of the continuing education is done in the working environment and is merely reflected as in-service training, which is referred to as staff development. Yearly re-registration with the professional body (SANC) merely depends on paying a fee and does not depend on the competency of the nurse. Due to the dynamic environment and technology changes as well as the results from research, it is important that practising professional nurses update their knowledge and skills on a regular basis to ensure that they practice evidence based

care. A further problem identified is that there is no system in place to ensure that the updated knowledge and skills is based on evidence. It may often be based on outdated textbook material.

The geographical, technological and social backgrounds of professional nurses in South Africa is vast and the researcher felt that research is needed to establish what kind of CPD model will be acceptable to the nursing profession in South Africa as well as the changing health needs of the South African population before the SANC implement a CPD system. An investigation into the need for a formal comprehensive CPD system to assist with formalising the proof of participating in CPD by professional nurse's in South Africa is thus required. A system to ensure that knowledge and skill transfer is based on the latest evidence will also be addressed.

1.5 Research aim

The overall aim of this project is to develop an evidence based model for CPD for professional nurses in South Africa.

1.6 Research objectives

The objectives of this study were to:

Conduct an analysis of current international CPD systems for nurses as well as the current CPD system for the Health Professions Council of South Africa (HPCSA).

Conduct a document analysis of relevant South African government legislation and policies that may influence CPD for professional nurses.

Assess the community's health needs in order to determine the health priorities.

Conduct a survey to assess the continuing professional development needs of professional nurses in South Africa.

Develop guidelines and a model for CPD for professional nurses in South Africa.

1.7 Research methodology

A combination of qualitative and quantitative research methods was used. A non- experimental design, using exploratory, descriptive and contextual strategies were followed to execute the different phases of the project. The methodology used during each phase is discussed in each chapter.

1.8 Ethical considerations

Informed consent was obtained from the participants when they agreed to submit the completed postal questionnaire. Ethical clearance to conduct the study was obtained from the Senate Higher Degrees of the University of the Western Cape. The execution of the project was based on the principles of Good Clinical Practice and the Democratic Nursing Organisation of South Africa's standards (DOH, 2000; Denosa, 1998).

1.9 Outline of thesis

Chapter one gives an overall introduction to the thesis. A comprehensive literature review to evaluate the need for continuous professional development as well as the theoretical framework is discussed in chapter two. Research methodology will be described in chapter three. Chapter four is a review of literature to evaluate current international and national CPD practices relating to health care professionals. A document analysis of relevant government policies and legislation that influence CPD for professional nurse is described in chapter five. The results of health indicators for South Africa are presented in chapter six. A survey was done to assess the continuing professional development needs of professional nurse in South Africa and the results are presented in chapter seven. A proposed model of CPD for professional nurses in South Africa based on all the available information gathered during previous chapters is

presented in chapter eight. Limitations, recommendations and implications for practise and research are discussed in chapter nine.

1.10 Definitions

Academic Education

Courses taken for undergraduate or graduate credit in an institution of higher learning that may or may not lead to a degree, diploma or completion of a certificate program. Although professional development begins on entry into the basic nursing education program, for the purposes of this definition, academic education refers to those courses taken in nursing colleges or universities after completion of the basic nursing education programme (Mellish and Wannenburg, 1999).

Competence

Competence is the ongoing professional nursing capability according to the level of expertise, responsibility, and domains of practice. This is evidenced by the behaviour based on beliefs, attitudes and knowledge matched to and in the context of a set of expected outcomes as defined by the nursing scope of practice, policy, code of ethics, standards, guidelines, that ensure performance of professional activities (Searle, 2000).

Continuing Education

Continuing education is the systemic learning experiences designed to augment the knowledge, skills and attitudes of nurses and therefore continuing education enriches the nurse's contribution to the quality of health care and her or his pursuit of professional career goals (Booyens, 2000).

Continuing Professional Development

CPD is the lifelong process of active participation by professional nurses in learning activities including credit bearing courses that assist in developing and maintaining their continuing competence, enhance their professional practice and support achievement of their career goals. This begins within

the basic nursing education programme, continues throughout the career of the professional nurse and encompasses the educational concepts of continuing education, staff development, credit bearing courses and academic preparation (ANA, 2000).

Lifelong Learning

Lifelong learning is an instrument for change in individuals, organisations and society (Kogan, 2000). According to Coffield (1997) lifelong learning is seen to be a means of competitiveness and personal development; it is a policy to combat social exclusion by enabling the unemployed to enter the labour market; it is a way of promoting the professional and social development of employees and it is a strategy to develop the participation of citizens in social, cultural and political affairs. It is part of the philosophical underpinning of Continuing Professional Development of professional nurses.

Model

A model is an approximation, representation, or idealization of selected aspects of the structure, behaviour, operation, or other characteristics of a real-world process, concept, or system. A model is a symbolic representation of empiric experience in words, pictorials or graphic diagrams. A model can also be referred to as a system (Chinn & Kramer, 2004; IEEE, 1990).

Outcomes based education

Outcomes based education is characterised by a focus on knowledge, skills, attitudes and values (Horst & McDonald, 1997). In this study outcome - based education refers to knowledge, skills, attitudes and ethical values pertaining to nursing which the professional nurse must possess to be competent.

Professional nurse

An individual who has successfully completed a basic three or four year diploma or degree in nursing at a college or university and is registered with the South African Nursing Council as a professional nurse (Nursing Act, 2005; Searle, 2000). The person must be qualified and competent to independently practise comprehensive nursing at a prescribed level and capable of assuming responsibility and accountability for his or her practice.

Staff Development

Staff development is based on the development of nurses in a particular institution for the needs of the services rendered by the specific institution whether it is a hospital, clinic, college, or university. Staff development is an aspect of human resource management to assess, develop, and evaluate the performance of nurses. Staff development is the education and training of nurses by the institution for meeting its own service needs (Booyens, 2000; Jooste & Troskie, 1995).

System

A system is a set of interrelated parts that work together to achieve a particular purpose (WHO, 1988). Therefore a system is a formal combination of various elements in the provision of continuing professional development activities (Horby, 2000). The input, throughput, output, feedback and environment are the essential components of a system as stated in the systems theory (van Tonder, 2004). The systems theory is used in this study as the theoretical underpinning of the study.

1.11 Summary

This chapter described the rationale for the researcher embarking on the scope of this study area. Chapter one gives a brief overview of the main aim and objectives and sought to orientate the reader to the relevant terminology in continuing professional development.

Chapter two

Literature review

2.1 Introduction

Continuing professional development (CPD) encompasses all the theoretical knowledge and practical skills that a professional nurse needs to master to stay updated in a changing environment in which she functions. There is a demand on nurses to critically evaluate their knowledge and skills, and continuously keep up to date with changes in practice. This includes knowledge and skills related to direct patient care, management, education, and research. CPD should entail the acquiring of appropriate knowledge, skills, attitudes, and values related to the area of expertise (Horst & McDonald, 1997).

2.2 History of CPD

During the 1970s it became obvious that basic undergraduate education for a profession or career did not fully prepare a person for lifelong work nor did it ensure competence a few years after graduating (Payne, 1993). This is also stated many years later by Roscoe (2002, p3) as “no professional completes their initial training equipped to practice competently for the rest of their life”. Dubin (1972) speculated that knowledge gained during studies has a half-life. The half-life concept was to estimate to what extent one was out -of- date with new knowledge and technology. Medicine and engineering was seen as having a half-life of five years whilst a psychologist’s knowledge and skills had 10-12 years half-life. There are no current studies that indicate the half-life of nursing.

Terminology used in this era was ‘continuing education’ or CE and in the 1980s-1990s it was referred to as ‘continuing professional education’ or CPE (Chiarella, 1990). The chartered society of Physiotherapy referred to

their CE as physiotherapy access to continuing education (PACE) up to 1996, when they questioned PACE and suggested that it should be changed to CPD (Gosling, 1996). From around the year 2000 onwards it was referred to as 'continuing professional development' or CPD, because CPD has broader associations than CPE/CE as CPD embraces life long learning (Gosling, 1996). In the United Kingdom, up to the period 1980s, professional development was not organised and was often a knee-jerk reaction to circumstances and was up to an individual professional person to update oneself. Since the 1980s professional development was being recognised as being important, and more effort was put in the process to organise CPD in a more systematic way (Madden and Mitchell 1993). In the UK, CPD for nurses came to the forefront of education in 1995 with the introduction of the post registration education and practice (PREP) standard (UKCC, 2000). A model for lifelong learning for the National Health Service (NHS) identified mandatory re-registration, post-registration, and skills development in CPD (Department of health UK, 2001). UK nurses were required by law to undertake study to maintain competence in order to re-register every three years as a qualified nurse (Snell, 1999).

Mandatory continuing education was introduced for medical doctors in the USA in 1971, but mandatory CE for nurses only become mandatory 14 years later in 1985 (Huston, 2006). In South Africa, the Interim Medical and Dental Council (NMDC) was the first professional body that required CPD and a system of CPD for all medical doctors and dentists was implemented from 1 January 1999 (HPCSA, 2000). Since the establishment of the Health Professions Council of South Africa (HPCSA) it became compulsory for all health professionals such as medical doctors, dentists, oral hygienists, dieticians, radiographers, occupational therapists, physiotherapists and emergency practitioners to participate in continuing professional development (HPCSA, 2002). A survey done on medical practitioners regarding CPD showed that 18 countries in Europe as well as the UK, USA, Canada, Australia and New Zealand need re-certification to

practise. In South Africa, nearly four decades later is there still no CPD system for nurses who make up the majority of the health professionals.

2.3 Benefits and outcomes of CPD

The most significant goal of CPD is to provide better patient care and improve health care to the community (Waddell, 1991; Nolan, Owens, Nolan, 1995 and Perry, 1995). Du Boulay (1999) states that through CPD one can achieve personal and professional growth and acquire new skills needed for new roles and responsibilities. Various studies have identified a range of benefits associated with the implementation of CE/CPE/CPD over a period of time. Improved patient care, personal, professional and organisational benefits are some of the most often cited (Table 2.1)

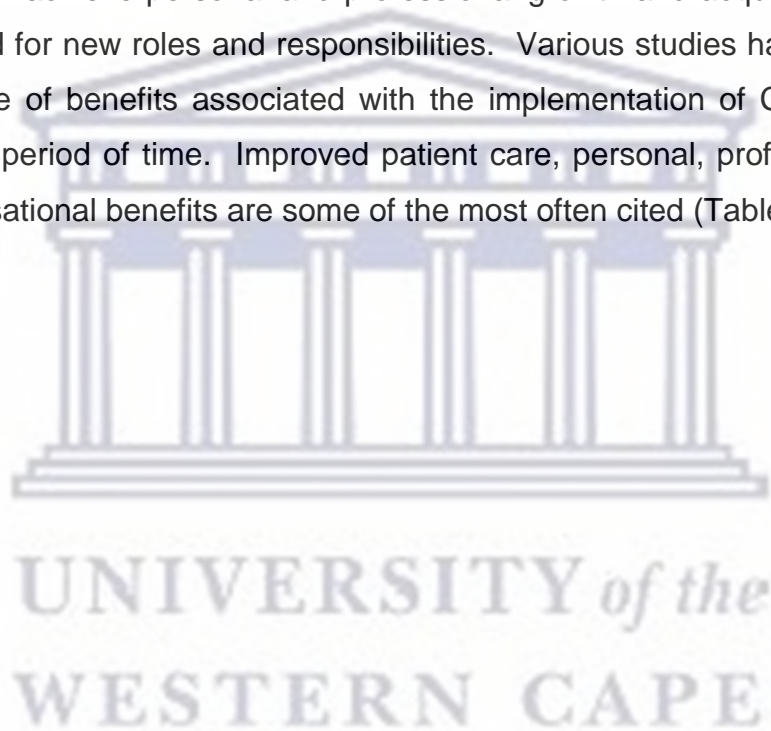


Table 2.1 Benefits and outcomes of CPD

Adapted from (Nolan et al, 2000)

Lathlean et al.,1986	Bignell & Crotty,1988	Barriball et al.,1992	Nolan et al.,1995	Wood,1998
Improved knowledge Interpersonal skills Development needs e.g.autonomy Personal awareness e.g.self awareness Professional awareness	Improved care Professional development Educational development Individual development	Improved knowledge /skills/attitudes Improved practice Enhanced job satisfaction Better staff retention Career development	Updated knowledge Improved care Facilitate change Enhance status of nursing Personal development Professional development Staff and personal benefits Interpersonal benefits Educational benefits	Individual level Increased confidence Improved knowledge Increased self awareness Increased professional awareness Patient care level improved communication enhanced individualised care research centred practice

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2.4 Challenges or barriers related to CPD

A number of factors that prevent or discourage participation in CPD are well reported in literature. Shepherd (1994) states that a lack of study leave, balancing family, work responsibilities, travelling long distances, discourage participation in CPD. There was also resentment at the perceived lack of financial support that is available for CPD (Dowswell et al., 1998). Lack of financial support is further highlighted by Hogston (1995) and Nolan et al. (1995). The lack of support from managers was mentioned by Hogston (1995) and McDonald (1994). In addition, Ayer and Smith (1998) found that time, pace and place available for study impacted on CPD either as a motivator or inhibitor.

It is often stated that CPD effectively underpins the competence of a health professional and that competence decrease after graduation due to the half life of knowledge and improvement of technology (McAuley & Henderson, 1981). Cross (1998) quoted O'Sullivan (1996) by stating that "Despite the promotion of CPD within the profession, there is still an enormous amount of research and awareness building needed to demonstrate successfully the value of CPD and to ensure its successes across the profession [on health care outcomes]". French & Dowds (2008) reported that there are very few studies that have objectively assessed the impact of CPD on physiotherapy practice [patient outcomes]. French & Dowds (2008) further reported on a study done by Brennen; Fritz & Hunter (2006) whose results showed that there are no differences in the clinical outcomes of the patients whose physiotherapists received "hands on instruction" CPD, versus physiotherapists who did not attend the hands on course. However, Harland & Kinder (1997) as referred to by Cross (1998) showed that CPD that was presented at a level I (one) are least likely to have any impact on the patient. They did show that CPD with higher order outcomes at level III (three) coincide with optimal impact on practice and patient care.

2.5 The cost of CPD

There are obvious costs involved in undertaking CPD. The provision of CPD has to be cost effective. Tennant & Field (2004) states that individual professionals contribute extra time and effort and endure a great deal of stress in undertaking CPD. McCormick & Marshall (1994) surveyed 23 different professions and showed that most of the CPD courses undertaken were paid for by the professionals themselves, followed by government subsidies and other sources such as employers or pharmaceutical companies. In contrast Peck, McCall, McClaren and Rotem(2005) showed that medical doctors are mainly sponsored by pharmaceutical companies and employers and fewer have to pay for their own CPD attendance.

In the UK, the government health services spent approximately one billion pounds sterling (12 billion rands) on CPD in 1999-2000 (Brown, Belfield & Field, 2002). By 2003-2004 the spending on nursing and allied health professions CPD cost about 13.4 million pounds sterling (170 million rands). This is a great investment in CPD. Resources for health care are scarce, and money allocated to CPD could otherwise be spent on direct patient care. However in South Africa the cost for CPD attendance is often borne by the individual, the employer and sometimes by the HWSETA with funding from the skills levy (Skills Levy Act, 1999). Medical doctors only benefit from the pharmaceutical funding support. To the researchers knowledge there is no published data on the cost of CPD in SA for any particular health profession.

2.6 Definitions of Continuing Professional Development

There are various definitions of CPD however; the most quoted definition by many authors refers to Madden & Mitchell (1993) who state that:

“Continuing professional development (CPD) is the maintenance and enhancement of the knowledge, expertise, and competence of professionals throughout their careers according to a plan formulated with

regard to the needs of the professional, the employer, the profession, and society”.

A critical analysis of the above definition follows:-

The definition encapsulates the essence of the need for CPD for professional nurses around the world and particularly in South Africa. It refers to “**maintenance**” i.e. maintaining what is already learnt, or maintaining an equilibrium in one’s nursing. Thus to keep up to date with knowledge so that the balance in nursing is not disturbed. When new knowledge becomes available but the professional nurse does not make an effort to enhance his or her competency in the specific field, then the equilibrium will be disturbed and the scale will be out of balance. It thus refers to a steady state, not entering into decline, where the knowledge lags behind new innovations or skills and emphasizes the importance of the improvement of one’s current abilities. Abilities also relate to the knowledge, skills, attitude and values of nurses (Horst & McDonald, 1997).

A further connotation to the above definition is that CPD is the “**enhancement**” of self development to improve the value and the desirability of knowledge, skills, attitudes and values of the professional nurse (Allen, 2004). It also acknowledges the existence of nursing expertise on the part of professional nurse as well as the improvement of the state of being competent i.e. having requisite or adequate ability (Allen, 2004).

“**Professional**” refers to a person who has undergone specialized training and education, which often includes long and intensive academic preparation, and some form of practical internship (Allen, 2004). Nursing in South Africa is classified as a profession because the method of career development meets the criteria as stated in the previous sentence. Currently student nurses undergo a four year degree or diploma at an accredited higher education institution. After successful completion of theoretical and practical components they are allowed to apply to register at the South African Nursing Council as a professional nurse and are then

regarded as registered professional nurses (this may change obtaining a licence to practise in the near future).

“Throughout their careers” implies that CPD takes on a life-long ongoing learning approach. Life-long approach also means that one would expect the professional nurse to adapt and grow in knowledge and skills as time and technology changes. It most particularly implies that professional nurses who practise nursing should engage regularly in CPD for the duration of their career.

CPD is also noted to be a **“planned process”**. There is a need for an individual plan to direct this development. This plan could take on the form of portfolio development; personal profiles and appraisal of individual performance in their work settings (Quinn, 1998).

Madden and Mitchell’s (1993) definition implies that CPD is based not only on the needs of the individual professional nurse but also on the needs of the employer, the nursing profession, and society as a whole. **“Needs of society”** as such for nurses, means the present and future health needs of the community. It further includes the actual client group that the nurses serve e.g. patients in hospitals or clinics.

Literature has revealed several definitions related to CPD. These definitions are tabulated in table 2.2.

Table 2.2 **Definitions of Continuing Professional Development**

Source	Definition	Main points
America: American Nursing Association (ANA, 2000p4)	“Nursing professional development is a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice and support achievement of their career goals”.	<ul style="list-style-type: none"> - is a life-long process - requires active participation - uses varied learning activities - develops and maintains competence - enhances professional practice - assists with career goals
Australia: Australian Nursing Council (ANC,2000)	Nurses and Midwives who are licensed to practice are expected to be able to demonstrate competence within their area of practice.	<ul style="list-style-type: none"> - license required to practice - need to demonstrate competence - area of practice
Canada: College of Nurses of Ontario (CNO,1996)	Competence is the nurse’s ability to use her or his knowledge, skills, judgement, attitudes, values and beliefs to perform a given role. Competence is maintained and improved by participating in the quality assurance programme.	<ul style="list-style-type: none"> - maintaining competence. - update knowledge - update skills, judgement, attitudes and values - participation - quality assurance program
Madden & Mitchell (1993)	“Continuing professional development (CPD) is the maintenance and enhancement of the knowledge, expertise, and competence of professionals throughout their careers according to a plan formulated with regard to the needs of the professional, the employer, the profession, and society”.	<ul style="list-style-type: none"> - maintenance of competence - knowledge enhancement - life long learning - planned - needs
UK: Nursing and Midwifery Council of the United Kingdom (UKCC,1999p7)	CPD is “the updating and extending of the professional’s knowledge skills on new development and new area of practice to ensure continuing competence in the current job the training for new responsibilities for a changing role and developing new areas of competence in preparation for a more senior post and also developing personal and professional effectiveness and increasing job satisfaction”	<ul style="list-style-type: none"> - update knowledge - update skills - stay abreast of new developments - learn new area of practices - ensure competence - train for new responsibilities and new roles - develop new areas of competence - develop personal effectiveness - develop professional effectiveness - increase job satisfaction

The common denominator between all the CPD definitions is the demonstration of maintaining competence in knowledge, skills, attitudes, and values. Competency in the area of practice is also high on the agenda. Individual differences between the definitions refer to issues related to job satisfaction, career goals, and quality assurance programs. Madden and Mitchell (1993) also emphasizes the importance that CPD should be a planned process.

The researcher arrived at an operational definition for CPD based on definitions as mentioned above. For the purpose of this thesis continuing professional development will refer to:

the lifelong active participation of the professional nurse in planned activities to maintain and update knowledge, extend skills, attitudes and ethical values and to demonstrate competence in present area of practice and judgement throughout her career. The above activities are done in a planned manner with regard to the needs of the professional nurse, the employer, the profession and the community's health needs. It is recommended that the CPD activities are credit bearing and should be a prerequisite for re-licensing.

2.7 Factors influencing CPD requirements

Political, social demographics, patterns of disease and new technology are some of the factors that support ongoing life long learning to ensure that professional nurses are staying abreast in their specialized field of interest

2.7.1 Political and social demographics

People in leadership positions such as politicians can influence the pattern of disease by implementing national life saving strategic programs. A very clear example of allowing the extensive outbreak of HIV in South Africa was the delay of the roll out of antiretroviral drugs at the time when Dr Manto Tshabalala-Msimang was the health minister. She unequivocally did not support the treatment of HIV/AIDS patients with antiretroviral medications, this lead to a delay in treatment

and an exponential growth in the incidence of HIV, especially amongst people younger than 50 (Blandy, 2006; Noble, 2009). Minister B Hogan, had a complete different view and stated: “The science of HIV and AIDS is one of the most researched subjects in the medical field. We also wasted time despite having one of the best plans to cope with the epidemic”, adding that South Africa must now show more urgency in implementing a national programme launched last year to fight HIV/AIDS. The political decision of withholding the ARV program can be directly related to the immediate increase in burden of disease related to HIV. Professional nurses now had to update their knowledge on HIV / AIDS instead of concentrating on other chronic diseases such as heart disease and cancer. A disturbingly high proportion (1:10) of young people are currently infected with HIV. This is even higher for women in the age range 20-24 years (1:4) compared to males (1:14) for the same age. HIV prevalence according to the National HIV Survey 2008 showed that:

10.0-11.9% in the whole population

15.5-18.4% amongst all people aged 15-49 years old

are infected with HIV (HSRC, 2008; Minaar & Bodkin, 2006).

Another example of political decisions that influence the need for CPD or updating of knowledge and skills is the implementation of the Termination of Pregnancy Act (Act 92 of 1996), whereby professional nurses now have to undergo continuing education to enhance their skills and competency to deliver the required service.

2.7.2 Patterns of disease

Patterns of disease are dynamic and change over time. At the present time for instance there is a need to concentrate on HIV/Aids and associated diseases such as TB. Some of the other diseases currently on the health needs agenda include: obesity with an overall prevalence of >29% in males and 56% in females, alcohol dependence 27.6%, hypertension 55%, dyslipidaemia 13%, diabetes 8.7% and chronic respiratory diseases 4.7%. Tuberculosis (TB) remains a serious problem with 460,000 new TB cases reported in 2007. This is an incidence rate of an estimated 948 cases per 100,000 population. Of this it is estimated that 31 percent

of all TB-HIV cases in Africa are in South Africa are Multidrug-resistant (MDR) TB. This resistance are largely caused by non-adherence to drug regimens or inappropriate drug regimens, which can be due to the lack of knowledge of professional nurses related to the disease. The professional nurse needs to update her skills to learn how to deal with patients who suffer from multi-drug resistance (MDR) and extreme drug resistance (XDR) TB (South African Health review, 2004 & 2007; USAID,2009). Professional nurses need to regularly update their skills to enable them to give the correct information to clients (ANA, 2000, Quinn, 1998; Towle, 1998).

2.7.3 Influence of technology

New health technologies include diagnostic and screening techniques, medical interventions, and techniques for drug delivery e.g. intravenous medications, surgical interventions, information technology and telecommunication are amongst the forefront of newer approaches to healthcare (Mc Connell, 2002). According to Axley (2008), the greatest driver of change is the introduction of computers and telecommunication technology including telemedicine. Telemedicine promotes high speed communication links between hospitals/ clinics/ doctors / nurses/ laboratories/ x-rays/ scans/ imaging and enables faster referrals and specialist reports (Abrahams, 2009). It also increases the capacity for remote consultations; surgical operations and teaching.

Furthermore, the same information is available to the clients, who now can question the diagnosis or treatment based on knowledge gained from these search engines. These information technology developments require substantial changes in the skill mix of staff and have major training implications for professional nurses (ANA, 2000; Quinn, 1998; Towle, 1998).

Advances in medical technology hastened the trend to move the care away from acute hospitals into primary healthcare. Outpatient surgery and day case surgery are on the increase. According to Mitchell (2007), there is a considerable amount

of elective surgery that can be taken on as a day case. A surgical case such as laproscopic cholecystectomy is given as an example whereby patients stayed in hospital for seven days post surgery to recover after a cholecystectomy surgery, can now be discharged few hours later because of innovations in procedure by doing it laproscopically. It is recommended that healthy people undergoing minor procedures such as urologic, ophthalmologic, ear, nose and throat procedures and procedures involving arms and legs could be done on an out patient basis in primary healthcare facilities. These outpatient procedures are rapidly on the increase due to improved surgical instruments and technology, less invasive surgical techniques, a team approach, and a desire to reduce health care costs (Outpatient-surgery, 2008). With new technology, the diagnosis and treatment can be done in the community healthcare settings. The trend towards day surgery as a result of minimally invasive surgery is new and professional nurses can only stay abreast with technology if they update themselves continuously (Gordon, 2005, Quinn, 1998; Towle, 1998).

2.7.4 Place of health care delivery

There is a shift in the emphasis of healthcare in South Africa, from curative hospital-based care to community-based primary healthcare (Dennill, King & Swanepoel, 2000; National Health, Act 51 of 2003). An example is the Healthcare 2010 plan for the Western Cape Province whereby the primary healthcare approach is favoured by the department of health in such a way that 90% of health contacts would be at the level of Primary healthcare (PHC) and District hospitals; 8% of health contacts will be at the level of the Regional or Secondary hospitals and only 2% of health contacts would be at the level of an Academic teaching hospitals. The 90%+8%+2% proportional split is an indicator of where health contacts will take place (Western Cape Health, 2002). Professional nurses will now need to update their primary health care nursing practices to enable them to work in the community clinics.

2.7.5 Consumerism, patient empowerment, and autonomy

Due to increased knowledge and awareness of rights the public has a higher expectation of the quality of services provided by professional nurses. Better educated and enlightened patients demand more information and greater involvement in decision making regarding their treatment and care. Change in the professional nurse-patient relationship is inevitable due the increase of available information to the consumers regarding diseases and nursing care that can be expected. Consumers have internet access where they can read about their diseases and question the healthcare providers' treatment and care (ANA, 2000; Towle, 1998).

2.7.6 Task shifting

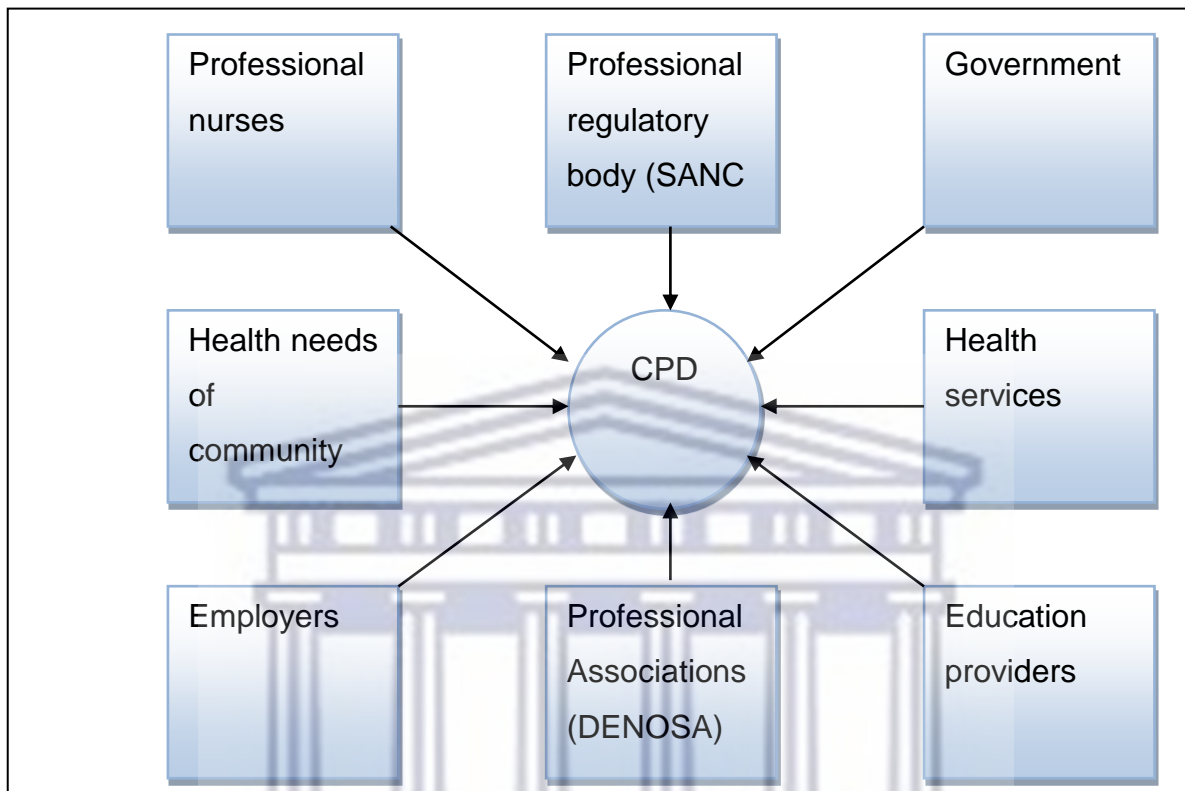
One of the least costly ways of delivering healthcare whilst maintaining quality is the matching of staff skills to the task and to the emerging technology (Quinn, 1998; Towle, 1998). Primary healthcare nurses are allowed to diagnose, prescribe certain medications and treat minor ailments such as coughs, colds, diarrhoea and TB. Historically this was a no - go area for nurses and only medical doctors were allowed to diagnose and prescribe treatment. Also the specialist nurse categories as stated in the SANC Teaching guide for a course in clinical nursing science leading to an additional qualification, Government notice R212 of 19 February 1993 such as post-basic(advanced) midwives (SANC, 1993) who carry out vacuum extractions has saved many mothers' and babies' lives. This was previously an area only for obstetricians. Another specialist nurse category is the post-basic (advanced) psychiatric nurse. This category of worker can now undertake therapies such as individual therapy; family therapy and group therapy and counselling (SANC, 1993). These tasks were previously reserved only for clinical psychologists and social workers. The Pick report mentioned a new category of mid-level worker namely the "medical assistant". This will have an impact on the role of the professional nurse and she will need to be updated as to what the function of the medical assistant is (Pick, Khanyisa, Cornwall, Masuku, 2001).

2.8 Stakeholders in CPD for professional nurses

It has become evident from literature that there are various interested parties or role-players in CPD. These are, the professional nurse, the health services (international, national, provincial, local and private), the employers both private/public sector, the professional regulatory body (SANC), education providers such as higher education institutions, the community by virtue of their health needs, the government and professional associations e.g. Democratic Nursing Organisation of SA (Quinn, 1998). Different roles are played by each of these role players. For instance it is expected that new regulations regarding CPD will be made available via the government gazette. SANC will then inform the public and the education providers who in turn will offer update-skills workshops to professional nurses. The employer needs to buy into this plan and allow the professional nurses in its employ to attend these update-skills workshops and may even be requested to support the professional nurses' attendance financially. Updated professional nurses can then offer nursing care proceeding from the latest evidence-based knowledge (Figure 2.1).

The logo of the University of the Western Cape, featuring a stylized classical building with columns and a pediment.

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Figure 2.1 Stakeholders in CPD for professional nurses

(Adapted from Quinn, 1998).

2.8.1 Professional nurses

Professional nurses are the main stakeholders that will need to buy into CPD. Davids (2006) argued that currently professional nurses in South Africa are not aware that it is their responsibility to continue learning and to seek learning opportunities. This is in contrast with what Section 59 of the Nursing Act (2005) requires from a professional nurse. If professional nurses believe that it is not their duty to continue learning, then they will not be able to keep up to date with the overwhelming development of technology and the current burden of disease. They will therefore fail in their ultimate duty of providing evidence-based care to their patients.

It is essential that professional nurses recognise themselves as adult learners and take responsibility for their own learning. In other words adults need to apply the

principles of andragogy when they participate in CPD. Andragogy is the term used when referring to the training and teaching of adults. Malcolm Knowles, who is a world renowned adult learning theorist, expounded that learning for adults should be based on andragogical principles and not on pedagogical principles which were developed for teaching children (Knowles 1990). Andragogy consists of learning strategies focused on teaching adults. It is often interpreted as the process of engaging adult learners in the structure of the learning experience.

Andragogy was originally used by Alexander Kapp, a German educator, in 1833. The term andragogy was developed into a theory of adult education by Knowles, an American educator. Knowles held that andragogy originates from a Greek word meaning "man-leading". It is imperative to distinguish andragogy from the more commonly used word pedagogy, which means "child-leading" (Knowles, 1984).

Knowles's andragogy theory includes four simple principles:

Adults need to be involved in the planning and evaluation of their instruction (Self-concept and motivation to learn).

Experience (including mistakes) provides the basis for learning activities (Experience).

Adults are most interested in learning subjects that have immediate relevance to their job or personal life (Readiness to learn).

Adult learning is problem-centered rather than content-oriented (orientation to learning) (Knowles, 1984).

Andragogy differs from pedagogy in that adult learners are self-directed. As a person grows and matures, a person moves from dependency such as experienced in the child to one of increased self-directedness. This self-directiveness allows for a change in the person's self-concept. The second assumption is that adults are a resource, which are rich in their life experiences and this rich life experience can be used for their own learning. Adulthood allow for the accumulation of a vast amount of experience to which the adult can relate or associate her or his new learning. Assumption three states that adults are ready to learn and that learning needs are based on social development roles and professional roles. Assumption four refers to the need for immediacy of application

of what is learnt. It is known that adults integrate knowledge the best if it is applicable for immediate use of solving day to day problems of living or working. The method of problem-centred orientation or problem based learning is the fifth assumption. Currently many higher education institutions are basing their teaching and learning programmes on case studies to allow for problem based learning (Dienemann, 1998; Knowles, 1984; 1990).

2.8.2 Professional regulatory body

The SANC is the professional regulatory body for professional nurses in South Africa. SANC is also the official Education and Training Quality Assurance (ETQA) body (SANC, 2007). The current Nursing Act 33 of 2005 makes provision for the implementation of CPD in section 39. The Act refers to the following: “The Council may determine conditions relating to continuing professional development to be undergone by practitioners in order to retain such registration; the nature and extent of continuing professional development to be undergone by practitioners; and the criteria for recognition by the Council of continuing professional development activities and accredited institutions offering such activities”. This is a very important factor that influences CPD as it states that CPD will be a prerequisite for registration, but this statutory requirement has not yet been implemented by SANC.

2.8.3 Government

The Government is responsible for Acts and policies such as the National Health Act (National Health Act, 2003) and Nursing Act 33 of 2005. Nurses are regulated by this act and CPD is one of the legal requirements. The SANC is a statutory body that reports directly to the Minister of Health.

2.8.4 Health services

The health services are responsible for prevention of disease, promotion of health, treatment, care and rehabilitation of the South African population. The health service authorities in SA are the employers of approximately more than 100 000,00

professional nurses and therefore they have a duty to make sure that the professional nurses that they employ are up to date in knowledge, skills, attitudes and ethical values in order to be competent to carry out their work (SANC,2008).

2.8.5 Education providers

Education is provided by various role-players to professional nurses. In future one would expect that courses, seminars and workshops would need to be accredited for CPD purposes by accredited providers approved by the SANC. Formal education is provided by Universities, provincial and private nursing colleges and private educational institutions. Currently the Universities which offer undergraduate or postgraduate nursing degrees in South Africa are included in Addendum 4. Many of the providers listed in addendum 4 have departments of continuing education or departments of lifelong learning, which in future could take on the responsibility to offer a variety of courses, workshops and seminars for the purpose of CPD.

In addition to the Universities, nursing education courses which include post basic courses are also offered by traditional institutions such as nursing colleges. There are many nursing colleges in South Africa which are authorised by SANC. Nursing Colleges who provide the four-year R425 Nursing Diploma have to be affiliated to a university (SANC, 1988). These are also listed in addendum 4. The list is not conclusive. Informal educational institutions can also contribute to the delivering of CPD courses for nurses. These education institutions usually offer education in the form of in-service education and staff development (Amos, Risow, & Ristow, 2004; Gerber, Nel, & Van Dyk. 1998).

2.8.6 Professional associations

Professional associations such as DENOSA do have CPD offerings such as a monthly "Update magazine", Curations nursing journal, library, support to conferences, offer conferences, financial support and education activities. The DENOSA recently embarked on a three year project encompasses courses that

will enrich nurses in their personal, professional, and socio-economic domains of their lives. The DENOSA recognises that this new project demands that the highest standards of accountability be embraced especially at provincial level, where the impact of the learning courses will be assessed.

2.8.7 Employers

The employer has a right to expect that a professional nurse is competent in the job that she or he has been appointed to. If they are not competent, they often do not perform up to standard making them ineffective in their jobs. Many employers conduct a yearly performance appraisal on each professional nurse in order to assess his or her performance. Performance of excellence is usually rewarded by performance bonuses or other incentives. Remedial action may be taken when a professional nurse is underperforming (DPSA, 2001; Muller, Bezuidenhout & Jooste, 2006). It is generally expected that employers should provide for CPD activity and specifically allow the employee to attend CPD activities during on-duty time. Employers can be refunded for accredited courses according to the Skills Development and Skills Levies Acts (Skills Development Act, 1998 & 2003; Skills Levies Act, 1999).

Both the public and the private sector in South Africa employ professional nurses. According to APEGGA Council (1997) the employer has a role to play in CPD to ensure that the professional nurse in their employment is competent. Employers of professional nurses should support the CPD efforts of their staff. Employer's support of CPD could involve a range of aspects (CIPD, 2002), (Table 2.3).

Positive support and collaborative engagement from employers will ensure a reciprocal relation where the positive support of the employer will allow the professional nurse to enhance and update her or his skills. This in return will ensure that the employer can expect an up-to-date service delivery to their clients via the professional nurse. This should also improve the professional nurse's job satisfaction.

Table 2.3 Employer Support of CPD activities

Support activities
Employers should have an overall positive attitude towards CPD
Provide CPD learning opportunities
Do performance appraisal periodically and when it is appropriate
Financially support CPD activities
Allow time to employees for involvement in CPD activities
Encourage employees verbally and non-verbally to engage in CPD
Provide assistance with documentation of activities and efforts by the professional nurse
Provide assistance with developing of work expectations by the professional nurse
Consult with professional nurses when drawing up a CPD programme at the work place

2.8.8 Health needs of the community

The community in general is unfamiliar with the concept of CPD. Healthcare consumers do have certain expectations of the professional nurse who takes care of them. Some of the expectations that healthcare consumers (or patients) have are that nurses should have the latest knowledge, skills, attitudes and ethical values related to their illness in order to assist them to make informed decisions. They also expect the professional nurse to practice the best evidence available. To sum up the expectation is that an up-to-date professional nurse, who has undertaken CPD, will be able to provide the latest information and nursing care to the healthcare consumer.

2.9 Professional misconduct cases and CPD

No literature could be found to support the assumption that CPD may decrease professional misconduct. All persons undertaking nursing in South Africa have to be registered with the South African Nursing Council (SANC). The Nursing Act 33 of 2005, section 30(1) asserts that the professional nurse is accountable for her or

his own actions. This is an indirect stipulation that being accountable means to be up to date with current practice and knowledge. The mission and vision of SANC subscribe to protect the members of the community by ensuring fully competent and safe practicing nurses. Being found guilty of misconduct is often related to incompetency. It is believed that the introduction of a CPD system may decrease the cases of misconduct especially those related to basic care, medication, and midwifery. A CPD system in nursing will stipulate the requirements for nurses to be updated regarding knowledge, skills, attitudes and values in their area of practice before they can apply for renewal of their licence annually.

A total of 843 cases of misconduct have been reported to the SANC from July 2003 to June 2008 (SANC, 2008). Some of the cases could have been prevented if the SANC had a CPD system in place that could test competency on a regular basis (Table 2.4). Although the 843 cases reported and investigated by SANC have occurred over a period of five years, SANC still views it as a serious problem as many lives were lost. Currently the reported and investigated cases are only the “tip of the iceberg”. It is well known that many cases of misconduct are handled or solved at ward or institution level, or settled out of court and never reported to the SANC. It is believed that CPD related to the most common misconduct cases such as the incorrect dosage of pharmaceutical products, could ensure that professional nurse are competent to practice and would know how to administer medication.

Table 2.4 Professional misconduct cases

Type of Offence	Number of Persons
Education related	19
Fraud/forgery	36
Maternity related	135
Medication related	143
Physical assault of colleague	15
Physical assault of patient	19

Poor basic nursing care	394
Section 36(see note)	47
Sexual abuse of patient	31
Theft	4
Total	843

(SANC, 2008). (SANC misconduct cases July 2003 to June 2008).

2.10 Organization and planning of CPD

The legal framework for CPD is vitally important as it legitimises the organizational and developmental structures (Ndege, 2006). Effective implementation of CPD needs to be based on research. The SANC not only needs to establish what the health needs of the country are, but it also needs to establish what would satisfy professional nurses and the other stake holders such as employers. The process of determining the needs, developing a CPD model, implementing the process, recording results and the evaluation of CPD must be followed through in a structured manner. Thus the assessment of CPD requires careful and logical planning (Karsdtadt, 2007).

2.11 Mandatory versus Voluntary CPD

Mandatory CPD is when the nurses are legally obligated to comply to undertake CPD. This is in order to get a licence to practice, or in the case of professional nurses in SA, register to practice. Kershaw (1984) and Hibbs (1989) state that if CPD were not mandatory in the nursing profession then many nurses would not update their professional knowledge either informally or formally. Brown (1995) supports mandatory CPD and states that it will make it obligatory for unproductive members of the profession to update themselves regularly who otherwise would not do so.

Voluntary CPD on the other hand is where the professional nurse can decide whether to engage in CPD activities or not. The United States of America (USA) has mandatory and voluntary CPD for professional nurses. Each state is responsible for its own CPD requirements. Thus, one state can have a mandatory CPD programme while another chooses to follow a voluntary protocol. The researcher could find no current studies that have evaluated the difference in misconduct or best practice between the states in the USA that have mandatory or voluntary CPD systems (table 3.1 on page 77). On the other hand, the government of the United Kingdom (UK) requires all health professions to set up systems of mandatory CPD (RPSGB, 2006).

2.12 Range of CPD learning activities

The range for CPD learning activities is wide. Professional nurses can thus use a blend of activities to ensure that they develop knowledge, skills, attitudes, and values. The use of electronic courses and readings on the internet are the method that other health professionals such as medical doctors and dentists in South Africa use. Some CPD activities are called “On – the - job methods” and “Off – the - job methods”, or what can be done at the institution and what needs to be done externally as illustrated in table 2.5 (WHO, 1988; Jooste & Troskie, 1995; Abruzzese, 1992; Muller, Bezuidenhout & Jooste, 2006).

Table 2.5 Range of CPD learning activities

On- the -job methods	Off –the- job methods
Healthcare audits	Distance learning
Job rotations	Academic studies
In-service training/education	Short accredited training courses
On-site supervision and guidance by specialists	Self study
Journal article review club	Guided studies
Team assignments and projects	Seminars and workshops
Review of patient records and reports	Conferences

Meetings with colleagues, mentoring & coaching	Meetings of professional organizations
Telephone conferencing	Meetings of scientific societies
Staff meetings and conferences	Certificates of Attendance
Support groups and problem solving groups	Research related activities

(WHO, 1988; Jooste & Troskie, 1995; Abruzzese, 1992; Muller, Bezuidenhout & Jooste, 2006).

Multiple educational methods and participation in learning activities have a more probability to sustain learning and change practice when these efforts are self-directed, based on learning needs, personal goals, relevant to practice, and have defined outcomes for the nurse and employer (Rouse, 2004).

2.13 Career planning and development.

Meyer, Naude and van Niekerk (2004), argue that attention needs to be paid to career development according to the expectations and desires of the professional nurse whilst providing them with in-service education and continuous education in the nursing unit. CPD could assist the professional nurse in developing future career plans. Organisations such as hospitals, clinics and health services in general have engaged in human resource planning and development which involves plotting on a chart the progress of a large number of personnel such as professional nurse through positions in the health services. Career development programmes in health services should have a focus on the individual nurse.

A career development programme should be a dynamic process, which strives to meet the needs of the employing organisation, the needs of the nurse managers and the professional nurse. Individual professional nurse are responsible for initiating their own career planning, and therefore should identify their own shortcomings related to knowledge, skills, attitudes, values and interests. They further need to engage with career development advisors or higher learning institutes to gain information about career options so that they can have career

goals and career plans (Sherman, Bohlander & Snell, 1996; Muller, Bezuidenhout & Jooste, 2006).

2.14 CPD and portfolio development

A portfolio is a file for carrying papers, pictures, certificates etc, which are assembled and presented as evidence when required and is often referred to as a “portfolio of evidence” (Allen, 2004). Cooke (1999) describes a portfolio as a “personal collection of evidence which demonstrates an individual’s acquisition of knowledge, skills, attitudes, achievements, and understanding”. A professional portfolio should contain materials that document the professional nurse’s competencies and all CPD learning activities. The portfolio provides a way for the professional nurse to monitor her or his own professional development, and it is easy to see where there are shortcomings (Oermann, 2002; Trossman, 1999). It is recommended that the professional nurse safeguard her portfolio and at least make copies of all evidence as it would be very difficult to gain access to original verification of courses attended if the portfolio should get lost. Portfolios can also be used for a record of professional experience, for reflective practice, for staff appraisal and job applications. Portfolios also contain certificates of attendance of various conferences, seminars and updates (Hull & Redfern, 1996; Brown, 1995; Kelly, 1995).

2.15 Current models of continuing professional development

There are various models of CPD available of which many are used in professions such as teaching, medical, and allied professions. CPD can be arranged in a number of different ways and for many different reasons. The main characteristics of various models from literature are discussed.

2.15.1 The Training model

This model of CPD supports a skills-based and technical view whereby CPD provides the professional the opportunity to update their skills in order to demonstrate competence in their work. It is delivered by an expert in the field of

practice and training takes mainly place at the workplace, but can be done offsite as well (Kennedy, 2005).

2.15.2 The Award-bearing model

This model places importance on the completion of award-bearing programmes usually at an institution of higher education such as universities. The “award” would be a certificate / diploma / degree from an institution of higher education, it is viewed as a symbol of quality assurance. All award bearing models is externally validated (Kennedy, 2005). This model is applicable as professional nurses are also required to obtain certificate/diploma/degree from a nursing college, university or other institutions .

2.15.3 The Deficit Model

The deficit CPD model relates to the addressing of the perceived deficit in the performance of the work by a professional person. It usually is dealt within the confines of performance management in the workplace (Kennedy, 2005). Professional nurses are also subjected to a performance appraisal from their supervisors and employers (DPSA, 2001).

2.15.4 The Cascade Model

This model involves an individual professional attending education and training activities and then imparts it or cascading the learnt activity to fellow colleagues. It is a means of sharing ones successful learning with fellow colleagues (Kennedy, 2005). The cascade model is applicable to professional nurses as it is expected from them to teach other staff members new skills learnt and also to give feedback from seminars and conferences attended.

2.15.5 The Standards-based Model

It has to do with the upkeep of standards in a profession. In this CPD model the emphasis is on professional standards or competencies (Kennedy,2005). Ethical

standards are high on SANC agenda and it is essential that all ethical and practice standards be adhered to.

2.15.6 The Coaching/Mentoring model

In this model there is a one to one relationship. Coaching appears to be a more skills based whilst mentoring appears to be 'counselling and professional friendship' (Rhodes & Beneke, 2002p.301). Mentoring is usually done by a more experienced professional with a new employee. Professional nurses who are senior often have to coach or mentor junior colleagues.

2.15.7 The Community of Practice Model

With the community of practice model it generally involves more than two people. This usually refers to a particular department or specialised unit and not actually the community as generally understand. The participant's awareness of the existence of the community is central to learning. The role played by the team member, learning could be positive or passive depending on the power play by dominant members of the team (Kennedy, 2005). In nursing also learning also occurs within a multidisciplinary context with doctors, social worker, occupational therapists, pharmacists etc.

2.15.8 The Action Research Model

The participant themselves are researchers with a view to improve the quality of action within the group (Kennedy, 2005). Nursing which can be seen as part of the medical model is always involved in action research. This model is often used in curriculum development where the educators work together with stakeholders, the nurses in practice and potential students, to ensure that all buy into the curriculum.

2.15.9 Sanctions model

According to Madden and Mitchell (1993), the sanctions model apply mostly to older established professions such as law, architects etc where CPD is seen as essential to maintaining an up to date knowledge for practice and sanctions can be imposed on the professional that does not comply to the updating of knowledge. Nursing could also impose sanctions once a CPD system is in place.

2.15.10 Benefits model

The benefits model tends to apply to newer professions such as social work. A benefits model focuses on improving professional status on a voluntary basis, increasing knowledge and skills for practice (Madden & Mitchell, 1993; Quinn, 1998). In nursing a benefits model can also be included because further studies are undertaken to improve ones own professional status.

2.15.11 The Transformative Model

This model of CPD involves a combination of a number of processes and conditions stated in the preceding models. The main feature being the combinations of practices and conditions that support a transformative agenda (Kennedy, 2005). Nursing needs a CPD model that is broad based and an all encompassing model. The transformative model may be a good example to use for nursing continuing development.

2.16 Theoretical framework

Theoretical framework refers to the relationship between concepts. A theoretical framework is commonly included in a thesis as it guides the research and determines what variables will be measured. It also explains the relationships between the concepts (Analytictech, 2008). The development of a model for CPD for professional nurses in South Africa is structured on the systems theory because of the inter-relatedness of the parts of a system which are the input, throughput, output and feedback. The researcher further decided to use a systems framework

as the draft document of CPD for nurses and midwives in South Africa was based on a systems framework (Kay, 2004). Smit & Cronje (2001) state that the particular value of the systems approach is the emphasis on the fact the activities in one part of the organisation affects the activities the other parts.

2.16.1 Definition of systems theory

A system is a regularly interacting interdependent group of items forming a whole that performs one or more specified functions (Allen, 2004). It can also refer to an organised way of doing or arranging something according to a fixed plan or set of rules, method or procedure (Kirkpatrick, 2001).

2.16.2 History of Systems Theory

Katz and Khan (1966), state that a systems theory is primarily concerned with problems of relationships or structures and of interdependence, rather than with the constant attributes of objects. The General Systems Theory (GST) was originally introduced in the 1930's by Ludwig von Bertalanffy, a biologist, who was concerned about the growing compartmentalisation of science (von Bertalanffy, 1968). GST allows for the sharing of advances from different disciplines, which contribute to the body of knowledge for general living as well as for scientific and non-scientific use (von Bertalanffy, 1968). More specifically, an Open System (OS) reacts with its environment while a Closed System (CS) does not (Pidwirny, 2006). Klir (1972) refers to the general systems theory as a collection of general concepts, principles, tools, problems, methods and techniques associated with a system. Donabedian (1980;1988), also developed applied systems theory further for analysing and describing of quality systems in health services by using three factors which were :structure (resources and administration), process (culture and professional co-operation) and outcome (competence development and goal achievement).

2.16.3 Principles of the systems theory

Gillies (1994) articulates that the principles of a system have the following components:

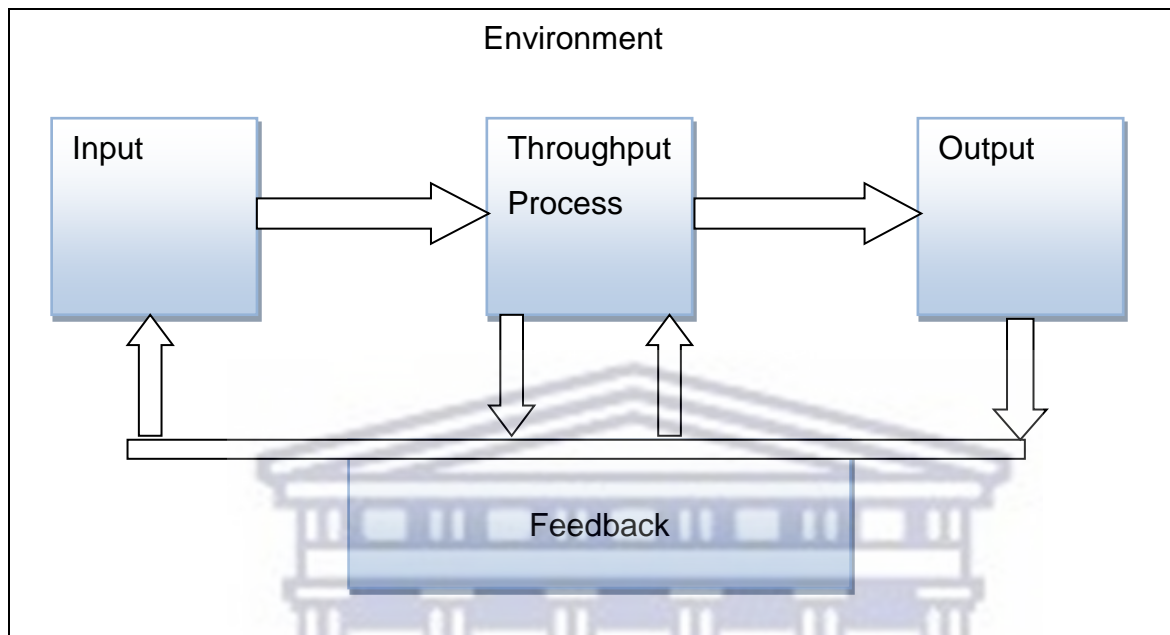
Input

Throughput / process

Output and a Feedback system (Figure 2.2)

Input, throughput and output are in constant communication via the environment wherein they function.



Figure 2.2 Principles of the systems theory

(Adapted from McEwen & Wills, 2002)

2.16.4 The characteristics of systems

Pearson, Vaughan and Fitzgerald (2002) ascribed specific elements with specific characteristics to a system before it meets the criteria that allow it to be called a system. Firstly, the elements need to have a common purpose. The parts of a system are inter-related and interdependent, but each part has boundaries. In all systems theory, there is an emphasis on the interaction of the parts to form the whole. Functionally what is important is the interaction of the parts and the eventual output. Two types of systems are traditionally described, a closed and an open system.

A closed system is one where the boundary does not allow for any interaction of the parts of the system with stimuli from the environment. An open system is one, which constantly interacts with its environment through its boundary. Both systems have an input to the system, an internal re-arrangement (throughput or process) of the system and from the processed information back to the system. Thereafter there is output from the system.

As stated above, a system can be defined in relation to its environment and its boundaries. The environment affects the system and vice versa. The system environment comprises of a set of objects, events or conditions that although not an integral part of the system, have significant bearing on the functioning of the system (Gillies, 1994).

The first component of a system is the input which comes from various sources. The input is the energy, material or information data that is supplied to a system. It can be suggestions, advice, or a contribution. It is the entry point in a system at which input is made in order to make a system work (Allen, 2004; Kirkpatrick, 2000). The input for this study will be derived from available literature on CPD. A variety of sources will be consulted to ensure that the input is sufficient to get the system working. Some of these resources will be books, journals and electronic search engines. This information will also assist in formulating the instrument that will be used to collect data from the professional nurse. It will also receive input from references related to international and national continuing education in the health professions arena in general and within the nursing profession in particular. The system will also be stimulated by relevant Government policies and legislation that govern the nursing profession. Input will also be received from vital role players in CPD namely professional nurses, employers, education providers and others.

Throughput refers to a series of actions, through which the system converts the input factors as well as those derived from feedback from within its own system or from the external environment or other related systems to achieve the end goal (outcome). The throughput process will result from the input in the form of policy document analyses, analytical reviews of the information obtained from the survey and health indicator statistics.

The final aspect in the systems theory is the output or outcome. Successful output will be measured with the tabling of an acceptable model for CPD for professional nurses in South Africa.

Feedback can be positive, negative or neutral information received from environmental responses interacting with the system or generated by the system itself (Kenney, 1995). These may come from the users of the system which in this case will be the professional nurses.

South Africa forms the environment in which the CPD for professional nurses will take place. The South African environment is influenced by the dynamics of society, the nursing profession, other health professions, the health circumstances, the economics, the political situations and many others that affect the environment in which the CPD will operate.

The proposed CPD model will be presented to the South African Nursing Council. It is hoped that they will use the proposed model for implementation of CPD for professional nurses in South Africa. It is further hoped that once the proposed model is accepted by SANC that it will be evaluated in a study before it is widely implemented to ensure that the model is applicable for professional nurse in South Africa.

2.17

Summary

The chapter has drawn on a literature review that guided the researcher to embark on the project. Several definitions of CPD are given and the need for and characteristics of the concept are discussed. Factors supporting the needs for CPD such as trends in healthcare, political aspects, new technologies, as well as debates around mandatory versus voluntary CPD were discussed. The manner in which various role players can contribute to the successful implementation of CPD is also discussed.

Findings in the literature were used to formulate the questionnaire that was used in the survey of the CPD needs of professional nurse. The literature revealed that the CPD activities must be based on andragogical principles. The systems theory is described as the theoretical underpinning on what the proposed CPD model will be based on. The philosophy of CPD is life long learning.

Chapter three

Research methodology

3.1 Introduction

Research methodology is the theory of correct scientific conclusions, which are taken within a specific theoretical framework. Logical reasoning in the decision making process during scientific research is a human process and therefore liable to error. The quality of the research findings is therefore directly dependent on the accountability of the research methodology. It is therefore necessary to follow a specific research methodology to exclude obvious wrong decisions and to enhance the validity of the research findings. The purpose of this chapter is to describe and justify the research methodology used to generate the answers to the research question. The research approach, design strategies, data collection, data analysis, population and sampling, validity and trustworthiness is discussed in this chapter. The aim of this research is to develop a model for Continuing Professional Development based on several methodological enquiries.

3.2 Research objectives

The objectives of this study were to:

Conduct an analysis of current international CPD systems for nurses as well as the current CPD system for the Health Professions Council of South Africa (HPCSA).

Conduct a document analysis of relevant South African government legislation and policies that may influence CPD for professional nurses.

Assess the community's health needs in order to determine the health priorities.

Conduct a survey to assess the continuing professional development needs of professional nurses in South Africa.

Develop guidelines and a model for CPD for professional nurses in South Africa.

3.3 Phases of research process

Phase A is described in chapter four and consists of a literature review related to current international and national CPD practices of health care professionals.

Phase B is a document analysis of relevant government policies and legislation that influence CPD for professional nurse is described in chapter five.

Phase C is an analysis reflecting the health indicators for South Africa and is presented in chapter six.

Phase D consists of a survey to assess the continuing professional development needs of professional nurses in South Africa and is presented in chapter seven.

3.4 Research approach

A qualitative approach was used during phases A, B and C to analyse the relevant documents. Document or content analysis is a methodology that is used to study recorded human communications, such as books, policies, websites, and journal articles. It refers to the common understanding of "Who says what, to whom, why, to what extent and with what effect?" (Holsti, 1969). Document analysis also refers to the "technique for making inferences by objectively and systematically identifying specified characteristics of messages." (Neuendorf, 2002). Document analysis commonly makes use of a qualitative approach where text are analysed but it can also be given in a quantitative way for example when the researcher refers to the prevalence of the burden of disease. The mixed methodology is used. The researcher first searched the databases like MEDLINE, CINAHL widely for documents related to CPD and the prevalence of diseases that may drive CPD. He then sorted, organized and interpreted all the data systematically. Underlying dimensions and patterns of relationships has been established during the analysis and the results are provided in a narrative form. (Polit & Hungler, 1993; Polit, Beck & Hungler, 2001; Peters & Malaviya, 1998).

In phase D the researcher made use of a quantitative approach, which refers to the numerical, systematic method of information collected in the course of the survey. Numerical data allows for manipulation through a pre-specified statistical procedure for assessing the magnitude and reliability of relationships among them (Polit & Hungler, 1995). An explorative, descriptive survey design was used during Phase D to establish the need for CPD. According to Brink (1996), exploratory research refers to the exploration of the dimension of a phenomenon so that it provides more insight about its nature. Polit and Hungler (1995) states that descriptive research aims to describe the characteristics of individuals and the frequency with which certain phenomena occur. This study explored and described the principles that should be utilized in the development of a model for CPD for professional nurses in South Africa. The context is situated in the milieu of the professional nurse in South Africa (Mouton & Marais, 1994).

3.5 Population, sample population and sample size

The term population refers to the entire set of study objects and consists of individuals, people, groups, organisations, events having some common characteristics or conditions to which they are exposed (Welman et. al, 2005; Polit & Beck, 2006). Population can also refer to sources or documents. There is often not enough time or money to gather information from everyone or everything in a population, the researcher would target a representative sample (or subset) of that population. Sampling is to select a set of elements from a greater population. The description of the sample elements must accurately portray the characteristics of the total population from which the elements were selected (Babbie and Mouton, 2001; Brink, 2006).

Phase A, B & C:

Books, journals and search engines were used to obtain sources of information related to:

A: Current international and national CPD practices of health care professionals.

B: Government policies and legislation that influence CPD for professional nurses.

C: Health indicators for South Africa

In addition the researcher wrote letters requesting booklets and information from the nursing associations, councils, and boards. Letters were written to the South African Nursing Council informing them of the study and requesting relevant information on relevant policies and documents.

A purposeful, non-random method of sampling was used during Phase A, B & C to select specific information-rich sources for in depth study related to each phase. The aim was to learn more about the issues of central importance to the CPD practices, government policies and legislation that influence CPD and health indicators of SA (Mugo, 2006). The researcher purposefully concentrated on CPD recommendations from the World Health Organisation and CPD systems available in the United Kingdom (UK), United States of America (USA), Canada, and Australia. The CPD systems available in Ireland, New Zealand, Saudi Arabia and other eastern countries were not be discussed due to the similarities of these systems in relation to those already chosen for review. The researcher reviewed CPD systems currently available in South Africa even though they were not specifically related to nursing but to other health professionals registered with the Health Professions Council of South Africa (HPCSA).

Specific purposefully selected documents were evaluated to form part of the sample of documents that were analysed during Phase B. The documents evaluated were:

Batho Pele White Paper.

Draft Document of Continuing Professional Development system for Nurses and Midwives in South Africa (2001).

National Health Act 61 of 2003.

National Human Resources for Health.

National Policy on Continuing Professional Development (CPD).

Nursing Act 33 of 2005

Skills Development Act 97 of 1998.

Skills Levies Act of 1999.

Accessible documents purposefully selected for Phase C included reports from:

Department of Health report on National HIV and Syphilis Antenatal zero prevalence, 2002

Department of National Health

District Health Barometer 2009

Health Systems Trust

Medical Research Council of South Africa

Medical Research Council report on Chronic Diseases of Lifestyle, 1995-2005.

National HIV and Syphilis prevalence report , 2008

Statistics South Africa

South African Health review, 2004

Phase D

The population for phase D included all professional nurses in South Africa that were registered with the South African Nursing Council in 2005. The minimum qualification required to be part of the general population was to be registered as a General Nurse on the registration roll. A total of 99,000 registered nurses were on the professional nurse SANC register at the time of the survey. A simple random sampling method will be used to reduce bias and ensured that every member of the greater population had an equal chance to receive a questionnaire. A simple random sample refers to a subset of nurses chosen from a larger set entirely by chance, such that each individual has the same probability of being chosen at any stage during the sampling process (Yates, Moore & Starnes, 2008). The researcher requested SANC to use a simple random sampling method when generating the address list of possible participants in the survey. Added to the request were names that could be used in the pilot study to ensure that they are excluded from the sample. A computer-generated random sample list was used which allowed for an equal distribution of participants. A 95% confidence level with a 2.17 confidence interval was used to calculate the sample. Statistical calculation showed that a sample size of 1998 should be sufficient to show that 95% of the

answers of the population will lie within the confidence interval. The researcher requested that the 2000 names selected were printed on an address label that included the potential respondent's name and full postal address.

3.6 Data collection, management and analysis

Since the documents used for the phase A, B & C have their origin in everyday contexts as there was no need for special storage or ethical approval. Accordingly, neither the researcher nor the aim of the investigation had any influence on the material itself. The costs of document analysis were lower than those of any primary study. But as any other method, document analysis also has its disadvantages: Firstly, documents only account for parts of the questions asked by the researcher, and secondly it always leaves room for interpretations by the researcher (Meyen, 2009).

Phases A, B and C made use of document analysis but a postal survey was used during phase D to assess the needs and opinions of professional nurses for CPD. The researcher took cognizance of the advantages as well as disadvantages of a postal survey (Serumaga-Zake, Raghunath, Kotze & Stiegler, 2005). One of the main advantages of a postal survey is the low unit cost of getting questionnaires to a large group of people. The expenditure is limited to printing costs of the questionnaire, envelopes and postal tariffs. A second advantage is that there is homogeneous stimulus to the respondent in that the questionnaire is the only means of communication between the respondent and researcher. There is very little place for the introduction of bias as the questionnaires are identical. Distance and accessibility are also not a problem when making use of postal questionnaires as a large geographical coverage can be obtained via postal questionnaires. Anonymity of the respondents can also be assured, as the researcher does not have face to face contact and identity identifiers are not used.. Many respondents can be reached and information can be collected over a relatively short period.

The main disadvantages of postal questionnaires is the high rate of non-responses (Burns & Grove, 2005). Freedom of the respondents to complete the questionnaire may lead to an introduction of bias. One will never know the reasons why

respondents did not complete the postal questionnaire. Often it may merely be the general negative attitude towards questionnaires and in this case, the questionnaire may not be read and immediately be thrown into a dustbin. Those respondents who read the questions and made an informed decision not to respond is a bigger problem and their responses could have influenced the outcome of the survey.

A postal questionnaire was sent to all the participants on the address list. To increase feedback from the respondents the researcher included a stamped self-addressed envelope in the package. This suggested that the respondent did not need to go out and purchase an envelope or a stamp (Babbie & Mouton, 2003). As the survey was anonymous, the researcher sent out a general reminder post card to all the respondents. He thanked those who had already returned the questionnaire and asked them to ignore the request of returning the questionnaire if they already responded. He appealed to those who had yet not replied, to comply with the request. A second reminder postcard was sent to increase the number of respondents.

The goal of using a postal questionnaire as the research instrument was to satisfy the overall aim and specific objectives of the study. This survey had the specific objective of obtaining the viewpoints of professional nurses regarding their CPD needs (Serumaga-Zake et.al., 2005). The questions were derived from the extensive literature search that was undertaken. An account of the order of the questions i.e. from simple to complex was taken into consideration when designing the questionnaire. All related questions were put together to enable the respondents to follow the logical flow of a thinking pattern when answering a questionnaire. Research has shown that it is always better to start with “soft” non-invasive, easy- to- answer questions to introduce the respondent to the process. The bio, social and demographic questions were thus placed first. Another restriction of a postal questionnaire is related to the size and the time that it will take to complete. It is advisable that the questionnaire should be short. A shorter questionnaire may encourage people to complete it. If the questionnaire is too long the respondents may feel that it will take too much time or may start and then

not fill in responses for the last pages as they are getting tired. According to Welman et al (2005), the length of the questionnaire often depends on the type of survey and the answers the researcher hopes to ascertain. It is recommended that a well-designed questionnaire should not exceed four pages. The questionnaire should have face validity, be friendly, clear, not overloaded and the questions equally spaced. The content and face validity need to be tested. Piloting of the questionnaire was done to ensure validity and reliability. Piloting of the questionnaire also assisted in clarifying complex words and questions, which could have created misunderstanding and distraction. The position of questions was carefully selected. This reason is that it is important first to lead the respondents to the questionnaire by asking non-threatening, easy -to -answer questions before asking sensitive questions. There were no known external factors such as political, cultural, time related or, respondents' environmental factors that could have influenced the quality of the responses at the time of the survey. The possible fear of being identified decreased when using a postal survey as there is no face- to-face contact.

According to De Vos (2002), a good storage and retrieval system is vital for keeping track of what data has been collected for permitting easy and reliable usage of data so that the research can be verified. In this study the literature reviewed was filed manually and the postal questionnaires were stored in numbered boxes. The researcher and data capturer who were the only people who had access. The data will be made available for an audit trail to verify the design and method utilised by the researcher.

Phase A, B & C made use of content analysis. Content or document analysis involves the examination of relevant documentation for the intention to establish concepts and emphasis about the communication that has been expressed in the documents. It is a data analysis method that aims to improve the quality of the deduction we make. The communication that is analysed can be verbal or written. The aim of the analysis was to objectively and systematically selecting specific parts that is related to the objectives of the analysis. The analysis further demonstrates how the selected communications are related to the outcome and

reflective inferences (Carney, 1972). Krippendorff (1980 p2) stated that content analysis is replicable and valid as it “provide knowledge, new insights, a representation of facts and a practical guide to action” According to Krippendorff (1980), must six questions be dealt with in every content analysis “Which data are analysed?

How are they defined?

What is the population from which they are drawn?

What is the context relative to which the data are analysed?

What are the boundaries of the analysis?

What is the target of the inferences?”

Furthermore is it important that the researcher should argue every analysed component evidentially. Thus all arguments were supported by evidence to justify the relevance and credibility of the information used. The arguments were meaningful and reasonable and illustrative arguing was demonstrated through convincing examples. Where needed, the researcher acknowledges reflexivity by acknowledging the problems of argumentation but mention a meticulous explanation for his reflection on the basis of the value of its particular contribution to the analysis (Mason, 2002).

Which data are analysed?

This step according to Johnson & Reynolds (2004), involves selecting the materials that are relevant and appropriate to:

Phase A – which is current international and national CPD practices of health care professionals.

Phase B – which is government legislation and policies that influence CPD for professional nurses is described in chapter five.

Phase C – which is the health indicators for South Africa.

What is the population from which they are drawn?

It is important to take note that the population should be comprehensive and all relevant sources should be viewed else bias can occur.

What is the context relative to which the data are analysed?

Merriam(1988), states that the type of document needs to be noted and not just the nature of the information in the document. The researcher therefore critically and purposefully selected the documents used for analysis.

What are the boundaries (categories) of the analysis?

Development of categories can be agreed upon before or after the text has been identified. These categories are “measured” and grouped. Categories depend on the nature of the documents and the subject that need to be covered. Additional categories can be added as the documents are analysed (Carney, 1972).

What is the target of the inferences?

Content analysis is only as good as the categories are and standardisation of the categories provides replicability and validity to the analysis. It is therefore essential that categories be specific and clear. Categories are then coded for processing or unitization. It is recommended that coding be done by more than one person to ensure that personal bias is not introduced as reliability will also depend on how well the coding was done (Krippendorff, 1980).

Advantages of content analysis are the fact that written documents allows access to information is not possible to be obtained via other research methodologies. Raw data are also nonreactive and is often available for many years. The sample size can also be increased if saturation has not been met and costs are low. The disadvantages of document analysis are that documents may be difficult to obtain and that researchers may be biased of what documents to included. Some researchers also state that document analysis may lack rigour and can lead to over generalization of the research results (Carney, 1972; Johnson& Reynolds, 2009).

A qualitative research methodology approach was used to analyse the relevant documents. The researcher then sorted, organised and interpreted all the data

systematically. Underlying dimensions and patterns of relationships was established during the analysis and the results were provided in a narrative form. (Polit & Hungler, 1993; Polit, Beck & Hungler, 2001; Peters & Malaviya, 1998).

During phase D the data was analysed quantitatively. Statistical comparison of nominal, ordinal and continuous variables was analysed using the Number Cruncher Statistical System (NCSS) as well as Epi info 2000 statistical programs. Tests of homogeneity of variance was applied to continuous variables. If the variables are homogenous, the ANOVA test will be applied. If variables were heterogeneous, the Mann-Whitney U or Kruskal-Wallis Test was applied. The Chi-square test was then be used for proportion and the Fisher's Exact test will be used when numbers are less than five. The Taylor series 95% confidence limits are used for relative risks. The results are expressed as means (standard deviation) or proportions i.e. 7 / 10 (70%). A relative risk (RR) and 95 % confidence level is also given. Confidence interval (CI) differs from a p value because a p value is estimating the parameter by a single value whilst the CI gives an interval estimate of a population parameter for example we can be sure that at a 95% confidence level that parameter will fall within the population and only 5% will not. CI is used to express the reliability of the results. The closer the CI the more reliable is the results. If the CI does not include one, then we can be sure that the result will fall within the 95% CI. If the CI includes one, then the result falls outside the 95% significance parameter (Zar, 1984). Data are depicted by using a variety of graphical charts as well as tables (Goldstein & Healey, 1995).

3.7 Rigour of the study

Validity is the ability of an instrument to measure the variable that it is intended to measure (Brink, 2006). Reliability is the consistency and dependability of the research instrument to measure a variable (Brink, 2006). Lincoln and Guba's model (1985), identifies criteria and strategies for establishing trustworthiness. There are four criteria for establishing the trustworthiness of qualitative data: credibility, transferability, dependability and confirmability.

3.7.1 Credibility

When participants are involved the researcher needs to ascertain that the results are believable from the perspective of the participant as the participant is the only one who can justifiably judge the integrity of the results. Document analysis was done during phase A, B and C. In this case the researcher had to ensure that the interpretation of the written text is true as he is the one responsible for the interpretation there of. He further ensured credibility by using government legislation and policies that affect CPD for professional nurses and statistical health indicators from recognised sources (Denzin & Lincoln, 1994; Glaser & Strauss, 1967; Guba & Lincoln, 1985).

3.7.2 Transferability

Transferability refers to the measure to which the results of qualitative research can be conveyed to other circumstances. Transferability is principally the responsibility of the researcher who is generalizing the concept. The researcher enhanced transferability by describing the text context and the assumptions of the documents. A complete research design, method, and literature control is also provided to support transferability of the information (Denzin & Lincoln, 1994; Glaser & Strauss, 1967; Guba & Lincoln, 1985).

3.7.3 Dependability

Dependability is based on the assumption of repeatability. In other words if the documents would be analysed by another person would they obtain the same results. Dependability also refers to the stability of the analysis over time and conditions. Stepwise replication is possible because of the solid description of the research design, method and literature survey. The inquiry audit also ensures dependability as relevant supporting documents were analysed by the researcher (Denzin & Lincoln, 1994; Glaser & Strauss, 1967; Guba & Lincoln, 1985).

3.7.4 Confirmability

Confirmability is a concept that refers to the objectivity or neutrality of data between two or more independent people about the data's meaning. It presumes that the researcher brings a unique perspective to the study. Confirmability is the concept that refers to the degree to which the results could be authenticated or substantiated by other readers. In other words would the documents be interpreted the same way if it was done by another researcher. The researcher documented the procedures of how he analysed the data Denzin & Lincoln, 1994: Glaser & Strauss, 1967; Guba & Lincoln, 1985).

3.7.5 Content validity (Phase D)

“The degree to which the items within a research instrument or measurement tool represent the universe of content for the concept being measured or the domain of a given behaviour” (Mosby, 2009). The questionnaire was tested for content validity to ensure that it test for what it set out to be tested. In other words proof of evidence to show the degree to which the content of the questionnaire matches the outcome that needed to be measured.

3.7.6 Face validity

Face validity is the extent to which an instrument looks as though it is measuring what it purports to measure (Polit&Beck, 2006). The questionnaire should have face validity, be friendly, clear, not overloaded and the questions equally spaced. The content and face validity need to be tested. Piloting of the questionnaire was done to ensure face validity. Piloting of the questionnaire also assisted in clarifying complex words and questions, which could have created misunderstanding and distraction. The position of questions were carefully selected. This reason is that it is important first to lead the respondents to the questionnaire by asking non-threatening, easy -to -answer questions before asking sensitive questions. There were no known external factors such as political, cultural, time related or, respondents' environmental factors that could have influenced the quality of the

responses at the time of the survey. The possible fear of being identified decreased when using a postal survey as there is no face- to- face contact.

3.8 Pilot study

A pilot study refers to a “small scale preliminary study conducted before the main research in order to check the feasibility or to improve the design of the research” (Haralambos and Holborn, 2000). The pilot study was carried out on members of a similar population, but not on those who formed part of the final sample. The reason is because the results of the pilot subjects may influence the later behaviour of if they have already been involved in the research. The results of the pilot study are presented in chapter seven.

3.9 Ethical considerations

Ethical clearance to conduct the study was obtained from the Senate Higher Degrees of the University of the Western Cape. The execution of the project was based on the principles of Good Clinical Practice and the Democratic Nursing Organisation of South Africa’s standards (DOH, 2000; Denosa, 1998).

3.9.1 Quality of the research

The research adhered to the highest possible standards of research planning, implementation and reporting. The researcher approached the research with integrity including the supportive and opposing views in the literature survey and remained aware of personal biases and values. The research was conducted honestly at all stages of the process. All the findings were reported fully without omission of significant data and included full details regarding research methods and designs used.

3.9.2 Confidentiality and anonymity

The data obtained in the questionnaire from the participants was protected in the report by making it impossible to link the data to a specific person. If anonymity

was threatened at any stage, all the research records will be destroyed. Only the researcher and data capturer saw the returned completed questionnaire.

3.9.3 Privacy

There were no face to face interviews with participants so there was no need to ensure privacy.

3.9.4 Consent

Informed consent was obtained from the participants when they agreed to submit the completed postal questionnaire

3.9.5 Harm

No physical or psychological harm was expected as only postal questionnaires were used and no sensitive questions are asked.

3.9.6 Termination

Research would be terminated if it no longer adhered to the standards set out in the planning. The participants in the questionnaire have a right to be informed of the research results or outcomes. The participants were guaranteed anonymity so it would not be possible to inform them individually. An article will be submitted to a SA nursing journal as well as to the Nursing Update magazine to inform the participants collectively of the results of the study. This will be done once the results of the thesis for the doctoral degree is known.

3.10 Summary

In Chapter three the research methodology was discussed with specific reference to the development of a model for CPD for professional nurses in South Africa. Steps to ensure rigor and ethical considerations were discussed. The results of the pilot study will be referred to in chapter seven. The next chapter is phase A of

the research and deals with the review of international and national CPD practices used for healthcare professionals



Chapter four
Phase A of Research
Review of International and National CPD practices used for healthcare professionals

4.1 Introduction

International and national literature and policy documents related to CPD are reviewed in chapter four. Several CPD systems were identified and reviewed from many countries, but the researcher decided to concentrate on CPD recommendations from the World Health Organisation and CPD systems available in the United Kingdom (UK), United States of America (USA), Canada, and Australia. The CPD systems available in Ireland, New Zealand, Saudi Arabia and other eastern countries have not been discussed due to the similarities of these systems in relation to those already chosen for review. The researcher also reviewed CPD systems currently available in South Africa even though they are not specifically related to nursing but to other health professionals registered with the Health Professions Council of South Africa (HPCSA).

4.2 World Health Organisation (WHO) and CPD

The World Health Organisation (WHO) is a world body concerned with the health of the human inhabitants globally and is based in Geneva, Switzerland. They provided information on continuous education (CE) of the health worker and the development of a system from as far back as 1988. WHO encourages that all countries worldwide to design their own system of continuing education as there is no ideal model of CE to adopt (WHO, 1988). WHO (1988), states that a system is “the sum of educational activities, the organisational structure which supports and manages those activities, the relationship between educational activities, the management, and agencies that provide healthcare such as the Ministry of Health”(WHO,1988 p.1).

Similarly to the USA, the WHO refers to CE rather than continuing professional development. In this context CE refers to all the experiences, knowledge and skills gained after the initial training until retirement age. Continuing education is concerned with a wide range of competencies and not only knowledge that helps to maintain or learn new competencies. The CE definition is similar to CPD definitions of other countries like the UK, USA, Canada and Australia.

The WHO asserts that health workers do have opportunities to continue their education however these opportunities are fragmented and uncoordinated. They emphasize the necessity to develop an appropriate CPD system before CPD is implemented. They recommend that CPD should be a nationwide co-ordinated programme and motivate for the collaboration with professional associations, worker unions, the community and the health workers, when implementing a CPD model.

4.2.1 Aims of the WHO's continuing education system

The aim of the WHO continuing education policy is to improve performance in the delivery of healthcare. They support promotion of health and prevention of disease and more specifically the improvement of health in communities. WHO states that CPD assists to maintain and improve competencies by increasing knowledge, skills, attitudes and ethical values that will result in safe and efficient health for all (WHO,1988).

4.2.2 Essential CPD components recommended by WHO

Role players

Government	Ministry of Health
All health care workers	Pharmaceutical companies
Health service managers	Professional associations
Worker unions	Publishing companies
Community members	Higher education institutions
Nursing education institutions	

WHO emphasizes the commitment of governmental institutions regarding CPD and believes that the Ministry of Health is the main employer of health workers and therefore should take the responsibility for the health of the population. They recognize that managers of health settings play an important role and recommend that managers be involved in the facilitation of CPD (WHO, 1988). Pharmaceutical companies are well known for playing a central role when it comes to updating health professionals regarding new medication or new adverse effects of medications.

It is understandable that all health workers and specifically nurses are part of the role players when decisions are made on the implementation of CPD. Role players who are not often mentioned are publishers of scientific journals (WHO, 1988). They also need to be involved as it is important that the work that they publish on current issues, statistics, illnesses and management is peer reviewed.

A further important and often forgotten role player is the members of the community as they are the consumers of the services delivered by professional nurses (WHO, 1988). They need to set their own standards to inform the healthcare worker what level of competency is expected from the professional nurse when they are visiting the healthcare facilities.

Higher education institutions and nursing education institutions such as nursing colleges usually are the forerunners when it comes to the updating of knowledge. These institutions are numerous and provide a variety of activities covering many topics regarding health related aspects. Worker unions and professional organizations have become more involved in CPD issues and will often present or request courses related to conditions of service to update their members (WHO, 1988).

Input

According to WHO (1988), legislation is a vital input for making appropriate policies and rules for continuing education. The Government has a duty to promulgate

legislation and this will provide regulations and policies regarding CPD. Without rules and regulations CPD cannot be enforced (WHO, 1988).

Throughput

The actions which will aid in the input factors being converted to the necessary outputs for continuing education include professional nurses actively participating in learning experiences such as health promotion presentations, workshops, meetings, writing articles, self-assessment, courses, self-study, and problem solving. However, this is not a conclusive list as health workers also conduct research and present findings (WHO, 1988).

Output (outcomes)

The output of the system must be the outcomes that will be reached with continuing professional development. These are namely, competent health workers, promotion of health and prevention of disease, improved healthcare performance and improved health status of community (WHO, 1988).

4.3 International CPD systems

The following countries CPD systems were reviewed: United Kingdom, United States of America, Canada, and Australia. Other country's systems were reviewed but due to the similarities they were not included in this discussion.

4.3.1 Aims of the United Kingdom (Britain, Scotland, Wales, and Northern Ireland) CPD system.

The Nursing and Midwifery Council (NMC), previously known as the United Kingdom Central Council (UKCC), governs Nursing in Britain, Scotland, Wales and Northern Ireland. The UKCC implemented the Post-Registration Education and Practice (PREP) document to assist the growth of CPD development.

Their aims are to demonstrate:

That the nurse has maintained and developed professional knowledge,

That the nurse demonstrates the development of new skills,

That the nurse has maintained and developed professional competence

That the nurse completes a portfolio for auditing/renewing registration (re-licensing) (UKCC, 1999).

Role players

Professional nursing bodies	The government
Nurses	The National Health Service (NHS)
Employers of healthcare workers	Education providers

The UKCC recommend similar role players as WHO but they include the National Health Service as one of their role players.

Inputs are:

The standards which all registered nurses must meet in order to renew their registration. By meeting the standard, the nurse is demonstrating that he or she has maintained and developed professional knowledge and competence (UKCC, 1999). Policies from other government departments, for instance the department of education and employment also affects CPD of nurses. Policies from other employers besides the government also influence the CPD requirements for nurses.

The UKCC acknowledges the importance of governments but emphasizes the importance of companies that employ nurses. These companies may also implement additional policies that the nurses need to ensure completely that CPD requirements are met.

Throughputs (processes)

The UKCC implemented a process of “Post Registration and Practice Standards (PREP)” to assist the throughput. This requirement consists of two separate aspects, both relate to registration. One is that in order for nurses to renew their registration with the NMC, all nurses should have undertaken CPD over the previous three years. This aspect is called the PREP (CPD) standard.

The second aspect is that in order to be able to renew registration, nurses, must have worked in some capacity in relating to their nursing, qualification for at least 750 hours during the past five years. Alternatively they must have completed an approved “return to practice course” (UKCC 1999). The process that UKCC has implemented is the “PREP Continuing Professional Development Standards”. The PREP (CPD) standard consists of three requirements. Firstly, a requirement to undertake at least five days (35 hours) of learning activity relevant to the specific work environment of the nurse. The 35 hours needs to be completed three years prior to renewal of registration.

The second requirement is to meet the “PREP Continuing Professional Development Standards” which infer the maintenance of a personal professional profile (portfolio) that record all the learning activities of the nurse in the previous three years. This portfolio is an extremely important document as it is the nurses evidence of having participated in CPD.

The third requirement is that any nurse needs to comply with a request for auditing their portfolio by the NMC. In other words, the UKCC does not audit every portfolio, but when it is requested, the nurse needs to immediately submit it for the auditing process. For auditing, nurses must comply with PREP (CPD) standards. The NMC has committed to audit random samples of portfolios each month starting in 2001. Nurses in the random selected sample are asked to complete a PREP (CPD) form describing the nature and outcomes of one of the learning activities they have undertaken during the past three years. The NMC will be auditing how the individuals in the sample have utilized the learning acquired from the CPD activity (UKCC, 1999; Quinn, 2000).

The NMC provides guidelines regarding the “PREP’S personal professional profile (Portfolio). Whilst the NMC has not approved a specific format, they recommend that the portfolio should be adequately constructed and should at least address the following:

Factual information about the nurse, e.g. qualifications, employment record, awards, scholarships etc.

A self-appraisal of professional performance, i.e. self reflection and self evaluation.
Action plans, goals and outcomes relating to the self appraisal.

Records of formal continuing learning, such as short courses, study days, conferences etc.

Records of informal or unstructured learning, such as reading books, journals, observing other practitioners, in-service education etc.

Record of hours worked within the three year period between registrations (Quinn, 2000).

Output (outcomes)

The nurse needs to be able to provide evidence of developing and maintaining professional knowledge, professional competence, and the development of new skills. He or she also needs to assemble a portfolio of evidence and have this ready for audit purposes upon request. The expected outcome of the random audit is to check for compliance to PREP's Continuing Professional Development Standards. Even though the portfolio is only audited at random it is still required for each nurse in order to renew his or her registration (re-licensing) (UKCC, 1999).

4.3.2 United States of America (USA)

The USA has a federal form of government which means that each of the 50 States has a State Board of Nursing. The USA has an established system of Continuing Education (CE) for all its workers. The American Nursing Association (ANA) was one of the first organizations in 1985 to adopt the United States Council on Continuing Education Units' (CEU's) mandatory CE recommendations. Many of the 50 States require some form of CE for licence renewal (Continuing Education requirements by State / Territory, 2001-2002). The state requirements range from a few hours of CE to 30 hours every two years (Huston, 2006) (Table 4.1).

The ANA requires that all nurses subscribe to their four philosophies for CPD. The ANA believes that firstly, professional development needs are influenced by the nurse's acceptance of accountability and responsibility for their own practice. The

second aspect is that lifelong learning is essential for nurses to maintain and increase competence in their nursing practice. The third aspect is that many educational options are necessary to meet the diverse needs of the nursing population. The fourth aspect is that nursing CE should be based on adult learning principles. By promoting these philosophies, the ANA aims to increase individual nurse accountability and responsibility in hopes that he or she will provide competent and safe care to the public (ANA, 2000).

Role Players

Registered nurses	State Boards of Nursing
The American Nursing Association	Employers of nurses
The Council on the Continuing Education Unit's (CEU's).	

The ANA regards the United States Council on Continuing Education as an important role player. The Council on the Continuing Education Unit's (CEU's), is a national body that regulates all continuing education, not only that related to nursing. However, the ANA assists registered nurses in remaining competent by developing standards of professional practice. The ANA also provides CE programmes, influences changes regarding nursing acts as well as other legislations and policies. State Boards of Nursing are responsible for the protection of the health and safety of the public by maintaining the licensing procedure for nurses. The boards also interpret, administer and enforce acts, rules and regulations. The employers of nurses are obligated to provide an environment of high quality care and safety to the sick. These employers must ensure ongoing competencies of their nurses (ANA, 2000).

Inputs are:

Nurse practice acts, rules and regulations of each state

Standards for Competence

The CPD requirements in many states for re-licensing.

The American Nurses Association's Scope and Standards of Practice for Nursing Professional Development.

The American Nurses Association's Standards of Professional

Performance for Nursing Professional Development.

Adult learning principles

The annual requirements for CE hours vary between the states, with 50 minutes representing one contact hour (Continuing Education requirements by State / Territory, 2001-2002; Casey, 1991; ANA, 2000). The ANA sets six standards against which it can measure the effective provision of CE offerings together with criteria for the achievement of each:

Standard 1 Assessment. The CPD educator collects relevant information from various sources related to potential educational needs of the nurse.

Standard 2 Diagnosis. This is done by analysis of the assessment data to determine the target audience and learner needs.

Standard 3 Identification. Educational outcomes are identified whereby the CPD educator recognizes the general purpose and educational objectives for each learning activity.

Standard 4 Planning. The CPD educator identifies and collaborates with content experts to develop activities to facilitate learner's achievements of the educational objectives.

Standard 5 Implementation. The planned educational activities are implemented.

Standard 6 Evaluation. The CPD educator conducts a systematic, ongoing, comprehensive evaluation of the educational activity (ANA, 2000).

In all the reviewed CPD systems the USA is the only country that has a category for a CPD educator. The CPD educator drives the process and the compulsory CE is a feature of why nurses in many states undertake their CPD activities.

Throughputs

Throughput is the process by which the CE system converts energy inputs from the healthcare environment into products or services such as a nurse who is

competent in knowledge, skills, attitudes and values. In order for the nurse to become competent, many appropriate CE activities can be utilized. The courses of CE must be relevant to the practice of nursing and be related to scientific knowledge or skills required and are related to direct / indirect patient care and learning experiences are expected to enhance the knowledge of the professional nurse at a level above that is required for licensure. Courses in nursing administration, education, management, research and other functional areas of nursing are acceptable (Delonghery, 1991). All levels of nurses must have CE in areas where nurses identify needs because all individuals have different learning needs (Delonghery, 1991).

A variety of methods are used to obtain CE credits. Some of the methods are:

Seminars	Conferences
Symposiums	Workshops
Home study	Teleconferences
Clinical practices	Self directed projects

(Delonghery, 1998).

Output (outcomes)

The output is the outcome or result of the systems throughput. The output in this instance is a competent nurse. The following are seen as the outcomes of the ANA CE system.

Nurses are accountable and responsible for their own nursing practice.

Nurses are able to provide competent care.

Nurses are able to provide safe care.

Nurses are able to provide quality healthcare with a view to improve the health of public.

Nurses are able to renew registration (licence to practice) because of compliance.

A summary table of requirements in different states in America.

Table 4.1 CE requirements in some states of America

State	Hours of CPD	Compulsory topics	Reference
California	30 hours every 2 years	None	California Board of Registered nursing (2004).
Florida	25 hours every 2 years	1 hour for HIV; 1 hour for domestic violence	Continuing Education requirements by State / Territory (2001-2002).
Indiana	None	None	Indiana Health Professions Bureau (2004).
Iowa	36 hours for a 3 year license & 24 hours for less than 3 year license	None	Iowa Board of Nursing (1998).
Michigan	25 hours every 2 years	None	Michigan Nurses Association (n.d)
Minnesota	24 hours every 2 years	None	Minnesota Board of Nursing (n.d)
Montana	None	None	Montana Board of Nursing (n.d)
New York	not specific	4 hours on infection control every 4 years, 2 hours on child abuse	Office of professions (2000).
Ohio	24 hours every 2 years	1 hour on law & rules in nursing practice	Ohio Board of Nursing(n.d.)
Texas	20 hours every 2 years	None	Texas Board of Nurse examiners (2003).

4.3.3 CPD system of CANADA

Canada is made up of 10 provinces and three territories. Only the Ontario CPD system will be discussed, as the CPD systems in the other provinces are very similar. In Ontario, the College of Nurses of Ontario (CNO) is the provincial regulatory body, which regulates nursing to protect the public interest, and CPD is referred to as quality assurance programme (CNO, 1996).

4.3.3.1 Aims of the Ontario CPD system

The aim of the CPD system of Ontario is to ascertain that the professional nurse maintains the standards of nursing by updating his or her knowledge and skills in order to render a competent service to the public. This enables the nurse to comply with legislative requirements and standards of practice (CNO, 1996).

Role players

Professional nurse	Community
Government	Employers
Education providers	College of Nurses of Ontario

Often, professional nurses, educators and experts are consulted for input regarding the quality assurance system as set up by the CNO (CNO, 2006). The government has the overall responsibility of making the laws of Canada however, the main legislation relating to CPD is the Regulated Health Professions Act of 1991 (RHPA, 1991). Education providers and employers are responsible for providing appropriate courses for the nurses in order to increase awareness and competency.

Inputs are:

The Regulated Health Professions Act
 The CNO's Quality Assurance (QA) programme
 Self-Assessment Tool
 Adult learning principles

The Regulated Health Professions Act (RHPA) requires that nurses formally examine their nursing practice to ensure ongoing competence (RHPA, 1991). To comply with the RHPA, the CNO introduced the QA programme, which involved self assessment tools underpinned by principles of the adult learning (CNO, 1996).

Throughputs are:

Self-Assessment Tool
 Professional standards

The Self-Assessment Tool is a tool based on self reflection. This tool is only one of many methods that can be used by professional nurses to meet the Quality Assurance programme of the CNO (CNO, 1996). Ontario's self reflective approach guides the professional nurse through a five - step process. The first step involves a self-assessment of her or his own performance in nursing practice. The

professional nurse is required to obtain feedback from her or his fellow workers on aspects related to his or her work performance. This second step is important as it offers the professional nurse the opportunity to evaluate his or her own performance against that of what colleagues think about their work capabilities. The third step involves the creation of an annual learning plan, based on the self - assessment and the feedback obtained. Implementation of the learning plan, which may involve the attending of learning activities, is then processed in step four. The last step involves the evaluation of new knowledge and skills that the professional nurse has learned and the impact that they make on her or his practice (Witmer & Cullum, 1999; CNO, 1996). The self-assessment tool, which promotes learning, is based on six professional standards. Nurses in Canada have to provide a professional and competent service while striving to improve the quality of practice. Nurses are accountable and responsible for their acts and need to uphold the ethical standards of the profession (Table 4.2).

Table 4.2 Professional standards of CNO

Professional Service to Public	Each nurse provides, facilitates, and promotes the best possible professional service. The Nurse responds to the needs of consumers in a way, which fosters trust, respect and collaborate and innovation.
Knowledge	Each nurse possesses and continually acquires knowledge relevant to the professional service she or he provides
Application of knowledge	Each nurse possesses and continually strives to improve the application of knowledge
Ethics	Each nurse understands, upholds, and promotes the ethical standards of the profession
Continued Competence	Each nurse maintains competence while striving to improve the quality of his/hers patients dimensions of practice
Professional behaviour – Accountability / Responsibility	Each nurse is accountable to the public and responsible for ensuring that his / her practice and conduct meet legislative requirements and standards of practice

(CNO, 1996).

Outputs are:

Competence

Professional service to public

Knowledge acquired

Ethical standards upheld

The professional nurse provides, facilitates, and promotes the best possible professional service and will endeavour to continually acquire new knowledge and ensure competency in his or her practice. The nurse responds to the needs of consumers in a way, which fosters trust, respect, collaboration, and innovation. While she or he continually strives to improve the application of knowledge she or he understands, upholds and promotes the ethical standards of the profession. Quality assurance also means that each nurse is accountable to the public and responsible for ensuring that his or her practice and conduct meet legislative requirements and all the standards of practice (Witmer & Cullum, 1999).

4.4 CPD system of Australia

Australia is a vast country with six states and two territories. The Australian Nursing and Midwifery Council (ANMC) is the national body for professional nurses and each of the six states and two territories are represented in the ANMC. All categories of nurses are regulated and accountable to the society for providing high quality care through safe and effective nursing practice. The ANMC developed national standards and codes as a framework to ensure that nurses practice evidence-based nursing care. The ANMC National Competency Standards for Registered Nurses are one of the sets of standards that guide the overall nursing practice in Australia. Each state and territory has its own Nursing Regulatory Authority (NRA) that oversees compliance of professional nurses with the competence standards. CPD is often referred to as continuing competence in Australia.

4.4.1 Aims of the Australian CPD

CPD for Australian nurses is aimed at maintaining continuing competence and improving nursing practice by a process of self-assessment. Professional nurses

need to submit a signed statement of declaration to the ANMC where they declare their continued competence to practise as a nurse in the current area of work. This declaration is needed in order for the professional nurse to obtain a renewal of the annual licence to practice. Professional nurses also need to submit a portfolio of evidence for auditing by the ANMC when requested (ANC, 2001).

Role players

The Australian Nursing and Midwifery Council (ANMC)

The Royal College of Nursing of Australia (RCNA)

Nursing Regulatory Authority

The education providers

Professional nurses

The employers

The public

The professional bodies in Australia are the ANMC and RCNA. These two professional bodies represent the interests of nurses and midwives as well as all issues related to CPD in Australia. The public includes people that receive care when they are sick and expect that health professionals, including nurses, maintain their competence to practice (ANC, 2001). The employers of nurses are responsible for providing their employees with adequate resources in order to complete their CPD requirements. The providers of educational courses should make sure that the courses are relevant, current and affordable.

Inputs are:

The government

Competency Standards for the registered nurses in Australia.

The Code of Ethics for nurses in Australia.

Nursing Regulatory Authority (NRA)

As with most other countries, the input is related to legislation, policies and principles. The government of Australia is responsible for all the legislation affecting nurses whilst it is the responsibility of the NRA to regulate nursing in the six states and two territories. The nurses of Australia subscribe to a code of ethics.

The “Competence standards” for registered nurses in Australia is the main guideline that informs CPD for professional nurses. These standards cover issues related to the contemporary role of professional nurse, management of care, counselling, health promotion, and client advocacy, facilitation of change, clinical teaching, supervising, and mentoring. The competence standards of the ANC may also be used for academic assessment, workplace performance review and measuring of continuing fitness to practice. It further reflects the unique characteristics of the nursing as well as broader attributes nurses have in common with other professions and occupations.

Throughputs are:

Participation in learning activities	Professional development
Education courses	Self - assessment
Declaration of competency	Supervised clinical experience
Networking	Mentoring

Throughput entails participation in informal and formal learning, the utilizing of evidence based practice, research, and professional activities. The professional nurse is responsible for recording her or his own professional development. A process of self-assessment is required which includes reflection, critical incident analysis, peer reviews, and evaluation of client outcomes. Professional nurses have to sign a statement of declaration of their continued competence to practice as a nurse in the current area of practice. This signed statement is a legal requirement before they can receive their annual practising certificate (license). (ANC, 2001).

Outputs are:

Competence	Approved declaration
Completed portfolio	

The professional nurse needs to maintain competence by developing a portfolio with evidence of CPD. She then needs to submit the portfolio for auditing purposes to the appropriate regulating authorities. This portfolio provides evidence that the professional nurse takes responsibility of maintaining her or his own knowledge and improves his or her practice by utilising evidence-based nursing care. When the nurse reapplies for his or her annual licence, he or she needs an approved, signed declaration stating that he or she will maintain their competency by continually seeking improvement. The approved signed statement of declaration serves as evidence that the practitioner has promised to comply with all the CPD requirements (ANC, 2001).

4.5 CPD system of South Africa

The current Health Professions Council of South Africa (HPCSA) is a statutory body, established in terms of the Health Professions Act No. 56 of 1974. The HPCSA, together with the 12 Professional Boards that operate under its jurisdiction, is committed to:

Promoting the health of South Africa's population,

Determining standards of professional education and training, and

Setting and maintaining fair standards of professional practice

(HPCSA, 2002).

There are approximately 21 categories of health professionals in South Africa. Most of these health professionals' register under the Health Professional Council of South Africa, but nurses and midwives register with the South African Nursing Council (SANC). There is currently no CPD system for nurses in South Africa. The medical and dental professions were the first to undertake mandatory CPD in South Africa. Thereafter CPD was introduced by various boards within the HPCSA and currently eight of the 12 boards have implemented compulsory CPD for their members. CPD points vary among the different boards registered with the HPCSA.

The 12 professional boards represented on the HPCSA are:

Medical and Dental Professions Board (30 continuing education units, of which at least five must be on human rights, ethics and medical law, within every year).

Professional Board for Speech, language and Hearing professions (30 points annually).

Professions Board for Optometry and dispensing opticians.

Professional Board for Dental Therapy and Oral Hygiene.

Professional Board for Dietetics (50 CPD points annually).

Professional Board of Radiography and Clinical Technology (20 CPD points annually).

Professional Board for Environmental Health practitioners.

Professional Board for Medical Technology (50 CPD points annually).

Professional Board for physiotherapy, podiatry, biokenitics (30 CPD points annually).

Professional Board for Occupational Therapy and medical orthotics and prosthetics (50 CPD points annually).

Professional Board for Psychology.

Professional Board for Emergency Care Practitioners (CPD voluntary at present) (HPCSA, 2002).

The original implementation of CPD had several problems, especially related to systems and administrative issues. Some administrative problems encountered were the HPCSA website, whereby there was an electronic delay in obtaining certificates of attendance from the providers of CPD and inaccuracy of the attendance data (HPCSA, 2004). The HPCSA has reconfigured its continuing professional development programme in July 2007 to ensure it addresses the ultimate objective of the philosophy of continuing professional development namely 'the acquisition of new, current knowledge and measurable professional skills, with an end benefit to the patient or client' (HPCSA, 2008).

4.5.1 Aim of the CPD system of the HPCSA

"Guided by the principle of "beneficence", healthcare professionals aspire to standards of excellence in healthcare provision and delivery. The Health Professions Act, 1974 (Act No. 56 of 1974) endorses Continuing Professional

Development (CPD) as the means for maintaining and updating professional competence and for ensuring that the public interest will always be promoted and protected or ensuring the best possible service to the community. CPD should address the emerging health needs and be relevant to the health priorities of the country” (HPCSA, 2005).

Role players

The government	The Professional body (HPCSA)
The education providers	The National Department of Health
The community	The employers
The medical doctors, dentists and all allied practitioners registered with the HPCSA	

There are various role-players in the CPD system of the HPCSA. The reason for this is that there are many health professions represented on it. The government has an interest in that it has to provide healthcare to its citizens, is an employer of health professionals and makes the laws which affects the health professions. The community is a role-player by virtue of being a healthcare consumer and expects competent professionals to take care of them when needed. The education providers have to provide courses to practitioners in order for them to meet their CPD needs.

Inputs are:

- The Health Professions Act, 1974
- The HPCSA as the professional body
- The Health Act, 2003

The Health Professions Act, 1974 (Act no. 56 of 1974), in section 26, states that the council may from time to time make rules which prescribe conditions relating to continuing education needed to retain registration with the council (HPCSA, 2005). The HPCSA affirms that the CPD system will be administered by the CPD division of the registrations department of the HPCSA and that the implementation of CPD will be delivered by approved accredited service providers. Service providers need to present learning activities and events throughout the year. They propose that

individual practitioners shall attend CPD activities in order to comply with the statutory requirements as determined by the council and that practitioners shall keep a record of their CPD activities. The individual professional boards will ensure that high standards are set and maintained for their accredited service providers (HPCSA, 2005).

Throughputs are:

Accredited providers
Development of portfolio
Certificate of attendance
Continuing education units

All learning activities attended for CPD must be from accredited providers except for activities of level 1 (see below). Individual health professionals must retain a certificate of attendance from the accredited service provider and keep a record of activities attended and the Continuing Education Units (CEU's) accrued. These activities need to be collected over a two year period. A portfolio of evidence needs to be compiled by the individual and be submitted to the HPCSA for audit purposes on their request (HPCSA, 2005). HPCSA allocate Continuing Education Units (CEU'S) or values to specific learning activities for CPD. It is requested from every registered practitioner to accumulate 30 CEU's over a 12 month period (HPCSA, 2005).

The learning activities of the HPCSA are categorized in three levels:

Level 1 CPD learning activities include small group discussions or breakfast meetings and presentations, formal hospital or inter- departmental meetings or updates, case discussions, formal ward rounds, formal lectures, mentoring, supervision, conferences, symposiums, refresher courses, and short courses (HPCSA,2005).

Level 2 entails CPD learning activities surrounding education, training, research and publications. Level 3 CPD learning activities are structured formal programmes by an accredited training institution with measurable outcomes.

These include post-graduate degrees and diplomas, short courses and portfolios (HPCSA, 2002). There is a detailed list of specific activities that a health professional undertakes during the course of her or his work that does not qualify for CEU's. The list is made available to the practitioners in order to avoid misunderstandings about what will be credited or not as a CPD activity (HPCSA, 2002).

The issue of non-compliance to CPD requirements of the HPCSA could range from receiving a letter requesting reasons, having an inquiry, an examination, working under supervision and any other action that is recommended by the professional board concerned (HPCSA,2005). There are also rules for special circumstances such as deferment. Practitioners who are out of the country, retired, ill, in non-clinical practice, community service or voluntary removal from register can request deferment. Restoration to the register as a clinical practitioner maybe requested when needed and when the person complies with needed requirements for re-registration (HPCSA, 2005).

Outputs are:

Development of profession
Improvement of patient care
Competent practitioner

The intended outcome for the CPD system for HPCSA is to produce safe and competent practitioners who maintain and acquire new knowledge, skills and ethical attitudes that promote professional integrity. Competent practitioners will result in the improvement in standards of patient care (HPCSA, 2004).

4.6 Summary of CPD systems

Table 4.3 summarizes the different CPD systems that were reviewed. Replication of characteristics of the CPD systems has been excluded due to the fact that there are aspects that are common in most countries CPD systems.

Table 4.3 Summary CPD

Aims	<p>To promote health and prevent disease and more specifically the improvement of health in communities.</p> <p>To maintain and improve competencies by increasing knowledge, skills, attitudes and ethical values that will result in safe and efficient health for all.</p> <p>To demonstrate the development and maintenance of professional knowledge, new skills and competence through the development of a portfolio of evidence.</p> <p>Have the professional nurse accept accountability and responsibility in order to improve the health of the public by providing competent and safe nursing care. Maintaining and updating professional competence and for ensuring that the public interest will always be promoted and protected or ensuring the best possible service to the community.</p>																				
Role players	<table border="0"> <tr> <td>Government</td> <td>Ministry of Health</td> </tr> <tr> <td>Professional healthcare workers</td> <td>Employers</td> </tr> <tr> <td>Health service managers</td> <td>Worker unions</td> </tr> <tr> <td>Pharmaceutical companies</td> <td>Publishing companies</td> </tr> <tr> <td>Community members</td> <td>Education institutions</td> </tr> <tr> <td>Professional nursing bodies</td> <td>Council for CE</td> </tr> </table>	Government	Ministry of Health	Professional healthcare workers	Employers	Health service managers	Worker unions	Pharmaceutical companies	Publishing companies	Community members	Education institutions	Professional nursing bodies	Council for CE								
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Input	<table border="0"> <tr> <td>Legislation (Acts)</td> <td>Policies</td> </tr> <tr> <td>Rules of the CPD system</td> <td>Adult learning principles</td> </tr> <tr> <td>Standards for competence</td> <td>Philosophy for CPD</td> </tr> <tr> <td>Self assessment tools</td> <td>QA programmes</td> </tr> <tr> <td>Scope and standards of practice</td> <td></td> </tr> <tr> <td>Return to practice program rules</td> <td></td> </tr> <tr> <td>Special circumstances such as deferment</td> <td></td> </tr> </table>	Legislation (Acts)	Policies	Rules of the CPD system	Adult learning principles	Standards for competence	Philosophy for CPD	Self assessment tools	QA programmes	Scope and standards of practice		Return to practice program rules		Special circumstances such as deferment							
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Certificate of attendance	CE units																				
Output	<p>Competent health workers</p> <p>Improved service delivery</p> <p>Improvement in health status of population</p> <p>Portfolio of evidence</p> <p>Improved accountability and responsibility</p> <p>Ethical standards</p> <p>Approved declaration</p> <p>Licence renewal annually</p>																				

Important additional information is the recommendation by WHO that countries develop their own model / system of CPD. The challenges associated with CPD relates to the cost effectiveness of CPD. It is important that the costs of assessments, developing, implementing and evaluation of CPD are effective in reaching the goal of competency and safety of the public (Delonghery, 1998).

Administrative systems need to work efficiently to record CPD. Ongoing evaluation of a system is needed to ensure that the programme continues to meet the goals. Evaluation includes measuring the impact on the learner, the service and the public's health (Delonghery, 1991).

It is a general viewpoint that CPD is seen as a method to strengthen competence. Although the methods differ in each country the end product is always similar in that there is a common understanding that CPD is directed to improve the individual to maintain competency and to be updated with the latest knowledge and skills. Ethics is also a high priority in all the CPD programs.

4.7 Summary

Chapter four gave an overview of different CPD systems internationally and locally. WHO recommends that each country should have its own system. The NMC have a CPD system based on Post Registration Education and Practice (PREP) standards and maintaining a Personal Professional Profile (PPP) record of the learning activities. The American nurses have a comprehensive model with some states opting for mandatory CE whilst other states opt for a voluntary system. Of importance is that the USA has an established system of Continuing Education (CE) and CE educators. The Canadian model of CPD makes use of the reflective practice principles and a learning plan whilst Australia uses a national competency standards framework and a code of ethics that gives direction to professional nurse. The HPCSA uses continuing education units that include points allocated to updating in ethics.

Chapter five
Phase B of Research
Relevant government legislation and policies that influence CPD for
professional nurses

5.1 Introduction

A document analysis was done to evaluate the current South African government legislation and policies that influence CPD for professional nurses in South Africa. The aim of the document analysis was to determine the legal implications regarding CPD for professional nurses in South Africa. Only sections of South African legislation and policies related to CPD for nurses were reviewed and reported on in chapter four. The following documents were utilised:

Batho Pele White Paper.

Draft Document of Continuing Professional Development system for Nurses and Midwives in South Africa (2001).

National Health Act 61 of 2003.

National Human Resources for Health 2005.

National Policy on Continuing Professional Development (CPD) 2005.

Nursing Act 33 of 2005

Skills Development Act 97 of 1998.

Skills Levies Act 9 of 1999.

Each document was analyzed and relevant information extracted and commented on.

5.2 The Skills Development Act 97 of 1998 as amended 2003

The Skills Development Act (1998) allows for the formulation of an institutional framework strategy for implementation in the workplace. This Act supports the development and improvement of the skills of the South African workforce

including those of professional nurse. The Act requires that workplace skills development strategies be within the National Qualification Framework as reflected in the South African Qualifications Authority Act of 1995. The workplace is required to provide for learnerships that lead to recognized occupational qualifications. The workplace is also required to financially support learners to develop their skills via contributions made by the employers towards the levy-grant scheme regulated by the National Skills Fund (Skills Development Act, 1998).

The Skills Development Act (1998) makes provision for the establishment of education and training sectors. Twenty five Sectors Education and Training Authorities (SETA) has been established since 1998. The establishment of the SETA's is to assist in the implementation of requirements stipulated in the Skills Development Act and the Skill Levies Act. The Health and Welfare Sector Education and Training Authority (HWSETA) is of importance for nurses as it addresses issues related to CPD. HWSETA attempts to create an integrated approach to the development of appropriate skills for health and welfare workers that will enable workers to render quality services of world-class standards (HWSETA, 2002). The HWSETA has several education and training providers, which plays an important role in providing CPD for professional nurses.

Of relevance for the development of a model for CPD for professional nurse in the Skills Development Act is the concept of developing the skills of the South African workforce specifically in this case the professional nurse. The rationale is that if nurses get the opportunity to develop their nursing skills this will not only enhance the outcome of a better health for all, but more pertinently, it will also directly enhance the quality of life experience for the individual nurse. Increasing the development of skills will show the way to worker mobility through career pathing. Productivity in the hospitals and clinics will improve due to the competitiveness of employers to ensure that skills development is offered at a high level. It is anticipated that after full implementation of skills development in all public and private sectors there will be an increase in the levels of investment in education and training in the labour market.

The offering of short developmental courses to professional nurses will enhance their knowledge and skills, without jeopardizing the risk of neglecting clients by not being on duty. These courses are short in duration and can be offered on more than one occasion. Employees also do not necessarily need to leave the work place as the Act encourages employers to use the workplace as an active learning environment. Employers need to provide professional nurses with the opportunities to acquire new skills and need to encourage professional nurses to participate in training programmes. The Act also provides for quality assurance for the education and training in the workplace (Skills Development Act, 1998).

5.3 The National Health Act 61 of 2003

When the National Health Act 61 of 2003 was introduced, many professional nurses had been trained in the health services governed under the previous Act. An example of this is that nowadays, there is more emphasis placed on primary health care rather than curative health care. The structure of the present day health services is different from those in which the nurses trained and the emphasis now is on a National Health System (NHS) (NHA, 2003). The Department of National Health promotes adherence to norms and standards for the training of human resources for health (NHA, 2003). Professional nurses are human resources in health and the adherence to norms and standards in training must thus be promoted. Occasionally, due to remote rural training schools, or any other determining factors, the basic training of professional nurse may be insufficient. For example students who trained only at remote hospitals may never be exposed to heart or kidney transplants or even intensive care facilities. Another challenge may also be due the increasingly dynamic changes in practice and technology which cause many gaps in basic training. Ongoing skills development courses can close this gap. The National Department of Health can fulfil this role by ensuring that updates are done and that professional nurses do attend these updates. These updates can be included in CPD for professional nurses.

One of the functions of the Provincial Department of Health is to plan, manage, and develop human resources and to provide financial support to ensure that the nursing workforce can develop the needed skills to stay abreast of new technology. Provincial authorities educate and train certain categories of nurses at nursing colleges and may provide bursaries for nurses who wish to study at higher education institutions such as universities. Beyond providing for the facilities and bursaries to aid in basic training, they also have a responsibility towards continuing education and training of nurses to comply with CPD requirements for professional nurse (NHA, 2003).

The National Health Act (2003) also addresses the private health establishments. These institutions must also comply with all the quality requirements and standards that may relate to professional nurses including quality assurance of short courses or workshops that could lead to CPD (NHA, 2003). Chapter seven of the National Health Act states that the National Health Council must develop policy and guidelines for the development of human resources. Regulation 48 (2) refers to the issue that provision should be made for appropriately trained staff at all levels of the National Health Services to meet the populations healthcare needs (NHA,2003). This entails that professional nurses be regularly updated to meet the changing healthcare needs that arise in communities from time to time.

Section 51(a) deals with the education and training of healthcare personnel and states that the Minister of Health must ensure that adequate resources are available for the education and training of healthcare personnel. These include resources for continuing education and professional development. The Act also considers the challenges of shortages of key skills, expertise, and competencies. It prescribes strategies in respect of scarce skills as well as the training and education of new categories of healthcare personnel where appropriate and needed. It is important to note that there are shortages in certain specialist areas of nursing. These shortages may differ in the nine provinces but some of the specialist shortages are: Intensive Care Nursing; Operating Theatre Nursing; Oncology Nursing and Trauma Nursing (NHA, 2003).

5.4 Batho Pele White Paper

The Batho Pele White Paper (Notice 1459 of 1997), (DPSA, 1997). was communicated via the Department of Public Service and Administration and it is about the transformation of the delivery of public service by the government workers. The transformation is required in all the government departments. Batho Pele means, "People first" ,so the government workers such as nurses employed in public hospitals must put the "people first". Nursing is a profession that takes care of people and it is essential that they put the patients first. The public demands a legitimate expectation that they will be put first and nurses have to be complying with and respect this principle.

The eight principles of Batho Pele are:-

Principle 1: Consultation

Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered (DPSA, 1997).

Principle 2: Service standards

Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect (DPSA, 1997).

Principle 3: Access

All citizens should have equal access to the services to which they are entitled (DPSA, 1997).

Principle 4: Courtesy

Citizens should be treated with courtesy and consideration (DPSA, 1997).

Principle 5: Information

Citizens should be given full and accurate information about the public service they are entitled to receive (DPSA, 1997).

Principle 6: Openness and transparency

Citizens should be told how national and provincial departments are run. They need to know how they are financed and how the money is spent. They also need to know who is in charge not only of the facility but also of their care (DPSA, 1997).

Principle 7: Redress

If the promise of service is not delivered, citizens should be offered an apology from all involved. A full explanation should accompany the apology and a speedy and effective remedy must be brought forward. Professional nurses need to listen to complaints made by citizens with a sympathetic ear and should respond in a positive manner (DPSA, 1997).

Principle 8: Value for money

The Public Services should be provided economically and efficiently in order to give citizens the best possible value for money (DPSA, 1997).

In terms of the Public Service Act, 1994 (as amended by the Public Services Laws Amendment Act, 1997), the Heads of Public Departments will be held responsible and accountable to ensure that the principles are implemented in the services. Improving service delivery is a continuous and progressive process. There is an ongoing place for improvement. As standards are raised, so higher targets must be set. Most professional nurse work within the government service and have a statutory obligation to provide high standards of services. These standards can be reached by ongoing CPD and quality assurance.

5.5 National Human Resources for Health-2005

A Strategic Framework for the Human Resources for Health Plan was developed to guide managers to meet the country's needs (NHRH, 2005). It was designed to direct education and training institutions in the production of human resources for the National Health System.

5.5.1 Core guiding principles of human resources framework

There are core-guiding principles in the framework of which Principles three, five and eight are important for continuing professional development. South Africans must enjoy a reliable supply of skilled and competent health professionals for self-sufficiency (NHRH, 2005). Principle three attends to the planning for the development of nurses (human resources) and is linked to the needs and demands of the health system that must be strengthened (NHRH, 2005). The optimal balance, equitable distribution, and use of skilled health professionals to promote access to health services are dealt with in principle four (NHRH, 2005). Principle five reinforces the issue that health workers must have the capacity and appropriate skills to render accessible, appropriate and high quality care at all levels (NHRH, 2005). Principle eight relates to the global health dilemma and states that South Africa's contribution to the global health market must be managed in such a way that it contributes to the skills development of health professionals nationally and globally (NHRH, 2005). CPD is a convenient form of ongoing professional development to ensure that all professional nurses contribute to the success of the implementation of the Acts and White paper.

Important aspects that are mentioned in the strategic health plan is the human resource development phase which is concerned with the accessing and using of skills development resources, mentoring, leadership and career pathing (NHRH, 2005).

5.6 National Policy on CPD

In 1999, the forum of statutory health councils including SANC established a Continuing Professional Development (CPD) programme. This introduced the principle that all registered health professionals must update their skills on an ongoing basis by means of a range of professional development and activities such as, self and group study, publications, teaching and acquisition of additional qualifications (NHRH, 2005). They recommended that the impact of CPD programmes for health professionals must be evaluated on a five yearly basis for each of the health professional categories to ascertain whether the programmes

meet the needs of the country. A direct link on how the system improves the quality of services provided by health professionals should be implemented and should form the basis of assessment and evaluation. The SANC therefore has to ensure that the content of the CPD programmes addresses the gaps or challenges identified in service delivery, either in terms of skills or knowledge. The Statutory Health Councils concerned, in partnership with the National Department of Health, must establish a CPD monitoring system that will enable assessment of compliance and good performance by the practitioners in order to influence the Performance Management System as applied in the public health sector (NHRH, 2005).

5.7 Skills Development

A key human resources strategy should comprise of a comprehensive professional nursing skills analysis for different programmes and fields within the health sector. This should then be followed by an organized education programme. These specific educational programmes should address both initial or baseline education and continuing education. It is recommended that these courses be appropriately funded through skills development. Skills development funding is funding arranged by the Health and Welfare Sector Education and Training Authority (HWSETA). The HWSETA plays a major role in the improvement of skills of health workers. Funding of courses is a legislated function, and all contributors to the skills levy must be encouraged to apply for funding from the HWSETA so that staff can be sent to participate in skills development programmes. The evaluation of the impact of CPD should therefore also assess the extent to which the HWSETA indirectly contributes to improving the quality of health services (HRPH, 2005).

In summary the National Human Resources for Health Plan of 2005 suggested that there should be a reliable supply of skilled and competent health professionals. The ongoing training should be linked to the needs of the health system and professional nurses must have appropriate skills to render accessible, appropriate, and high quality care at all levels of the health services. The updating of skills and professional development are important and need to be implemented as soon as

possible. It is also recommended that CPD programmes be evaluated every five years in order to ascertain their efficacy in improving the burden of disease profile. It is essential that CPD programs address the gaps or challenges identified in service delivery, either in terms of skills or knowledge. A CPD monitoring system for assessment of compliance and good performance needs to be established.

5.8 South African Nursing Council (SANC) document analysis

The Nursing Act, 33 of 2005 and a Draft Document of Continuing Professional Development System for Nurses and Midwives in South Africa are analyzed in the following section (SANC, 2001).

5.8.1 Nursing Act, 2005 (Act No.33 of 2005)

The South African Nursing Council was established by Nursing Act, 2005 (Act No 33 of 2005).

Functions of the South African Nursing Council

Section 4 (1) (l) (iv) states that the council will “determine the requirements for any nurse to remain competent in the manner prescribed” (Act 33, 2005). The word “remain competent” is the essence and purpose of CPD worldwide. “Competent” would mean having sufficient knowledge, skills, attitudes and values that is adequate for the performance of nursing activities (Watson et al, 2002). Training (CPD) can improve competency (Muller et al, 2006).

Scope of the profession and the practice of nursing

Chapter 2, section 30 (1) states that “A professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice”. “A midwife is a person who is qualified and competent to independently practice midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice”. The words ‘independently practice’ means being self reliant as a professional and capable of making informed decisions regarding the patient’s care

(Muller et al, 2006). Confidence and competency can be obtained by regularly engaging in ongoing professional development through education and training. The words “capable of assuming responsibility and accountability for such a practice” refer to obligation of a professional nurse, to engage in CPD and being answerable as to what is learnt from the CPD activities (Muller et al, 2006).

Conditions relating to continuing professional development

Conditions relating to continuing professional development captured in section 39 of The Nursing Act No. 33 of 2005 read as follows:

“The Council may determine-

- (a) conditions relating to continuing professional development to be undergone by practitioners in order to retain such registration;
- (b) the nature and extent of continuing professional development to be undergone by practitioners; and
- (c) the criteria for recognition by the Council of continuing professional development activities and accredited institutions offering such activities.”

It is assumed that specific criteria will be set by SANC that will determine who, how, when, where and by whom continuous professional development will be done and offered. It can also be expected that the SANC will accredit courses and institutions that participate in offering activities that may count under CPD activities. Finally, it is hoped that some processes will be in place to ensure that professional nurses comply to CPD requirements before they re-register. It is not clear to what extent the SANC will require a specific number of hours for CPD to be completed or whether it will be based on hours or points.

In summary, one can anticipate the following:

A CPD system will be put in place. The system will determine who needs to comply with CPD. Accreditation of activities could be based on points or hours and activities can be in various forms. Only accredited institutions will be allowed to offer courses that count towards CPD and professional nurses will have to obtain a specific number of points or hours to enable them to re-register.

5.9 The Draft Document of a CPD system

A draft document on CPD for Nurses in South Africa (2001) states that the proposed year for implementation of CPD would be 2003. It is of concern to note that up to the completion of this thesis no regulation regarding CPD has materialized. With-holding CPD can compromise the community's right to safe nursing and midwifery care. It may also be regarded as a legal offence as the legislative requirement of the Skills Development Act 97 of 1998 states clearly that it is essential to develop the skills of the South African workforce and to increase the levels of investment in education and training and also to encourage employers to use the workplace as a learning environment. SANC forwarded the draft CPD system document to the researcher in 2004 when the council was informed about the researcher's intention to develop a CPD system for South African nurses. Principles were laid down on which the system was to be based and these were: validity, simplicity, realism, practicability, affordability and attainability.

The draft CPD system recommended that the following administrative factors be considered:-

The SANC will administer the CPD system.

The SANC will also appoint accreditors such as universities and colleges of nursing who will be responsible for accrediting and reviewing CPD activities of providers according to guidelines.

It was recommended that one hour will equal one CPD point.

The time requirements for submissions of CPD activities are not stated but 15 CPD credits per year will be required from both nurses and midwives to enable them to register.

In the Draft Document, there are specific recommended areas such as a focus section which addresses the ethical practice of nursing. It also points out areas that should be covered by CPD. A banking system was recommended whereby professional nurses who attained more than the prescribed points per year could carry points over to the following year. It was further suggested that those nurses returning to practice after a period of five years or more, must complete a "return to practice programme" of 40 CPD points.

The draft also covers opportunities where professional nurse may ask for deferment. However, it was stipulated that nurses practising abroad would not be granted exemption from CPD points. A list of various activities that could be recognized for CPD was included in the document. The most important aspect of the draft is that nurses should maintain and update their knowledge and skills. The CPD portfolio file is the evidence of what and how they have updated their knowledge and skills. On licensing annually, the nurse is required to complete a CPD statement. The appointed CPD officer at SANC could request a five percent (5%) random sample of nurses to submit their portfolios to be audited. Other than the draft CPD there was no further development about a CPD system from SANC.

5.10 Summary of principles obtained from document analysis

The following are the principles that were obtained from a document analysis of relevant Government policies and legislation:

The professional nurse must be competent in knowledge, skills, and attitudes and must have ethical values.

The professional nurse must be confident to carry out independent practice and this confidence can be enhanced by regularly engaging in meaningful CPD.

The professional nurse will have to engage in CPD in order to be capable of assuming responsibility and accountability in highly technologically and advanced 21st Century healthcare settings.

The professional nurse must have proof of having undertaken CPD activity in order to retain the registration or before a professional nurse can re-register after voluntary de-registration.

The SANC could prescribe the format which CPD activities can consist of such as seminars, workshops, short courses, articles etc.

SANC may also determine the hours that would constitute units or points.

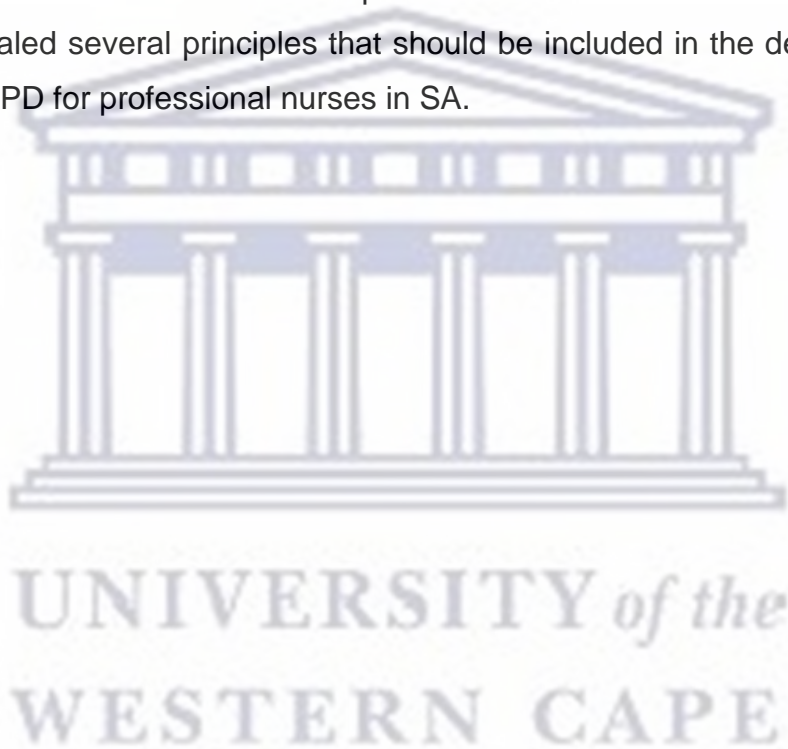
Specific measuring criteria will be used to accept an activity as a valid CPD activity.

The education providers offering CPD activities such as courses and programmes will need to be accredited if they wish to be recognized as a CPD provider.

The professional nurse must undertake CPD activities with accredited institutions or organizations and not with any institution as the effort will be not accepted towards CPD if activities were done at non accredited facilities.

5.11 Summary

Chapter five, which is Phase B of the research, consisted of a content analysis of documents relevant to government legislation and policies that influence the development of a model for CPD for professional nurses in SA. The document analysis revealed several principles that should be included in the development of a model for CPD for professional nurses in SA.



Chapter six
Phase C of Research
Health needs analysis

6.1 Introduction

Estimation of the burden of disease is indispensable to conduct effective planning and implementation of targeted interventions related to human resources and planning for continuing education and training. A community's needs are expressed in various ways and one is the health status of its members. Health needs can be summarised by using an epidemiological profile of the community's data on morbidity and mortality rates as well as health indicators such as the prevalence of specific diseases. If the data reveals a high morbidity rate in a preventable disease, such as measles, then CPD can be provided to nurses who provide immunisation or child health services. CPD would assist them to improve their skills and techniques in order that they improve the services and thus decrease the morbidity of the disease (Hooper & Longworth 2002; WHO, 1988).

Chapter six reflects on the health needs of the country as deduced from secondary data. The data from the following agencies are utilised:

Department of National Health

Statistics South Africa

Medical Research Council of South Africa

Health Systems Trust

South African Health review, 2004

Department of Health report on National HIV and Syphilis Antenatal zero prevalence, 2002

National HIV and Syphilis prevalence report 2008

Medical Research Council report on Chronic Diseases of Lifestyle, 1995-2005.

The above mentioned documents were assessed and information was extracted when it appeared to be relevant in referring to the burden of disease.

6.2 Health Needs of the Population

Health needs according to Searle (2000) are those signs, symptoms, and processes that devote the interaction of the individual the family, the group, the community with any actual or potential health problem that requires nursing interventions. Professional nurses are trained over a particular time period, currently four years. During their years of training specific health needs may be prevalent. Currently there are cholera outbreaks so student nurses receive information on cholera. The problem is that professional nurses who trained in other eras may have spent more time learning about polio or measles and are therefore not equipped to work with patients suffering form cholera. Some professional nurses may have learned about cholera but have forgotten how to manage the patients presenting in casualty. CPD is thus important to be in line with the current health needs. Thus the importance to recognise that health needs changes over time is a core component when engaging in CPD activities. The concentration of CPD activities need to relate on how to assist in illness prevention, health promotion, treatment, and rehabilitation of the population's prevailing health needs. Not only does the prevalence of a specific illness change over time, but new illnesses may develop, such as HIV and AIDS. The severity of the illness may increase such as tuberculosis (TB) changing to Multi drug resistant TB and later to extreme drug resistant TB.

Tuberculosis was treated with anti-tuberculosis drugs which had high success rates. Since the late 1990's there was the discovery of patients who were resistant to the mainline of TB medications. This resulted in Multi-drug resistant TB (MDR-TB). The high burden of TB in SA, especially the combination of TB and HIV, resulted in a steep increase in the incidence of MDR-TB (Bamford, Loveday & Verkuijl, 2004). A further problem is that MDR- TB in Africa may be more prevalent than previously stated and the evidence shows that the re-treatment failure rate was the most predictive indicator for MDR-TB. This could be addressed by training and educating Primary Healthcare Nurses who would come across this in their practice on a regular basis. The recent report of an outbreak of XDR -TB in South

Africa, with its extremely high case-mortality rate, has drawn wide attention to healthcare services (Amor, Nemser, Singh, Sankin & Schluger, 2008). The above demonstrate the importance of why CPD should be based on the most prevalent diseases. This does not mean that all nurses should be updated with regards to all trends and developments in the health scene rather, nurses should increase their competency in their field of practice.

6.3 The current burden of disease

The burden of disease does not only refer to causes leading to death. According to WHO (2005), many non-fatal conditions such as unipolar depressive disorders, adult onset of hearing loss and alcohol abuse should also be considered when the health needs of a country are considered. Considerable variations in the burden of disease are seen between the different WHO regions. Generally the WHO regions fall into two groups – those in which infectious diseases dominates, and those in which the burden of disease is dominated by vascular disease and depression. It is well known that HIV and AIDS together with lower respiratory infections and diarrhoeal diseases are the leading causes of the burden of disease in Africa (Table 6.1).

Table 6.1 Leading causes of burden of disease

	Disease or injury	DALYs (Millions)	Percent of total DALYs
	African region		
1	HIV/AIDS	46.7	12.4
2	Lower respiratory infections	42.2	11.2
3	Diarrhoeal diseases	32.2	8.6
4	Malaria	30.9	8.2
5	Neonatal infections and other	13.4	3.6
6	Birth asphyxia and birth trauma	13.4	3.6
7	Prematurity and low birth weight	11.3	3.0
8	Tuberculosis	10.8	2.9
9	Road traffic accidents	7.2	1.9
10	Protein energy malnutrition	7.1	1.9

Eastern Mediterranean region			
1	Lower respiratory infections	12.2	8.5
2	Diarrhoeal diseases	8.3	5.9
3	Ischaemic heart disease	6.2	4.3
4	Neonatal infections and other	6.1	4.3
5	Birth asphyxia and birth trauma	5.5	3.9
6	Prematurity and low birth weight	5.3	3.8
7	Unipolar depressive disorders	5.2	3.7
8	Road traffic accidents	5.1	3.6
9	War and conflict	3.8	2.7
10	Congenital anomalies	3.7	2.6

South East Asia region			
1	Lower respiratory infections	28.3	6.4
2	Diarrhoeal diseases	23.0	5.2
3	Ischaemic heart disease	21.6	4.9
4	Unipolar depressive disorders	21.1	4.8
5	Prematurity and low birth weight	18.3	4.1
6	Neonatal infections and other	14.3	3.2
7	Birth asphyxia and birth trauma	13.9	3.1
8	Tuberculosis	12.4	2.8
9	Road traffic accidents	11.0	2.5
10	Cerebro vascular disease	9.6	2.2
	Disease or injury		

America region			
1	Unipolar depressive disorders	10.8	7.5
2	Violence	6.6	4.6
3	Ischaemic heart disease	6.5	4.6
4	Alcohol use disorders	4.8	3.4
5	Road traffic accidents	4.6	3.2
6	Diabetes mellitus	4.1	2.9
7	Cerebro vascular disease	4.0	2.8
8	Lower respiratory infections	3.6	2.5
9	COPD	3.1	2.2
10	Congenital anomalies	2.9	2.1

European region			
1	Ischaemic heart disease	16.8	11.1
2	Cerebro vascular disease	9.5	6.3
3	Unipolar depressive disorders	8.4	5.6
4	Alcohol use disorders	5.0	3.3
5	Hearing loss, adult onset	3.9	2.6
6	Road traffic accidents	3.7	2.4
7	Trachea, bronchus, lung cancers	3.3	2.2
8	Osteoarthritis	3.1	2.1
9	Cirrhosis of liver	3.1	2.0
10	Self-inflicted injuries	3.1	2.0

Western Pacific region			
1	Cerebro vascular disease	15.8	6.0
2	Unipolar depressive disorders	15.2	5.7
3	COPD	11.9	4.5
4	Refractive errors	10.6	4.0
5	Road traffic accidents	9.6	3.6
6	Alcohol use disorders	8.6	3.2
7	Ischaemic heart disease	7.9	3.0
8	Hearing loss, adult onset	7.0	2.6
9	Birth asphyxia and birth trauma	5.7	2.1
10	Tuberculosis	5.6	2.1

(WHO, 2005).

Table 6.1 shows the countries of the world divided in the six WHO regions. These divisions of regions make it easier to report on the global burden of disease. The Africa region has 46.7 million people living with HIV/AIDS. HIV/AIDS ranks the highest for the burden of disease in the African region. HIV/AIDS does not reflect in any of the other five regions as a burden of disease. The second highest burden of disease in the African region is lower respiratory infections which affects up to 42.2 million people. Lower respiratory disease is ranked number one in both the Eastern Mediterranean and South East Asia regions whilst in the American region it is number eight. Poorer regions such as Africa, Eastern Mediterranean and South East Asia regions have a prevalence of diarrhoeal diseases. Malaria affects 30.9 million people in Africa whereas it is not a big burden of disease in other regions of the world. Developed regions such as America, European region and Western Pacific region have a high burden of disease in unipolar depressive disorders and cerebrovascular diseases.

Notably most countries differ in respect of the top 10 burden of disease in a region. The global burden of disease highlights the areas in which the professional nurse should have CPD. In the Africa region this will include HIV/AIDS, lower respiratory infections, diarrhoeal diseases, malaria, neonatal infections, birth asphyxia and birth trauma, prematurity and low birth weight, tuberculosis, road traffic accidents and protein energy malnutrition amongst others (WHO,2005). CPD in South Africa can play a vital role to decrease the impact of the global burden of disease affecting the Africa region.

6.4 Tuberculosis

Tuberculosis (TB) ranked eight in the top ten burden of diseases in the Africa region. South Africa is one of the countries where TB is a major public health problem and currently fourth on the list of 22 high-burden tuberculosis (TB) countries in the world. South Africa adopted the directly observed treatment short course (DOTS) programme during 1996. This is a good example of where CPD could have been implemented to upgrade all primary healthcare nurses' knowledge and competencies. DOTS case detection has only reached the 70% target in 2006, the researcher believes that this could have been reached much earlier if it was done via a CPD -accelerated programme. Progress towards fighting the TB epidemic in South Africa is likely to become a bigger challenge over the next few years due to co-infection with HIV/AIDS. Currently, as many as 44% of new TB patients test positive for HIV (UNAIDS, 2009). Multidrug-resistant (MDR) TB, as well as XDR-TB is largely caused by non-adherence to drug regimens or inappropriately dispensed drug regimens. These problems exacerbate the epidemic. Professional nurses need to learn how to educate TB sufferers regarding the importance of adherence to medication. This can once again be done via CPD (UNAIDS, 2009).

6.5 National HIV and Syphilis Antenatal zero prevalence

A national survey was done during 2007 to estimate the magnitude, growth and spread of the HIV/AIDS and syphilis prevalence rates at antenatal clinics in the South Africa. The study report was released in 2008 by the National Department of Health (DOH, 2008). The report showed that 19% of women who attend the antenatal clinics are between the ages of 15-19. Professional nurses need to receive CPD to address the high rate of teenage pregnancies. This can be done by CPD courses related to promotion of the ABC principle, abstinence, be faithful and the use of condoms in males and females. Voluntary counselling and testing (VCT) could also be added to the programme. As expected, the highest rate of HIV infection is in the childbearing age group. Nearly a third (31.5%) of pregnant women between the ages of 20-24 and a quarter (23.5%) between the ages of 25-29 have tested HIV positive (DOH, 2008). The professional nurse can also do very

important work of VCT and promoting anti retroviral therapy (ARV) as well as the promotion of the prevention of mother- to- child transmission (PMTCT) by updating her knowledge through CPD (Table 6.2).

Table 6.2 Prevalence of HIV in amongst pregnant women

Age Group (Years)	2005	2006	2007
15-19	20.2	19.1	19.0
20-24	30.7	31.7	31.5
25-29	23.7	23.2	23.5
30-34	15.3	15.2	15.1
35-39	7.5	7.7	8.1
40-44	2.2	2.2	2.1
45-49	0.3	0.3	0.2
Missing	0.08	0.7	0.5
Total	100	100	100

(DOH, 2008)

6.6 Cancer rates in South Africa

Cervical cancer is accountable for at least 17.2% of all cancer deaths in women in South Africa. Early screening and teaching of breast examination can detect cervical and breast cancer early. These are also skills that need to be taught on an ongoing basis to professional nurses that enter the public health or primary healthcare domain (Table 6.3).

Table 6.3 Female Cancer death rates in South Africa

Rank	Cause of Death	%
1	Cervix	17.2
2	Breast	15.6
3	Trachea/bronchi/lung	10.9
4	Oesophageal cancer	9.9
5	Colorectal cancer	6.9
6	Liver cancer	4.9
7	Stomach	4.7
8	Pancreas	3.7
9	Ovary	3.5
10	Leukaemia	3.2

(MRC, 2006)

Trachea, bronchi and lung cancer is the main cause of cancer -related deaths in men. The professional nurses can reduce these cancers by promoting the cessation of tobacco smoking programmes. CPD can be implemented to assist professional nurses with the skills to organise anti- smoking campaigns (Table 6.4).

Table 6.4 Male Cancer death rates in South Africa

Rank	Cause of Death	%
1	Trachea/bronchi/lung	21.9
2	Oesophageal cancer	16.7
3	Prostrate	11.8
4	Liver cancer	7.8
5	Stomach	6.5
6	Colorectal	5.4
7	Mouth and oropharynx	4.6
8	Leukaemia	3.8
9	Pancreas	3.7
10	Larynx	3.0

(MRC, 2006).

6.7 Chronic diseases of lifestyle

The most common chronic diseases of lifestyle in South Africa include obesity, hypertension, dyslipidaemia, diabetes mellitus, chronic respiratory disease, stroke and osteoporosis (MRC, 2006). These are the diseases that can be managed by the professional nurse if she or he is updated by CPD. Most of the above-mentioned diseases are also preventable. Hypertension can be managed at a clinic by the professional nurse and only be referred to the doctor if there are problems with constantly elevated blood pressure or there are side effects to the medication. Professional nurses can teach patients relaxation, stress management, and low sodium foods as part of treatment. The problem is that management of these diseases is only covered in basic undergraduate nursing training. This knowledge changes over time, but CPD would equip the professional nurse to practise evidence-based nursing that incorporates the latest research. Thus nurses who have undergone CPD will not only rely on information that they received during their undergraduate training.

6.8 Notifiable Medical Conditions.

Notifiable diseases in South Africa are mainly communicable diseases (Table 6.5). South Africa has an effective immunisation programme which is credited with low numbers of cases of childhood illnesses such as measles. Areas that need attention are malaria, TB and TB meningitis. CPD for the professional nurse will help her or him to be up-to-date on the latest prevention strategies which they will be able to communicate to the communities that they work with (Edelman & Mandle, 1998).

Table 6.5 Notifiable Medical Conditions for 2005

Condition	Cases	Deaths
Malaria	5271	45
Measles	587	2
Meningococcal infection	28	3
Rabies	2	2
Tuberculosis pulmonary	23034	651
Tuberculosis meningitis	297	35
Hepatitis B	98	3
Diphtheria	138	0
Acute Flaccid Paralysis	94	0

(DOH, 2006).

6.9 Premature deaths in South Africa

Several diseases or specific causes contribute to premature deaths in South Africa. These premature deaths contribute to the decrease in life expectancy for the people in South Africa. The UNAIDS (2006) list of countries by life expectancy recorded the life expectancies of 221 countries. South Africa ranked 213 out of 221 with a life expectancy in 2006 as low as 42.4 years. Swaziland had the lowest life expectancy of 32.2 years and Macau had the highest life expectancy of 84.3 years. Many of the premature deaths are deaths that could have been prevented. If professional nurse are aware of what diseases or incidents are responsible for premature deaths they can educate the community on how to prevent these. Diseases (UNAIDS, 2006). It is noted that HIV/AIDS is ranked as number one as a cause of premature death. Ranked as second is death related to

homicide/violence. The professional nurse is aware of the relationship between substance abuse and violence. Thus CPD can be used to inform the professional nurses of the premature deaths and update them on how to educate the community. Most of the premature deaths listed below fall within the scope of the professional nurse and can be reduced by providing CPD to the professional nurses who works in the community (table 6.6).

Table 6.6 Top eighteen specific causes of premature mortality

Rank	Cause of death(burden of disease list)	%
1	HIV/AIDS	39
2	Homicide/violence	7.5
3	Tuberculosis	5.0
4	Road traffic accidents	4.1
5	Diarrhoeal diseases	3.8
6	Lower respiratory infections	3.8
7	Low birth weight	3.3
8	Stroke	2.7
9	Ischaemic heart disease	2.4
10	Protein-energy malnutrition	1.4
11	Suicide	1.4
12	Diabetes mellitus	1.2
13	Hypertensive disease	1.1
14	Fires	1.0
15	Septicaemia	1.0
16	Chronic obstructive pulmonary disease	0.9
17	Neonatal infections	0.8
18	Asthma	0.8

(South African Health Review, 2000)

6.10 Principles for incorporation in model

The following principles are important to consider for implementation in the CPD model.

Illnesses that have the highest prevalence rates such as HIV and Tuberculosis need more attention from professional nurses and they should have compulsory CPD in these selected areas to enable them to keep abreast with current evidence-based research and trends.

Cancer prevention and health promotion as well as knowledge of early detection and screening will improve survival rates. Professional nurses need to be updated

on health education and screening techniques for cervical and breast cancer in women and prostate cancer in men.

Many chronic diseases of lifestyle such as hypertension, dyslipidaemia, diabetes mellitus, chronic respiratory disease and stroke are preventable and treatable.

Under the notifiable diseases (table 5.5), diseases such as malaria, hepatitis B, meningitis, TB meningitis also need more emphasis. CPD for the professional nurse helps him or her to be up to date on the latest prevention strategies.

6.11 Summary

Statistics of the health diagnosis reveals the health needs that are prevalent from period to period. The professional nurse is responsible for the community's health and therefore the statistics in this chapter show that there are many areas where CPD can be undertaken to stimulate nurses' interest in the prevention and treatment of diseases. The principles that were obtained here will be included when developing a model for CPD for the professional nurse in South Africa.

The logo of the University of the Western Cape features a stylized classical building with a pediment and columns. Below the building, the text "UNIVERSITY of the WESTERN CAPE" is displayed in a serif font, with "of the" in italics.

UNIVERSITY *of the*
WESTERN CAPE

Chapter seven

Phase D of Research

Survey

7.1 Introduction

Data presented in chapter seven reflect the answers received from the national survey done on professional nurses' perceptions and recommendations on continuing professional development (CPD) needs in South Africa. The survey concentrated on data related to extracting information on the CPD needs of professional nurses in South Africa. Additional data related to biographical, socio-demographical, occupational and educational background were also collected from the respondents. Chapter seven critically discusses and compares the results of the survey with local and international data. Data are displayed in an organized, concise assembly of information that permits the drawing of conclusions as an integral part of analysis (De Vos, 1999).

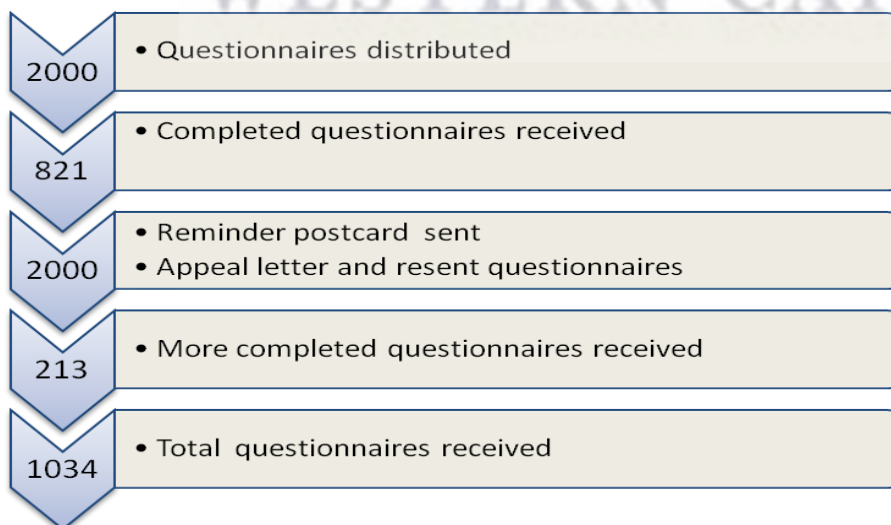
7.2 The pilot study

The purpose of the pilot study was to detect possible flaws in the measurement procedure such as ambiguous instructions and inadequate time limits (Welman et al, 2005). Five nursing experts were chosen to validate the questionnaire to ensure face and content validity. The pilot study participants were excluded from the random sample list from the SANC in order to prevent them from being part of the study sample. Each person was contacted directly via telephone and a time was arranged for them to come in to the study office of the researcher to fill out the survey and provide their feedback. All comments received were incorporated in the final draft of the questionnaire.

7.3 Survey response rate

The researcher used a postal questionnaire to obtain information regarding the CPD needs of the participants. A total of 2000 questionnaires were distributed according to the random sample names list provided by the South African Nursing Council (SANC). Initially 821 participants responded. The researcher tried several methods to improve the response rate. A postcard was sent as a reminder a month later to all the participants and a further letter of appeal with a copy of the questionnaire was resent at a later stage. This extensive effort to motivate respondents to participate increased the number of respondents with another 213. In total 1034 questionnaires were received. Research on acceptable response rates uncovers a wide range of percentages. The consensus is that a response rate of a postal questionnaire of 50% or above is adequate for analysis. A response rate of 60% is generally seen as good, and a response rate of 70% is very good (Babbie & Mouton, 2003). The current response rate including the additional efforts to encourage potential participants to return their questionnaires was 52%. The researcher acknowledges that this response rate may be slightly lower than anticipated and interpretation of results gives cognizance to the low response rate. Furthermore this is only one phase of the study and incorporation of the other information will all contribute to the development of a CPD model for professional nurse in South Africa (Fig 7.1).

Figure 7.1 Response rate



7.4 Socio- demographic data

Socio-demographic aspects of the respondents such as gender, age, geographical location, work setting, current practice, and qualifications were recorded. Demographic questions are an important part of any questionnaire. They are used to identify characteristics such as age, gender, income, race and geographic place of residence. Demographic data helps to depict an accurate picture of the group of professional nurse who participated in the survey (Ing Advisors network, 2007).

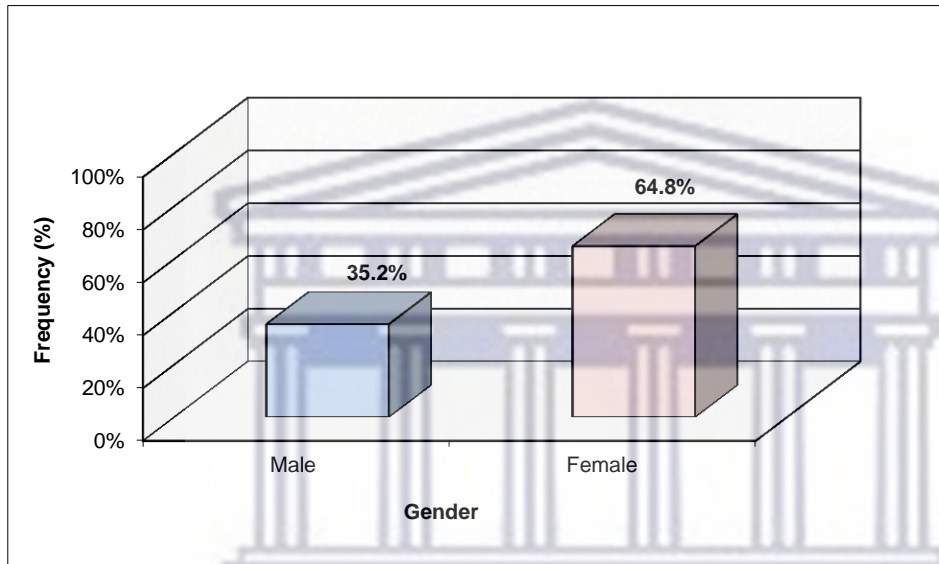
7.4.1 Gender distribution

Historically, males dominated the nursing profession prior to the 20th century, especially in regard to providing medical care to South African miners and military personnel (Smith, 1990). However, female nurses became more dominant after Florence Nightingale encouraged females to take up nursing as a profession during 1894 when she started to train female nurses (Adamson et al, 2004). A male dominance of nurses has also not been found internationally. Turkey has no male nurses and countries such as Ireland, New Zealand, Namibia, Mauritius, Bolivia, Samoa, Macau and Bahrain have minimal number of male nurses (Pearson, 2001). Gender in the nursing career may be influenced by factors such as religion, culture, economy, war and prestige. Recently there has been a natural growth in the increase of males entering the profession in countries such as Austria, Tanzania, Italy, Spain and Chile where males make up more than 20% of the nurse population (Pearson, 2001). Malawi also has reported an increase in male students of up to 15.3% over the last few years (Adamson et al., 2004). Males have nearly equalized the equilibrium in The Democratic Republic of Congo where 45% of the total nurse population is males (Pearson, 2001).

In South Africa the gender picture has changed dramatically. The current South African gender of the nursing population consists of 94.2% (n=95226) females and 5.88% (n=5959) males (SANC, 2006). This is similar to that of the United States where male -registered nurses compromise of 6% of the total professional nurse population (Rodgers, 2007). The survey showed that of the 1034 questionnaires received, nearly twice as many were from the female gender 670 vs 364 (Figure

7.2). One would have expected a much larger percentage from the female group to be consistent with the total professional female registered nurses in South Africa (SANC, 2007). The address list that the researcher received from the council did not state whether the candidate was male or female, bias was therefore not introduced when the questionnaires were mailed to the possible participants.

Figure 7.2 Gender distributions of participants



7.4.2 Age distribution

Statistics from SANC showed that the nursing population of South Africa is mostly middle-aged with a mean age of 40 and a range of less than 25 years to greater than 69 years. In 2005 only 59 registered nurses were younger than 25 years of age (SANC, 2006). In this survey only 862 of the participants volunteered their age. This is recognized as a limitation and in future it may be appropriate to ask date of birth instead of age. The mean age and range of this study was very similar to the overall registered nurse population with a mean age of 38.1 and a range between 20 and 66 years of age. There were no statistical differences in age between male and females (table 7.1).

Table 7.1 **Age Distribution**

Gender	n/N	Mean age	SD	Range(years)
Males	318/862	39.2	10.8	22 – 65
Females	544/862	37.5	9.6	20 - 66
Total	862	38.1	10.12	20 – 66

Buchan (1999) refers to the “greying” of the United Kingdom (UK) nursing workforce meaning that nurses tend to be older. Some of the contributing factors could be that there was a larger intake of student nurses during the 1970’s and 1980’s. In 1985 England had 71,260 nursing students, but 10 years later, in 1995, this number dropped by half to 37,580 (Buchan, 1999). A second factor is that the new student intakes have a broader, more mature age range. Previously, the majority of students started their nursing programme after leaving secondary school with a mean age of 17 -18 years. South Africa may be facing the same age profile changes as experienced in the UK as stated by Buchan (1999), as it is found that students who apply to study nursing are no longer doing so immediately after completing secondary school. The average age of first year nursing students undertaking the Bachelor Curationis Degree (basic nursing degree) is 25.4 years at the University of the Western Cape, (University of the Western Cape’s service desk, 2007).

7.5 Geographical location

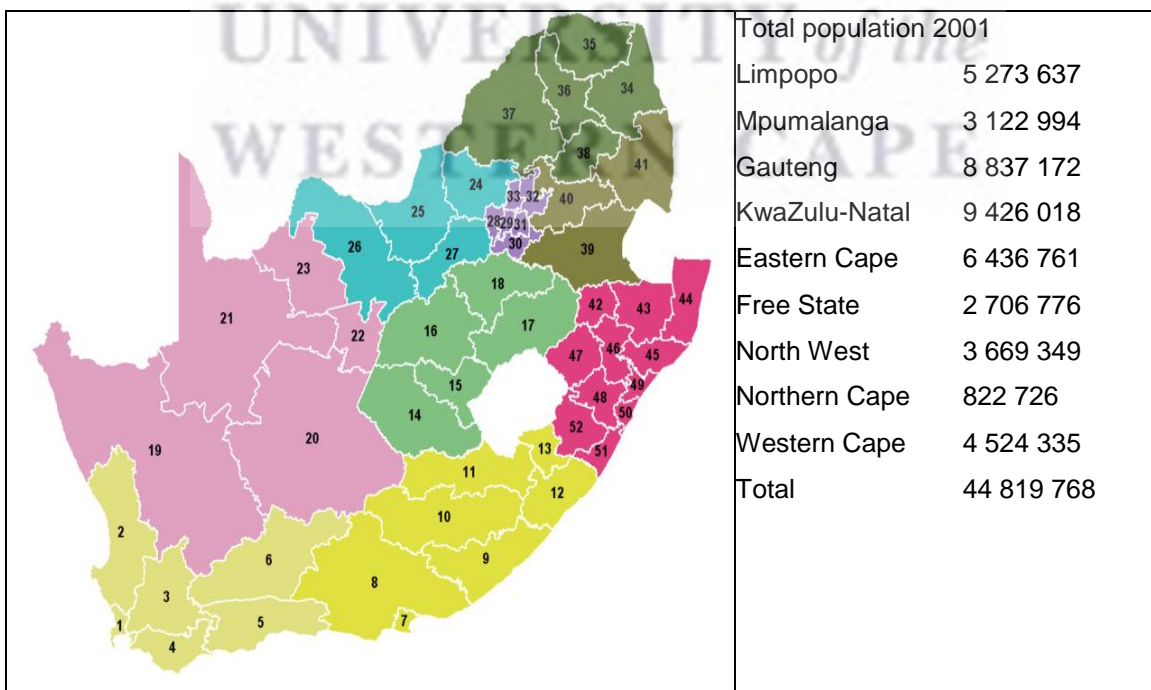
South Africa is the 25th largest country in the world and has a coast line that stretches more than 2500 kilometers across the Atlantic and the Indian Oceans. It is divided into nine provinces each with its own health budget. The researcher recorded the number of postal questionnaires that was sent according to the classification of the postal code that reflects the province of where the questionnaire was sent to. Some inferences were made between the provinces and the classification of city, peri-urban, town and rural areas. Respondents who stated that they work in “city and peri-urban areas” were located under the three main provinces that have large academic and tertiary hospitals vs Gauteng (10), KwaZulu Natal (5) and the Western Cape (5). The Free State has two academic hospitals and the Eastern Cape two main referral hospitals, but with a lesser bed

capacity than the provinces mentioned above. Respondents who stated that they work in towns were classified under these two provinces. Provinces with vast rural areas and many small towns and small hospitals were classified as rural hospitals (SANC, 2006).

According to the geographical division 1 184 questionnaires were sent to the three provinces which have large academic hospitals and that were classified as city and peri-urban areas. The researcher received 759 (73.4%) of these questionnaires back. As the sample was a random sample one can expect that a smaller number of questionnaires were posted to the Eastern Cape and Free State (375) as well as the other four provinces (440). Slightly more questionnaires 14.5% were received back from the areas that were classified as towns than the areas that were classified as rural 12.1% (figure 7.3).

The higher response rate from the cities and peri-urban areas may be due to the fact that professional nurses who work in academic and tertiary hospitals are more exposed to research and therefore participated in the study.

Figure 7.3 Map showing the nine provinces and districts



Statistics South Africa (2004) Map of South Africa (Map of South Africa, nd.)

Table 7.2 show the percentages of responses from each province. Gauteng (45.7%) and North West (40.8%) had the highest response rates.

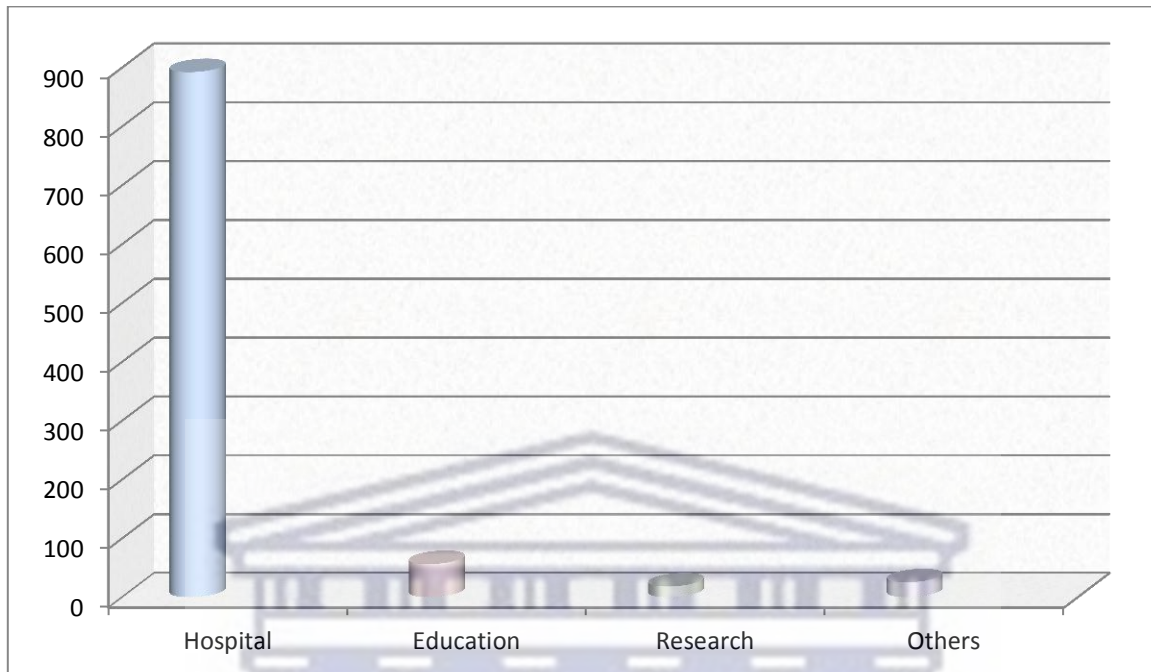
Table 7.2 Geographical distribution of study sample

Province	Registered nurse population	Number of questionnaires posted	Number of respondents
Gauteng	26274 (26.5%)	512 (1.9%)	346 (45.7%)
KwaZulu-Natal	19445 (19.6%)	389 (2.1%)	219 (28.8%)
Western Cape	13239 (13.6%)	283 (2.1%)	194 (25.6%)
Eastern Cape	12176 (12.9%)	234 (1.9%)	107 (71.3%)
Free State	7175 (7.4%)	142 (2.0%)	43 (28.7%)
Limpopo	7540 (7.6%)	150 (2.0%)	37 (29.7%)
Mpumalanga	4774 (4.8%)	101 (2.1%)	22 (17.6%)
Northern Cape	1936 (0.2%)	45 (2.3%)	15 (12.0%)
North West	6495 (6.5%)	144 (2.2%)	51 (40.8%)
Total	99 054	2 000	1 034

(SANC,2005)

7.7 Work Settings

The responses to the settings where professional nurses work are illustrated in figure 7.4. The largest population 892 (90%) in the survey stated that they work in a hospital or clinic setting. Only 56 (5.7%) responded that they work in educational settings such as universities, nursing colleges and or universities of technology. Very few respondents work in research institutions such as the Medical Research Council 18 (1.8%) or in settings such as old age homes, and homes for disabled persons 25 (2.5%). This demographic finding of the survey is supported by literature since according to Pearson, (2001), the majority of nurses are employed in hospitals or in Community Health Centres.

Figure 7.4 Work settings of professional nurse

7.8 Area of Practice

Table 7.3 shows that nine hundred and seventy five respondents (94.7%) indicated that their current area of practice was direct patient care. According to Pearson (2001) most nurses worked in areas requiring direct patient care. A further 22 (2.1%) were involved in Nursing Education. Those involved in Nursing Administration functions were 30 (2.9%). One (0.1%) of the respondents was involved in research as an area of practice, whilst 2 (0.2%) respondents chose in “other” area of practice, or did not specify the area (0.2%). The “other” could be areas such as those involved in phlebotomy, old age homes, and medical representatives amongst other areas that professional nurses practice.

Table 7.3 Current Area of Practice

Area of Practice	No. of Respondents	Percentage
Direct Patient Care	975/1030	94.7
Nursing Education	22/1030	2.1
Nursing Administration	30/1030	2.9
Research	1/1030	0.1
Other	2/1030	0.2

7.9 Categories of Registration

Eight hundred and sixty two (83.4%) respondents stated they were registered in General Nursing. Although this should have been 100% (since we requested SANC to draw a random sample from registered nurses only), it is important to note that all participants received their General Nursing qualification but some have chosen to seek other qualifications as well. As such, some have chosen to put this more advanced qualification as their registration category. There was not a big difference between registered midwives (56.6%), registered psychiatric nurses (44.2%) and registered community nurses (49.7%). Registered nurse educators (12.2%) and registered nurse administrators (10.4%) were, as expected, in the minority. It should be noted that participants could mark more than one category of registration if they have received more than one certification (table 7.4).

Table 7.4 Categories of Registration

Categories of Registration	No. of Respondents	Percentage
Registered General Nurse	862/1034	83.4
Registered Midwife	586/1034	56.6
Registered Psychiatric Nurse	458/1034	44.2
Registered Community Nurse	514/1034	49.7
Registered Nurse Educator	127/1034	12.2
Registered Nurse Administrator	108/1034	10.4
Other	20/1034	1.9

7.10 Number of registered qualifications

The results shown in table 7.5 reveal that professional nurses had diplomas as well as degrees. Seven hundred and thirty four respondents stated that they had a basic diploma and 529 responded that they had a basic degree. There maybe an overlap as many degree nurses may have first completed a diploma and then registered for a post basic degree. Surprisingly very few respondents had two diplomas (5) but one had as many as four diplomas. This is representative of the different curricula that were available in the country over the last decades. The integrated 3 ½ year course started in 1975. This meant that registered nurses could complete a diploma that offered them registration as a registered nurse and

a midwife, within one qualification. In other words there was no longer a need to add one year diplomas in specialities such as midwifery, psychiatry, or community health to the basic diploma. The mean age of 38 years also supports the fact that most of the respondents who answered the questionnaire did their basic training after 1975. Further education, such as masters degree (75) and doctoral degrees (22), are reflective of the fact that registered nurses are taking up the responsibility of advancing their career paths. Since 1986, the basic course for becoming a professional nurse has changed to a four year degree or diploma; hence most professional nurses seemed to have the four year qualification. According to Klopper (2007) there were 1946 masters- prepared nurses and 472 doctoral-prepared nurses' from the year 1951 till 2006. However there are in fact many professional nurses who have MA, MPH, MBA and MTec and MNursing degrees which are all masters nursing degrees. These were not taken into consideration in Klopper's study. The same applies to doctoral-prepared nurses such as those with PhDs, DTecs etc. These nurses were not counted in the sample of DCur nurses probably because only those with the specific DCur degree were the sample and not all doctoral prepared nurses. Added to this, very few of these doctoral-prepared nurses are in a clinical setting, where their skills are most needed.

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Table 7.5 **Number of Registered Qualifications**

Qualifications	No. of Qualifications		
	1	2	4
Diplomas	734 (99.2%)	5 (2%)	1 (0.1%)
Basic Nursing Degree	528 (99.8%)	1 (0.2%)	-
Masters Degree	75 (7.25%)	-	-
Doctoral	22 (2.12%)	-	-

An interesting finding was that the responses to the question on any other courses than those registered with the SANC that respondents were interested in. Respondents tended to list interests outside the scope of the registered nurse such as; pottery, bead making, painting, music and sport. Few showed interest in work -

related courses such as human resources management, project management, intensive care nursing, trauma nursing, and theatre nursing. The majority of the respondents left this question unanswered.

Despite the “greying age” of the nursing fraternity, five hundred and four (86%) had studied a registered nursing course five or less years ago. It is important to address the 14% who did not attend any nursing - related courses in the last five years. These are the candidates who will be able to enhance their knowledge through CPD to ensure that all practising professional nurses are up to date with their knowledge and skill related to their work specialization discipline.

Table 7.6 Time Elapsed since last Registered Course

Categories	No	Percentage
5 Yrs or less	504/585	86
6 – 9 Yrs	45/585	8
10 – 15 Yrs	14/585	2
> 15	22/585	4

7.11 Type of Employment

The majority of the respondents were employed in a permanent full time post that ensures full benefits to the employee. Thus 93% of professional nurses should be able to benefit from the skills levy development fund from their employees and should be able to receive financial compensation to attend a course in CPD.

Table 7.7 Type of Employment

Type	Full Time	Part Time
Permanent	911/978 (93%)	67/978 (6.9%)
Temporary	27/56 (48.2%)	29/56 (51.8%)

7.12 CPD needs of the professional nurse

The majority of respondents (table 7.8) 1024 (92%) agreed that there is a need for CPD for professional nurses in South Africa. According to Palmer et al. (1994), today's professional nurses, more than at any other time, is faced with an

increasing obligation to evaluate and improve their practise and this is done by CPD. Similarly, the majority of the respondents (90.4%) agreed that CPD should be made compulsory in order for a professional nurse to be able to re-license to enable her or him to continue their practise. CPD for nurses is linked to the legal right to practise in several countries internationally. In Australia re-licensure requires that the practitioner provide evidence of attendance at appropriate CPD activities (Royal College of Nursing, Australia, 1996; Davee & McHugh, 1995). In South Africa, medical doctors, dentists and other health professions governed by the Health Professions Council of South Africa have to undertake mandatory CPD to re-license in order to practice (HPCSA, 2004). Respondents (97.8%) strongly supported the concept that CPD may be seen as a way of self empowerment. They (99.1%) also agreed that CPD is a method to address the needs of the services rendered by the institution. More respondents felt that CPD should be voluntary (75.9%) rather than mandatory (53%). These two questions were proposed as two separate questions and not as one question. It can be seen from the responses that some answered twice instead of it being either voluntary or mandatory. Despite the fact that more respondents felt that CPD should be voluntary, they did agree that if it should become mandatory (71.7%), some form of penalty should be implemented if the professional nurse does not comply to the requirements. CPD for nurses is mandatory in the UK and in many of the states in the USA. It is also linked to the legal right to practice (Royal College of Nursing Australia, 1996). Countries such as Australia do implement a voluntary continuing education programme but do require their professional nurses to show competency before they can re-license to practise (Royal College of Nursing, Australia, 1996). CPD according to the American College Health Association (April 2002) professional persons must maintain appropriate levels of knowledge, skills and judgment, to provide people with competent-health related services based on the established health needs of the population(ACHA,2002). If CPD should become mandatory it would mean that failure to comply with the mandatory requirements could result in withdrawal of a licence to practise until such time that the professional nurse conforms with the requirements. Professional nurses would thus be in breach of the regulations if they were to practice without current practising licenses and risk legal action or be taken off the registers.

Most (91%) respondents favoured the concept that CPD activities should be in a credit bearing standard unit format that could give recognition to some former qualification. It is also supported (92.7%) that CPD should only be provided by an accredited SANC- approved provider. CPD is positively viewed as a way to keep abreast of current health trends (97.2%) and of maintaining professional standards of practice (99%). The Institute of Biomedical Sciences (IBMS) in the United Kingdom states that CPD also enables one to meet the present and future health needs of patients and deliver health outcomes and priorities (IBMS, 2007). This statement is supported by Peck (2000) who stated that CPD is the process by which health professionals keep updated to meet the needs of patients.

Nearly all (98.5%) of the respondents agreed that CPD can promote job satisfaction and enhance professional career goals (99%). They felt that CPD would create a positive competitiveness amongst professional nurses to stimulate each other to update their knowledge. Formal, standardized CPD schemes benefits the individual by maintaining competence and competitiveness by promoting job satisfaction and career prospects (EFOMP, 1997). It is known that CPD does create competitiveness in professionals (EFOMP, 1997). In the UK, the professional nurses particularly face stiff competition, especially those wanting to develop (Nursing Standard, 2007). According to Coffield (1997), lifelong learning is seen to be a means of competitiveness and personal development. CPD can confer professional recognition and enhance career prospects (NEWI, 2007). There are many benefits of CPD as a lifelong learning because it increases job satisfaction by promotion of professional ideas and new initiatives (IBMS, 2007). Furthermore has it been shown that CPD has a positive impact on job satisfaction and motivation (NEWI, 2007).

Table 7.8 CPD viewpoints

Items	Strongly Agree	Agree	Disagree	Strongly Disagree
There is a need for continuing Professional Development (CPD) for professional nurse.	767/1032 (74.3%)	257/1032 (24.9%)	8/1032 (0.8%)	0
CPD should be made compulsory in order for a professional nurse to re-license in order to practice.	487/1006 (48.4%)	423/1006 (42%)	91/1006 (9%)	5/1006 (0.5%)
CPD is a way of self-empowerment.	510/1017 (51.1%)	475/1017 (46.7%)	29/1017 (2.9%)	3/1017 (0.3%)
CPD can be used to address the needs of the services rendered by the institution.	389/988 (39.4%)	590/988 (59.7%)	3/988 (0.3%)	6/988 (0.6%)
CPD should be voluntary.	258/985 (26.2%)	490/985 (49.7%)	175/985 (17.8%)	62/985 (6.3%)
CPD should be mandatory.	158/1003 (15.8%)	373/1003 (37.2%)	413/1003 (41.2%)	59/1003 (5.9%)
If CPD should become mandatory there should be a penalty for non compliance with CPD requirements.	266/998 (26.7%)	449/998 (45%)	240/998 (24.0%)	43/988 (4.3%)
CPD activities should be in a credit bearing format aiming towards a formal qualification.	435/1004 (43.1%)	473/1004 (46.9%)	90/1004 (8.9%)	11/1004 (1.1%)
CPD should only be provided by an accredited provider approved by the SANC.	467/1016 (45.7%)	478/1016 (47%)	64/1016 (6.3%)	10/1016 (1%)
CPD is a way to keep up to date with current health needs.	526/1016 (51.8%)	461/1016 (45.4%)	22/1016 (2.2%)	7/1016 (0.7%)
CPD is important in terms of maintaining professional standards of practice.	583/1016 (57.4%)	423/1016 (41.6%)	3/1016 (0.3%)	7/1016 (0.7%)
CPD can promote job satisfaction.	569/1021 (55.7%)	437/1021 (42.8%)	7/1021 (0.7%)	8/1021 (0.8%)
CPD should be able to enhance professional career goals.	545/1023 (53.3%)	467/1023 (45.7%)	5/1023 (0.5%)	6/1023 (0.6%)
CPD would create positive competitiveness amongst professional nurses.	550/1025 (53.7%)	457/1025 (44.6%)	15/1025 (1.5%)	3/1025 (0.3%)

7.13 Method of recording CPD credits

We are currently living in a time period of increasing use of technology such as cell phones, computers with internet, and automatic teller machines (ATM's) and many others. Despite the increased use of electronic technology, 500 (48.7%) of professional nurses still prefer that CPD credits to be captured manually. Given the number of professional nurses currently registered (101289) (SANC, 2006), this task will pose difficulty for the SANC to capture the manual submissions. Very few supported the concept that credits should be captured electronically alone 136 (13.2%). At least 391(38.1%) supported the concept that credits could be captured manually and electronically (table 7.9).

Table 7.9 Method of recording CPD credits

CPD Credits to be recorded N=1027	No. of Respondents	Percentage
Manually	500/1027	48.7
Electronically	136/1027	13.2
Both	391/1027	38.1

7.14 Timeframe to submit CPD for credits

Respondents were given several options to choose a timeframe to submit their CPD for credits to the South African Nursing Council. More than half (57%) chose to submit annually, whilst 32% stated that CPD credits should be submitted every second year. Fewer (16%) respondents were in favour to submit their CPD credits to SANC every third year, whilst those that chose "other" were 3% only. In Australia, professional nurses must retain a record of the CPD and submit for auditing when drawn in the sample yearly (Nurses and Midwives Board Western Australia, 2009). In the UK, professional nurses need to submit their CPD on an annual basis to be drawn at random for audit purposes (NMC, 2002).

Table 7.10 Timeframe to submit CPD for credits

Time Frame	No. of Respondents	Percentage
Annually	592/1034	57
Every 2 nd Year	333/1034	32
Every 3 rd Year	165/1034	16
Other	29/1034	3

7.15 Level of health priority

The level of health priority in a South Africa can be viewed as national health priorities, provincial health priorities and local health priorities. The level of health priority that professional nurses need to be updated on should be taken into consideration if CPD becomes mandatory. It was good to learn that the majority (89.4%) of respondents felt that the national health priorities are the most important priorities to address through the implementation of CPD. Fewer (4.2%) supported the concept that provincial health priorities is of importance. Slightly more (5.9%) agreed that local health priorities should get priority (table 7.11). In the USA health priorities depend upon the national health problem being experienced, such as currently osteoporosis is a main health priority, whilst in SA HIV/AIDS is the current health priority (HST, 2005). Priority health areas in South Africa (2004 – 2009) are the following: Child Health, Nutrition, Maternal and Child Health, HIV / AIDS, TB , Malaria, Mental Health, Substance Abuse , Chronic Diseases and emergencies (DOH, 2006).

Table 7.11 Level of health priority addressed by CPD

Level	No. of Respondents	Percentage
National	924/1033	89.4
Provincial	43/1033	4.2
Local	61/1033	5.9
Other	5/1033	0.5

7.16 Short courses to improve scarce skills

CPD short courses could be used to improve scarce skills shortages. Due to the fact that short courses do not meet the 120 credit requirement by SAQA for recognition, SANC has stopped the recognition of short courses. They may have to reconsider their decision as the majority (98.7%) of respondents supported the statement that short courses could be used to improve scarce skills shortages in nursing, e.g. Intensive Care Nursing, Operating Theatre Nursing, Oncology Nursing, Trauma Nursing and other identified areas (table 7.12).

Table 7.12 CPD short courses

Level	No. of Respondents	Percentage
Strongly Agree	705/1017	69.3
Agree	299/1017	29.4
Disagree	10/1017	1
Strongly Disagree	3/1017	0.3

7.17 CPD update courses

Most respondents (98.5%) agreed that CPD update courses related to subject specialities could be an effective method to update knowledge for those wanting to return to work after a long absence (table 7.13).

Table 7.13 CPD update courses

Level	No. of Respondents	Percentage
Strongly Agree	527/1010	52.2
Agree	468/1010	46.3
Disagree	15/1010	1.5
Strongly Disagree	0/1010	0

7.18 CPD applied in Human Resources Development

The question posed to the respondents was whether CPD could be applied in human resources development i.e. the development of the professional nurse. Respondents supported this statement (95.5%) (table 7.14). In a research study done in Finland, the viewpoint of surveyed nurses was that CPD could be useful in human resource development in order to maintain a high quality of care in the future (Lanmintakanen, Kivinen, Kinnunen, 2008).

Table 7.14 CPD applied in Human Resources Development

Level	No. of Respondents	Percentage
Strongly Agree	394/1034	38.1
Agree	593/1034	57.3
Disagree	22/1034	2.1
Strongly Disagree	1/1034	0.0
No Response	24/1034	2.3

7.19 CPD system is long overdue

The Nursing Act 33 of 2005 clearly makes provision for CPD in Section 39 “Conditions relating to continuing development”. Presently, the SANC has not addressed CPD at all. Professional nurses are in full support of introducing a CPD system in South Africa and agree that such a system is long overdue (91.6%) (table 7.15).

Table 7.15 A CPD system is long overdue

Level	No. of Respondents	Percentage
Strongly Agree	428/1000	42.8
Agree	488/1000	48.8
Disagree	72/1000	7.2
Strongly Disagree	12/1000	1.2

7.20 The range of learning experiences for CPD

CPD embodies the whole range of learning experiences that lead to improved performance in the delivery of healthcare. The respondents could choose as many items as possible. The choices were based on Muller (2007) and WHO (1988) recommendations. In-service training (84%) was ranked the highest when asked regarding the range of learning experiences that professional nurse would see beneficial for CPD (table 7.16). According to Booyens (2000), in-service education is the education of personnel while the person is doing the job or rendering a service to patients. In-service means updating, training, educating and informing the person about the present requirements of the job. Jobs in the healthcare services are never static and are rapidly changing there is a need for continuous in-service education of healthcare workers. Healthcare (Nursing) audits were chosen as a preferred CPD learning method by 71% of the respondents. According to Lellan (1997), a chart audit is conducted by retrospective review of randomly selected patient charts which document the care given to a patient. Deficiencies discovered during the audit can be used as a learning experience

whereby action is taken to remedy the situation. On site supervision and guidance by nurse specialists as a type of learning experience was chosen by 67%. This would consist of dedicated educational programmes and support of the nurse seeking to practice at an advanced level (An Bord Altranais, 1998).

The use of journal articles as learning experience was chosen by slightly more than half (56%) of the respondents. Journal articles and media publications are also cited as CPD activities by Rughani (2001). South African professional nurses are not publishing as many articles as their counterparts in other countries. Writing for publication is definitely a short-coming amongst South African professional nurses. This is another aspect that could be built into CPD. For instance, professional nurses who published in an accredited peer reviewed journal should be able to get CPD credits for their contribution to scientific knowledge. Team assignments and projects are also a neglected field in nursing. Nurses are often used as field workers with no acknowledgement of their contributions. This type of learning experience was chosen by 56%, which confirms the interest of professional nurses in collaborative projects. Team-based learning is used in a number of European countries (UK, Belgium, Italy and Spain) according to Muller (2007) and Rughani (2001).

Often, only a few members from a specific organisation is allowed to attend a conference and financial supported. It is desirable that those who attended a conference, share the information they have gained, with other professionals. There is clearly support for this method as a CPD learning method as 61% of the respondents reacted positively to the outcome. This method is often referred to as professional participation where one is invited as a speaker to share her or his information with other professionals (CPD, 2007). Distance learning or self study was supported by slightly more than half (54%) of the respondents. This could be a valuable option for the professional nurses who work in rural work areas such as farm nursing, rural hospitals and clinics where access to other methods of CPD may be scarce. According to Wetzel (2009) the popularity of distance learning programmes is based primarily on the flexibility of the programme to fit the nurses'

schedule as most are in full time employment. In South Africa, the University of South Africa (UNISA) is the most well-known distance learning institution.

Academic studies as a choice have to do with formal education and training courses at universities, colleges and universities of technology. This type of learning experience was chosen by 60% of the respondents. This method is referred to as tertiary -related courses under continuing professional education and should be recognised as CPD credits (CPD, 2007).

Nearly two thirds of the respondents (60%) supported the notion of study days during the week for learning experiences. Having a study day during the week is a method used by the University of Bristol, Faculty of Health and Social Care, in Continuing Professional Development as one of the teaching/learning methods and strategies for continuing education. As mentioned previously, many professional nurses (71%) support the idea of attending and completing accredited short training courses (table 7.15). Similarly, 73% support idea of attending seminars, workshops and conferences as opposed to learning activities. Several institutions such as the HPCSA and the University of Bristol recognise these activities as accredited CPD activities. Muller (2007), states that seminars and conferences are educational methods that are used to convey the latest developments to a larger audience.

Professional nurses are often requested to join a professional organization. Meetings held by these professional organizations are also related to enhancing knowledge, especially in areas of specialization e.g. Community Nurses Association, Midwives Association. It was felt by the respondents (65%) that meetings attended for the purpose of professional associations should be given recognition for CPD credits. Technology is increasing every day. Professional nurses in South Africa may not yet appreciate the full impact and advantages of the use of Electronic Learning (e-learning) or answering quizzes via electronic media and therefore at this stage may not support electronic media. Although the use of e-learning was only supported by slightly more than half (55%) of the respondents, it is crucial that SANC should take note of the general advancement of technology.

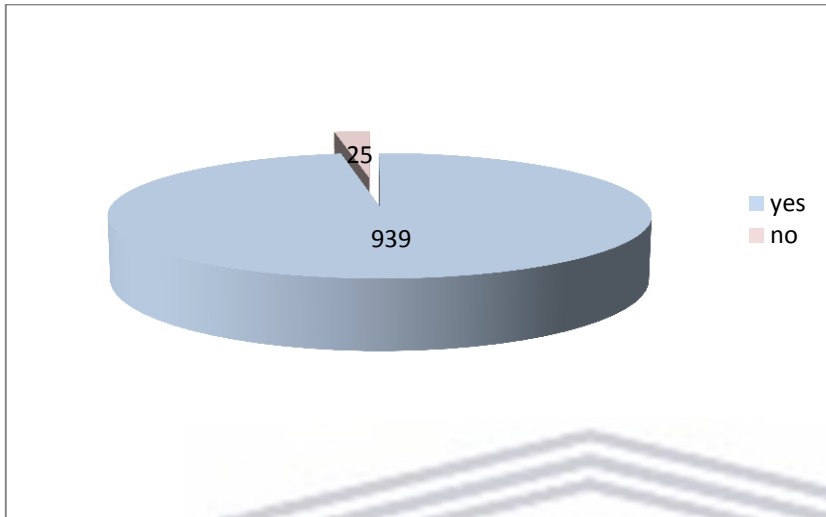
E-learning is essentially the application of information and communication technologies (ICT) to deliver educational services e.g. internet, email, and software programmes (Klein & Ware, 2003). The American Academy of Nurse Practitioners (AANP, 2006) conducted a survey in April 2006, which states that 68% of respondents indicated that they used the internet daily, and 72% used e-mail daily. In South Africa, it is currently not known what percentage of the South African Professional Nurse population is computer literate. Respondents (68%) however showed interest in the thought of having IT staff - support groups and problem-solving groups.

Table 7.16 The range of learning experiences for CPD

Item	No. of respondents	%
Healthcare (Nursing) audits.	733/890	71
In-service training.	867/940	84
On site supervision and guidance by nurse specialists.	637/811	62
Journal articles.	580/794	56
Team assignments and projects(Task groups).	576/785	56
Presentations to colleagues.	631/818	61
Distance learning – self study.	559/768	54
Academic studies.	622/812	60
Study days during the week.	620/815	60
Short accredited training courses.	732/891	71
Seminars, workshops, conferences, updates.	759/874	73
Meetings of professional organizations.	675/869	65
Electronic-Learning.	566/776	55
Staff support groups, problem solving groups.	703/836	68

7.21 Should your employer fund all CPD activities?

All employers of professional nurses should contribute to the skills development levy. The majority (97.4%) thus felt that their employers should fund all their CPD activities (figure 7.5). In the UK, employers contribute a portion to of CPD activities.

Figure 7.5 Should your employer fund all CPD activity?

7.22 Policies provided by employer

The respondents (99.58%) further felt that employers should have formal policies for study leave. This would mean that they get a full day salary when they attend a full day seminar / workshop and that this day is not deducted from their yearly study leave (table 7.17).

Table 7.17 Policies provided by employer

Item	Yes	%	No	%
Formal policies for study leave.	962/967	99.6	5	0.4
Study leave to attend seminars etc..	929/932	99.7	3	0.3
Formal policies for financial support.	801/805	99.5	4	0.5

7.23 Barriers preventing participation in CPD

Respondents were asked what kind of challenges they would anticipate that might prevent them from participating in CPD activities. Nearly two thirds (63%) responded that family and social commitments might prevent them from engaging in CPD activities (table 7.18). These findings correspond with those of Gould, Drey and Berridge (2007), which state that the demands of undertaking CPD conflicted with home and domestic commitments. Time constraints were chosen by 46%, which is also supported by Gould, Drey and Berridge (2007) who found that time

was a factor especially when having to travel to CPD venues and arranging child-care. Most were unhappy about using their own time. Many respondents (56%) felt that their employers may place restrictions on them for engaging in CPD activities. Often, only senior management is permitted to go to CPD activities while other employees are not. Gould, Drey and Berridge (2007) state that managers expected their employees to invest personal time on CPD even though the CPD was focused on how to improve service delivery. The Nursing and Midwifery Council (UK) states that one of the ways to dealing with the challenge of managing time is to get organized in your work life so that so that if you fulfil your work life and your life outside of work, then you as an individual nurse, your family and the employer will benefit (NHS, 2007). Five percent chose 'other' but did not elaborate and could be due to financial constraints as short courses; conferences etc. are expensive if no financial assistance is provided by the employer. Another barrier could be the relevance of the courses offered to nurses as part of CPD.

Table 7.18 Barriers to CPD engagement

Item	No. of respondents	%
Family and social commitments	650/1034	63
Time constraints	582/1034	46
Employer restrictions	577/1034	56
Other	51/1034	5

7.24 Future engagement in CPD activities

Nearly all (99.1%) of the professional nurses felt that they are self-motivated in relation to CPD activities and will plan their activities to progress along a planned career pathway (98.7%). Respondents (99.4%) felt that CPD will enable them to contribute to developments in their nursing career. They valued the education which involves members of the multi-disciplinary team (97.4%) (table 7.19).

One of the objectives of the Training and Education Department of the Wales Centre for Health is to lead, develop, and facilitate multi-disciplinary public health training (Wales NHS, 2007). The multi-disciplinary team context in South Africa also appears to be very important to professional nurses, with an overwhelming

majority valuing this type of education (Uys & Middleton, 2004; Stuart & Laraia, 2002).

Although many nurses (89.9%) felt that CPD would be essential for survival in all nursing practices, some acknowledged that CPD activities may be time-consuming and expensive (54.8%). Most of them also felt that CPD will enhance clinical supervision and mentorship skills (94.9%) and can assist in career planning (97.4%). According to Booyens (2000), career planning involves the analysis and specifications of a nurse's career objectives and the application of various methods of achieving the career planning objectives. A majority (91.6%) of the respondents felt that CPD activities should be dictated by the service needs of the employing organization. This is slightly in contrast with the previous statement where the majority of respondents felt that national health priorities ranked higher than local health priorities.

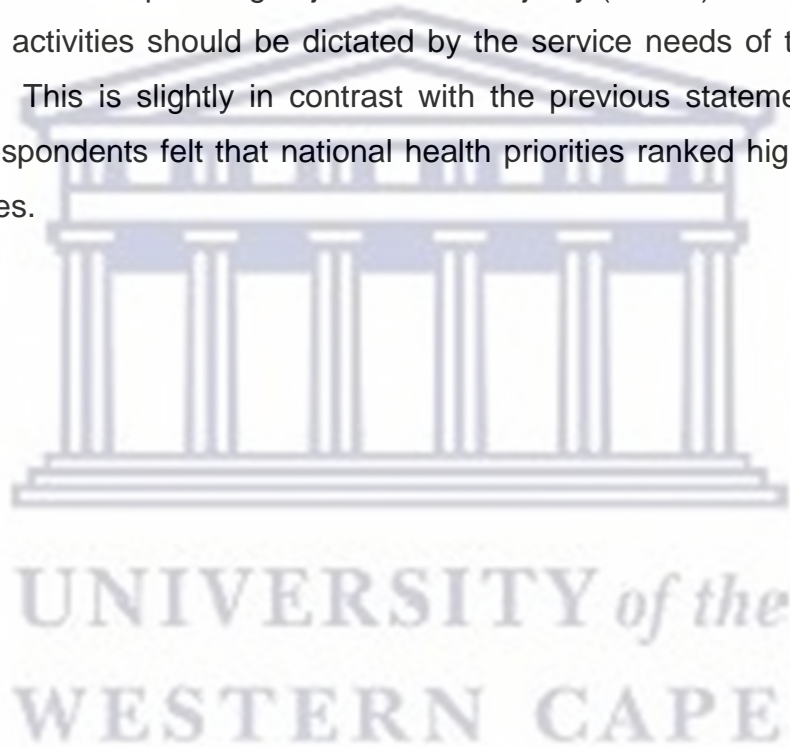


Table 7.19 **Future engagement to CPD activities**

Item	Strongly agree	Agree	Disagree	Strongly disagree
I am self-motivated in relation to CPD activities	589/1030 (57.2%)	432 (41.9%)	9 (0.9%)	-
I will plan my activities to progress along a planned career pathway	472/1019 (46.3%)	534 (52.4%)	13 (1.3%)	-
CPD will enable me to contribute to developments in my nursing career	517/1019 (50.7%)	596 (48.7%)	6 (0.6%)	-
I value education which involves members of the multi-disciplinary team	404/1016 (39.8%)	585 (57.6%)	17 (1.7%)	10 (1.0%)
CPD will be essential for survival in all nursing practice	324/1009 (32.1%)	583 (57.8%)	74 (7.3%)	28 (2.8%)
CPD activities will be time consuming and expensive	150/1002 (15.0%)	399 (39.8%)	335 (33.4%)	118 (11.8%)
CPD will enhance my clinical supervision and mentorship skills	384/1022 (37.6%)	586 (57.3%)	37 (3.6%)	15 (1.5%)
My career planning will be assisted by my CPD activities	458/1022 (44.8%)	538 (52.6%)	22 (2.2%)	4 (0.4%)
CPD activities should be dictated by the service needs of the employing organization)	430/1017 (42.3%)	501 (49.3%)	76 (7.5%)	10 (1.0%)
There should be structured CPD activities within my place of work	500/1028 (48.6%)	517 (50.3%)	10 (1.0%)	1 (0.1%)

7.25 Planning a CPD portfolio

A CPD portfolio is an important document in that it is evidence gathered by the professional nurse to prove that she or he has participated in CPD activities over the years. It also assists when she or he is applying for a new vacancy or for promotion purposes. Most importantly it can be called upon by the professional body for auditing purposes. The respondents stated that a portfolio should consist of the following documents:

Certificates of attendance

Written transcripts

Copies of unpublished / published work

Written references

The above findings are supported by Hull and Redfern, 1996, Brown, 1995 and Kelly, 1995. Ninety eight percent (table 7.20) chose 'other' could be because materials in a portfolio for self- growth and career development will differ from ones in a portfolio designed to justify a career ladder promotion (Oermann, 2002).

Tables 7.20 Planning of CPD portfolio

Item	Yes	%
Certificates of attendance (short courses, workshops, etc)	1017/1020	99.7
Written transcripts which verify modules, hours of study and results	847/867	97.7
Copies of unpublished / published work that you have written or contributed to	717/727	98.6
Written references	640/650	98.5
Other	81/83	97.6

7.26 Principles for consideration for CPD model

The following principles will be considered for incorporation in to the CPD model.

There is a need for CPD for professional nurses in SA.

CPD should be compulsory for all professional nurses.

CPD may be seen as a way of self empowerment.

CPD is a method to address the needs of the services rendered by the institution.

CPD could be voluntary or mandatory.

Some form of penalty should be implemented if the professional nurse does not comply with the requirements.

CPD activities should be in a credit bearing format and CPD should only be provided by an accredited SANC- approved provider.

CPD is positively viewed as a way of keeping abreast of current health trends and of maintaining professional standards of practice.

CPD can promote job satisfaction, enhance professional career goals and create positive competitiveness in professionals.

Timeframe to submit CPD for credits can be annually, every 2 years or when stipulated by SANC.

The national health priorities were the most important health priorities to be addressed by CPD.

CPD short courses could be used to improve scarce skills shortages in nursing, such as Intensive Care Nursing, Operating Theatre Nursing, Oncology Nursing, CPD could be useful in human resource development in order to maintain a high quality of care.

Professional nurses are in full support of introducing a CPD system in South Africa and agree that such a system is long overdue.

CPD embodies the whole range of learning experiences such as in-service education, conferences, seminars etc.

Study days during the week are supported for the short courses.

Most felt that their employers should fund all their CPD activities.

Barriers preventing participation in CPD could be related to time, family commitments, financial, and employer constraints.

Professional nurses felt that they are self-motivated in relation to CPD activities and they valued the education in a multi-disciplinary team context.

A CPD portfolio is an important document in that it is evidence gathered by the professional nurse to prove that she or he has participated in CPD activities.

7.27 Summary

The survey questionnaires received back from the professional nurses provided valuable information about their viewpoints on CPD. Although CPD is a new concept for nurses in South Africa, they were able to answer the questionnaire.

The majority of the participants wanted the implementation of a CPD system. Many viewed CPD as beneficial to the professional nurse, patients, the health services, and the profession as a whole. Various traditional methods of CPD were chosen such as short courses, in-service education and seminars. There were also those who wanted electronic courses.



Chapter eight

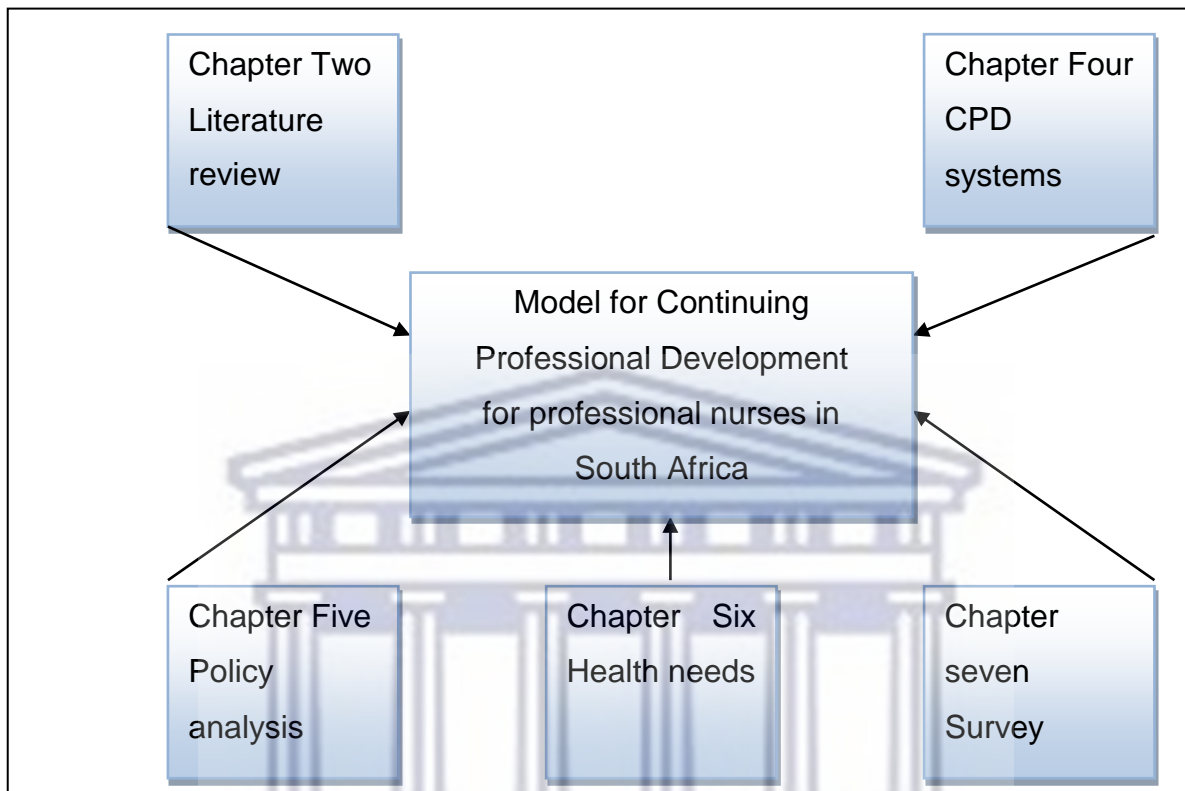
The development of a model for CPD for professional nurses in South Africa

8.1 Introduction

The development of the “Model for Continuing Professional Development for professional nurses in South Africa” is derived from the information gained from the previous chapters (Figure 8.1). Chapter eight will introduce the reader to an overview of the development of the model. The main aim of this thesis was to develop a model that can be forwarded to the SANC to serve as a basis for the implementation of CPD for professional nurses in South Africa (Figure 8.2). The purpose was not to test the model. Testing of the model will hopefully be done at postdoctoral level, once the SANC has agreed in principle to the proposed model.

8.2 Overview of the Model

The framework on the CPD model is developed to meet the aim “to develop a model for CPD for professional nurses in South Africa”. The major categories that are defined in the model are derived from the theoretical framework that guided the study and from the findings of the different chapters of this thesis (Figure 8.1). Information gained from the foregoing chapters guided and validated the basis of the model. Furthermore, the development of this new proposed CPD model is evaluated against the criteria suggested by Chinn and Kramer (2004) and Meleis (1985). These authors are regarded as pioneers in the area of theory and model development in nursing and are widely used by other health disciplines. Chapter eight also describes the complete proposed model and guidelines that will be submitted to the SANC for possible implementation on a trial basis to evaluate the feasibility of this new proposed CPD model.

Figure 8.1 Development stages of the model for CPD in nursing

8.3 Criteria used for evaluating the proposed CPD model

It is essential that any new model be exposed to evaluation before implementation. The researcher used the criteria recommended by Chinn and Kramer (2004) to evaluate the proposed CPD model:

What is the purpose of this model and why was it generated?

What are concepts of the model?

How are these concepts defined?

What is the nature of relationships?

On what paradigm and assumption does the theory build?

What are the propositions of the model?

What is the structure of the model?

8.3.1 What is the purpose of this model?

The general purpose of model development is important because it specifies the context and situation in which the theory applies. The question that needs to be answered is “Why was the model formulated?” The answer is clear. The Nursing Act 33 (2005) states that a CPD system needs to be implemented. The SANC is responsible for the implementation of it. To date no model for CPD has been brought forward by the SANC. The researcher felt that it would be important to develop a model for CPD for professional nurses in South Africa that could be tabled at SANC. If SANC approves the model, it can then be implemented, monitored and evaluated. The model will serve as a structure by which the professional nurses can maintain and update their professional knowledge, skills, attitudes and ethical values so that they can be competent. It is important that the purpose statement has a value orientation or connotations in order that the purpose of the model is made clear. The value orientation for this model is “being competent” as opposed to “being incompetent” in today’s dynamic world of nursing (Chinn and Kramer, 2004). The model is applicable to a particular group of people namely: professional nurses.

The next question that arises is: What is the purpose of this CPD model? The researcher has reviewed the literature to ensure that the model will be able to serve as a base on which CPD for nurses can be implemented. It is envisaged that the implementation of CPD will ensure that competent nurse practitioners will provide up-to-date nursing care and thus decrease the risk of malpractice that could harm the person who receives nursing care. The model also addresses the larger community by addressing the national health needs of the country. The purpose of the model further explains the understanding of why professional nurses should be competent and why they should maintain and update their professional knowledge, skills, attitudes and ethical values. The proposed model has no stop dates as it is built on the underlying principle of a lifelong learning philosophy. What is important is that the model should be regularly evaluated and updated to meet the current needs of the profession. The endpoint of the model is to provide the professional nurse with a platform to participate in continuing professional development until retirement from the profession. The purpose that is

not explicitly embedded in the matrix of the model is the concept that to be a professional person one has an obligation towards oneself, the profession, the patient (community) and the employer, and thus the professional person undertakes CPD to remain competent.

8.3.2 What are the concepts of the model?

Chinn and Kramer (2004), defines the word concept as an idea which may be an invention, thought or a notion, its benefits, and alternative uses or its presentation as outlined in this CPD model. Meleis (1997) argues that defining a concept allows one to delineate sub concepts and dimensions of the concept. The concept characteristics provide the determinants for the application of the model. Concepts get processed and it is during this phase that the theorist smoothes off the rough edges of the concept by clarifying the understanding of it and thus enhancing the precision and understanding of the concept. The major concepts that delineate the boundaries of this model are:

Input

Throughput

Output

Feedback

8.3.3 How are these concepts defined?

Input is an abstract concept that denotes the entry point where data / suggestions / advice is inserted into a system which activates or modifies the process. In this model the input is informed by literature, CPD practices, legislation and policies, health needs of the community and the survey of professional nurses. The transformation of input (i.e health needs) into output (meeting health priorities) by the systems is called throughput. In other words the “raw” material is entered via the input concept and modified via throughput to deliver a specific output. The output is the result obtained via the transformation of the input. Feedback describes the situation when the information gained from the input, throughput, or the output is used to improve the previous or the following step in the system.

Feedback usually involves an event which is part of a chain of cause-and-effect that forms a circuit or loop. Naturally most systems have an obvious input and output; and a feedback loop to increase the input. For instance:

Input: An outbreak in measles

Throughput: CPD courses specifically orientated on mass immunization skills.

Output: Competent professional nurse that can do immunization.

Community benefit due to competent nurse will be the decrease of measles incidence due to the success of the immunization.

Monitoring, evaluation and feedback are crucial to ensure that the CPD system operates at maximal capacity and always endeavours to reach a state of equilibrium to produce competent up- to- date professional nurses. The feedback is extracted from the output, throughput and environment at regular intervals. Peer evaluation forms an important role in evaluation during CPD updates as peers can evaluate the performance of each other measured against a standard benchmark set by CPD. CPD providers need to ensure that all their activities are benchmarked at an international level but also fulfil their purpose at a national and local level.

8.3.4 What is the nature of relationships?

For a model to be functional it is important that the concepts are interrelated and that the model and the theory interact. In this model there is a reciprocal relationship between the propositions such as the environment, the principles of adult learning, and the philosophy of lifelong learning which form the basis of the model. Within this framework we see that input, throughput and output is interrelated to each other. Input is received from the literature and policies and practices. These feed into the processes that need to take place to ensure that the input matters are attend to. During the throughput the professional nurse will engage in CPD activities that will improve the output, which lead to a competent professional nurse that render competent nursing care, which improves the health of the community.

8.3.5 On what paradigm and assumption does the theory build?

Paradigmatic origin

All researchers have their own values and beliefs that may influence their results. The term paradigm originated from the work done by Thomas Kuhn in 1962 and refers to a generally accepted worldview or philosophy (Kuhn, 1962). This CPD model is founded within the boundaries of the researcher's assumptions and it includes criteria for assigning value to the research project and the methods used for developing the model. The paradigmatic perspective of this model is the Philosophy of life-long learning based on the principles of adult learning. The major concept is continuing professional development for professional nurses in South Africa. Assumptions are beliefs or ideas that we hold as accepted truths with little or no evidence of foundational or theoretical reasoning being applied. Assumptions are made daily by every-one of us. We assume that we going to wake up tomorrow to do certain tasks for instance (Chinn and Kramer, 2004). It is important that the researcher declares his assumptions so that the reader can understand his assumptions and exclude any conflict of interest that might have occurred. The assumptions built in this model are based on the findings from the previous chapters.

Assumption 1 The professional nurse is an adult learner

Features of the adult learner, based upon the research and theory of andragogy and social learning theory, have been asserted by authors such as Dirkx and Lavin (1995). The researcher based the assumption of adult learning on Malcolm Knowles's theory of andragogy and assumes that professional nurses are adult learners and therefore display the following characteristics as learners: Professional nurses are diverse and they bring a wealth of life experiences to the learning situation. They also continue to increase their learning as they progress (Dirkx and Lavin, 1995). Professional nurses prefer to focus on issues that concern them. They maximise all the available resources and active forms of learning assist them to bond the learning content to their own meaning structures (Dirkx and Lavin, 1995). Professional nurses tend to be pragmatic learners and want to be able to relate the content to specific circumstance in their lives and want to see changes in their performance after learning has take place. The information

received must be appropriate and developmentally paced (Dirkx and Lavin, 1995). Professional nurses will engage in CPD or learning activities to improve their performance in other social roles, but they will not let their other responsibilities, such as jobs and families take a back seat to their learning activities (Dirkx and Lavin, 1995). Adult learners prefer to have some degree of control over their learning and expect that their learning time or contact time will be well spent (Dirkx and Lavin, 1995). Professional nurses tend to be voluntary learners and believe that education will enhance their sense of self (Dirkx and Lavin, 1995).

Assumption 2 CPD is essential

CPD is essential for the professional nurse in order to remain competent in knowledge, skills, attitudes, and ethical values.

Assumption 3 CPD has progressive outcomes

CPD will have positive outcomes for all role players in CPD namely the professional nurse, employer, the community, the health services, SANC, government, and education providers.

Assumption 4 Several key players need to be involved

Various role players will carry out their part to make CPD a success.

8.3.6 What are the propositions of the model?

Propositions are statements of relationships between two or more concepts. Propositions expand the theory with description, explanation or predictions and are essential for providing links between concepts (Chinn and Kramer, 2004; Meleis, 1985).

Lifelong learning

Lifelong learning is the overarching philosophy of continuing education. It is part of the philosophical underpinning of CPD of the professional nurse. Lifelong learning needs to be embraced by professional nurses to ensure a positive attitude towards

CPD. If the professional nurse does not believe in lifelong learning she will show no desire to develop.

Environment

The environment in which the professional nurse operates is dynamic and continuously changing. It is also recognised that the health needs of the South African community, political influences, educational practices, medical and nursing practices as well as administrative and technology are always changing. The competent professional nurse is objectively aware of the changes in this dynamic environment and prepares herself to cope with the demands of an ever-changing environment. Cognisance to the ever changing environment is important as it determine the basis on which CPD will be focus on.

Adult education principles

The integrative approach to continuing professional development involves key elements built on andragogical principles which assume that the professional nurse has:

A self-concept and can direct her own learning.

Has accumulated a reservoir of life experiences that is a rich resource for learning.

Can study independently

Has learning needs closely related to her practice and is skilled to make critical decisions when solving problems.

Is self-motivated.

Without the assumption that the professional nurse is an adult learner that can take responsibility for her own development will the implementation of CPD not be successful.

8.3.7 What is the structure of the model?

The individualised as well as the overall ideas are systematically organised so that each one feeds into the next one (figure 8.2). The systems theory is discussed in detail in chapter two, which relates to the input, throughput and output of the

model. The single structure of the model allows for concepts to move towards the purpose.

Clarity

Meleis (1997), states that models are enhanced by visual presentation. Figure 8.2 is a clear visual presentation of the CPD model. An examination of the various concepts shows that they are all interrelated and functionally interdependent.

Linkages

In systems theory, the subsystems must be able to communicate with each other (Arndt and Huckabay, 1980).

Borders

The borders depict the environment in which CPD needs to function. The environment refers to the healthcare environment of the professional nurse in the South African context. The environment impacts on the input phase of the system. The healthcare environment is dynamic and the healthcare needs of South Africans are changing constantly. The environment can also be influenced by the international community, political influences, educational and technological changes. All of these play individually and collaboratively important roles in the changes that occur in the environment. The environment has a ripple effect on the input of the model and determines what policies and regulations will be made. It also determines the health priority needs of the country that should be addressed by CPD.

The bottom line and arrows depicts the monitoring, evaluation and feedback. Feedback is a mechanism of monitoring and evaluation that is a continuous process. This is the most dynamic part of the system as it allows for adjustment by receiving information from the subsystems of input, output, throughput, and environment. Monitoring, evaluation and feedback are the heartbeat of the system and are used to steer the operation of the CPD system.

The arrows in this figure show linkages and the flow between the subsystems.

Left side

The left chevron depicts the input. The input is the energy that gives direction to the CPD model. The input into the CPD model varies and receives information from the external environment by way of legislation, policies, role-player agendas, health priorities, government regulations, and briefs, SANC, community, employers, education and from professional nurses themselves. Feedback from the ongoing monitoring and evaluation forms an integral part of the Input. Input is itself a subsystem of the whole CPD system.

The CPD model can receive information used during the input phase from the environment as well as from the throughput and the output. This is where all the “gears” of the system meet and information can come from varied sources. If the external environment changes, for example if there is an outbreak of Avian Flu that kills many people then the input needs to be adapted to ensure that policies and guidelines are made on how CPD should be offered to address this new health challenge. Inputs can also come from feedback from the subsystems such as from throughput where the evaluation from CPD courses can show a shortage of a specific skills, or from output where the statistics would show that the implemented policy guidelines are maybe outdated and that new measures should be put in place to ensure that the morbidity of a specific disease is decreasing.

Middle

The middle chevron depicts the throughput. Throughput is referred to as matter, energy, and information that are modified or transformed within the system (Kenney, 1995). The throughput consists of a number of essential processes required of the CPD model. Throughput is made up of the stipulations for CPD as decided on by the SANC. It is hoped that the SANC will accredit service providers, determine levels of CPD activities, add values to the levels and will determine the requirements of CPD units in a specific time period. The SANC may also request compilation of a portfolio of evidence and submission of it for auditing purposes. The principles of adult education are the method of delivering the CPD range of offerings. Feedback to throughput can come from the other subsystems. Throughput is a subsystem of the whole CPD system.

Right side

The final right rectangle depicts the output. Output can also be referred to as outcomes. The final outcome is the development of a competent professional nurse that is competent in knowledge, skills, attitudes, and ethical values. This competency allows the professional nurse to renew her licence to practice. Output is also a subsystem of the whole CPD system. The professional nurse provides, facilitates, and promotes the best possible professional service to all people that she or he renders nursing care to. This is based on ethical values of integrity, honesty, fidelity, charity, responsibility and self-discipline.

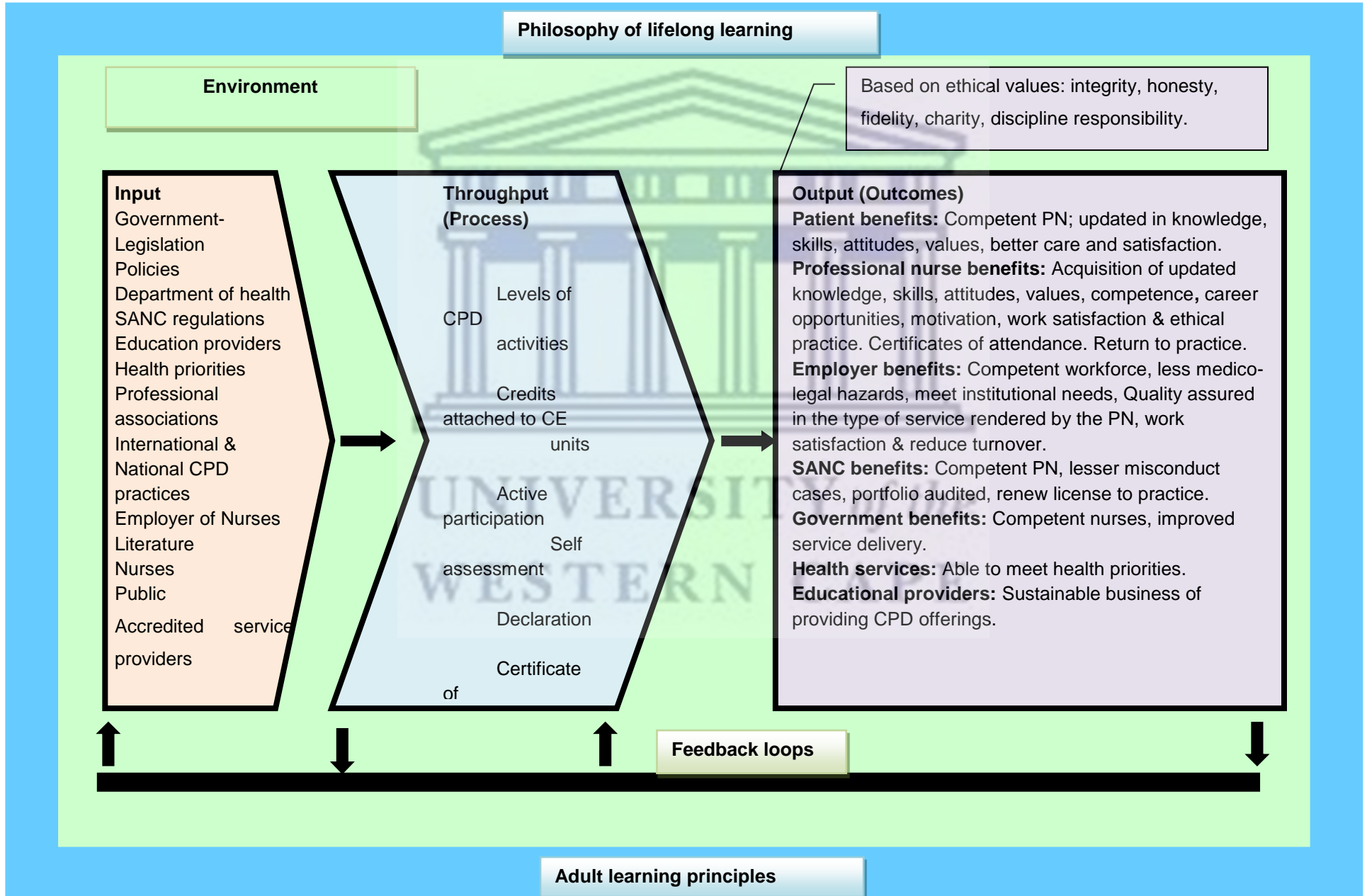
The outcome is the competent professional nurse

Competent will mean being competent in knowledge, skills, attitudes and ethical values. Knowledge in nursing is about the theoretical information needed to make decisions, while skills are referred to as practical or clinical dexterity. Attitude embodies the feelings of the professional nurse. Attitudes are generally positive, negative, or ambivalent views towards a person, place, thing (learning opportunity) or event. Ethical values are a formal set of rules which are explicitly adopted by professional nurse about what is right or wrong. It is expected that professional nurses are committed to the highest ethical standards. Bucknam (1997) recommended the following core ethical values for the development of professional practitioners to assist them in developing solutions to ethical dilemmas encountered in professional practice (table 8.1).

Table 8.1 Core ethical values according to Bucknam (1997).

<p>1. Integrity exercising good judgment in professional practice adherence to ethical principles</p>	<p>4. Charity kindness caring good will tolerance compassion/mercy adherence to the Golden Rule [do unto others as one would like to be done to them]</p>
<p>2. Honesty truthfulness fairness sincerity</p>	
<p>3. Fidelity faithfulness to clients [patients] allegiance to the public trust loyalty to employer, firm or agency loyalty to the profession for the theist, faithfulness to God</p>	<p>5. Responsibility reliability/dependability accountability trustworthiness</p>
	<p>6. Self-discipline acting with reasonable restraint not indulging in excessive behaviour</p>

Figure 8.2 Transformative Model for CPD for Professional Nurses in South Africa



8.4 Checklist for criteria of model development

A checklist was used to ensure that all the criteria to evaluate a model were adhered to according to Chinn & Kramer (2004) and Meleis (1985) (table 8.2).

Table 8.2 Checklist

Description	Applied
Purpose	Yes
Why was the theory / model formulated?	Yes
The purpose statements have a value orientation. Value connotations are important to understand the purpose of the theory/model.	Yes
Is there a purpose for the nurse?	Yes
Is there a purpose for the person receiving care?	Yes
Is there a purpose for the society?	Yes
Does achieving the theoretic purpose require a nursing context?	Yes
Does the purpose reflect understanding?	Yes
When would the theory/model cease to be applicable?	Yes
What is the end point?	Yes
What purpose not explicitly embedded in the matrix of the theory / model can be identified	Yes
Concepts	Yes
Is there one major concept?	Yes
Are the concepts broad or narrow?	Yes
Can the concepts be related?	Yes
Definitions	Yes
Which are the concepts defined?	Yes
Which concepts are not defined?	Yes
Are there similar definitions for different concepts?	Yes
Relationships	Yes
What are the major relationships within the theory?	Yes
Structure	Yes
How are overall and individualised ideas organised?	Yes
If outlined, what would the theory look like?	Yes
Does the structure move concepts away from, towards the purposes?	Yes
Could more than one structure represent the overall structural relationships?	Yes

8.5 Guidelines for implementation of the CPD model.

The format of this part of the document utilises the HPCSA August 2006 CPD guidelines for the health professions.

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i Terminology

Academic year: A period between January to December in any calendar year comprising a minimum of 44 weeks.

Accreditor: This refers to a person, an educational service provider, or a group that meets the set criteria. The role of the accreditors role is to check all applications from those who want to provide CPD learning activities (HPCSA, 2006).

Attendance register: This can be in an electronic or manual format. It is the record of persons attending a learning activity that must be kept by the registered service provider. The register should reflect the following details of all the participants: full name, surname, SANC registration number, how many credits were approved for the course, date and time. The professional nurse must also sign the register. The register must be kept for five years after the activity. The register may be used in the future for verification by the CPD department (HPCSA, 2006).

Audit: This is the formal checking by an assessor to check for CPD compliance.

Compliance check: This takes place four times a year (January / April / June / November). The persons are selected by an approved sampling method from the SANC registers. The CPD department of SANC conducts these checks. Professional nurses must submit their Portfolio of evidence (by post /courier /personally or otherwise) within 15 working days of receiving a letter to submit. The prescribed fees must be paid also (HPCSA, 2006).

Competence: The ability of a professional nurse to effectively and efficiently use his or her knowledge and skills appropriately which includes attributes such as knowledge, skills, judgment, values and beliefs, which are required to perform as a professional nurse in all situations and practice settings.

Continuing professional development: is the lifelong process of active participation by professional nurse in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice, support achievement of their career goals. This begins within the basic nursing education programme and continues throughout the career of the professional nurse. It encompasses the educational concepts of continuing education, staff development and academic preparation.

Continuing education units (CEU's): are the weightings or values that are attached to the learning activities that can be used for CPD (HPCSA, 2006).

CPD committee: This committee consists of a minimum of four council board members. This committee advises regarding CPD matters (HPCSA, 2006).

CPD department: This department is situated within the SANC offices and manages the entire CPD process for the nursing profession (HPCSA, 2006).

CPD learning activities: These are CPD activities that have outcomes. Participation in these activities nurses gain CEU's (continuing education units). There are various levels of CPD activities (HPCSA, 2006).

Postponement: This is written permission requested by the professional nurse to the CPD committee and granted by them to excuse the professional nurse from CPD obligations in a specific period of time. There are conditions for re-entry into nursing practice and CPD. The prescribed fees must be paid for postponement to be considered (HPCSA, 2006).

Portfolio of evidence: is an individual professional nurse's CPD activity record. This file contains all the evidence of every learning activity attended or completed by the professional nurse.

Service providers: This refers to a person, an educational institution, or a group that meets the set criteria (HPCSA, 2006).

1 Introduction

The nursing profession is a noble and ethical profession. The professional nurse has to be competent to provide nursing care that is based on both evidence and ethics to care successfully for the community. This requires a conscious commitment to consistently and continuously be updated with regards to knowledge, skills, professional attitudes, and ethical values. The professional nurse should aspire to the highest standards of excellence in the provision and delivery of healthcare in South Africa. The Nursing Act, 2005 (No. 33 of 2005) endorses Continuing professional development as a means of maintaining and updating professional competence.

The levels of CPD activities are set out from simple to complex and any listed activity can be chosen by the nurse in order to give choice and flexibility and takes into account that nurses are adult learners. The model for CPD professional nurses subscribes to a philosophy of lifelong learning. The responsibility for CPD is essentially that of the individual professional nurse. The beneficiary is the nurse, the profession, the patients, the employer, the SANC, the government, and all other stake holders. The model for CPD will address the South African circumstances by providing a variety of learning opportunities which will be accessible to both rural and urban nurses.

In terms of section 39 of The Nursing Act No. 33 of 2005 “The Council may determine-

- (a) conditions relating to continuing professional development to be undergone by practitioners in order to retain such registration;
- (b) the nature and extent of continuing professional development to be undergone- by practitioners; and
- (c) the criteria for recognition by the Council of continuing professional development activities and accredited institutions offering such -activities.”

2 General

The CPD system will be managed by the CPD department of the Council. A generic set of guidelines for accreditors and service providers will be developed by the CPD Committee. CPD activities will be provided by accredited service - providers. Service - providers will have to keep record of all activities that they offered. The professional nurses will comply with the terms of CPD activities in order to meet the requirements of the council for the renewal of yearly registration (HPCSA, 2006).

3 Process

CPD activities are presented by an accredited service provider to the professional nurse.

3.1 Service provider

An accredited Service Provider will publish the proposed activities together with the CEU's on the SANC webpage and will be able to advertise in magazines, newspapers, flyers and the internet. Service providers shall be requested to keep an attendance record of all the CPD activities. The Service provider shall issue an attendance certificate to all who attend their accredited CPD courses.

The following information need to be on the certificate:

Name and surname of candidate

SANC registration number of the attendee.

Name and number of the accredited service provider;

The topic of the activity

The level of the activity

The number of CEU's for that activity

The commencement and completion date of the course.

The accredited hours and units that were allocated (HPCSA, 2006).

3.2 Summary record of CPD activities

This is an official record sheet of the CPD committee which is sent to a professional nurse annually (Addendum 6). This is a summary sheet, on which the following must be recorded by the professional nurse for each CPD activity attended.

Name and surname

SANC registration number

Name and number of the accredited service provider;

The topic of the activity

The level of the activity

The number of CEU's for that activity

The commencement and completion date of the course. (HPCSA, 2006).

This is the third sheet of the portfolio- of- evidence file. When a professional nurse is drawn in an audit sample for a compliance check then this is the sheet that is sent to the CPD department.

4 Standard of measurement-continuing education units (CEU's)

The standard of measurement of a CPD activity is in a unit form, called a continuing education unit (CEU). CEU's are allocated according to time and one CEU equals one hour of CPD activity. There is a limit of a maximum of 8 CEUs per day (excluding break time of lunch). A minimum of 35 CEU's will be required per year (HPCSA, 2006).

The following is compulsory content that must be covered in a year.

Compulsory content	Number of CEU's
Ethos and professional practice	10
Regional / national / provincial / local health priorities	10
Your area of practice	10
Area of interest	5
Total	35 CEU's per year

The accumulated CEU's are valid for a period of 36 months from the date the CPD activity took place. A CPD cycle commences in January and ends in December each year.

5 Categories of CPD learning activities

There are four levels of activities. A professional nurse may only obtain the maximum of 20 CEU's at level one. The rest of the CEU's can be made up at level two, three or four. This depends on the individuals' circumstances and learning needs (HPCSA, 2006).

5.1 Level 1 Activities (a maximum of 20 CEU's can be obtained in a year)

These CPD learning activities may or may not have a measurable outcome and are presented on an ad hoc basis. This can include activities that the professional nurse does in her own time without the boundaries of an accredited provider. The professional nurse then needs to seek approval from an accredited provider to ascertain the quality of the activity and allocate a CEU unit and certificate for it.

These activities include:

In-service education

Small group discussions

Presentations

Formal hospital/clinic/health unit updates

Case study discussions

An organised lecture or teaching & learning ward rounds.

On site mentoring, coaching and supervision activities.

Team assignments and projects

Conferences, seminars and workshops

Short courses without a measurable outcome (HPCSA, 2006).

5.2 Level 2 Activities (a maximum of 20 CEU's can be obtained in a year)

This level of activities relates to the updating or acquiring of new clinical skills competencies. Nursing is a clinically based profession and therefore the acquiring or updating of clinical skills is given prominence.

Basic nursing skills -2CEU's per skill

Intermediate nursing skills -3CEU's per skill

Advanced or specialised nursing skills- 5CEU's per skill

The use of new technological skills must also be categorised as basic, intermediate or advanced skill with the corresponding CEU's.

5.3 Level 3 Activities (a maximum of 20 CEU's can be obtained in a year)

A professional nurse may only obtain the maximum of 20 CEU's at level three; the rest of the CEU's can be made up at level one or three. Level three activities include teaching and learning, research and scholarship. Activities such as teaching and assessments that fall into a professional nurse's job descriptions relating to the above will not be accredited. Ten CEU credits can be awarded if the professional nurse is the first author of a journal article publication or chapter in a book. Co-authorship will earn four CEU's. The written review of an article or chapter in a book as a reviewer carries the weight of four CEU's. Presenters and authors of a paper or poster presented at a congress or refresher course accrue eight CEU's. All presenters of accredited short courses can claim eight CEU's if they are not part of their routine job description. (HPCSA, 2006).

Answering of a set of short questions or questionnaires in journals with a pass rate of 75 % is worthy of four CEU's per journal.

Professional nurses who are external examiners of theses or dissertations on completion (eight CEU's each). Individual modules of structured master degrees, honours degrees and post graduate diplomas with part time enrolment for study (four CEU's on completion of a module) (HPCSA, 2006).

Activities of nursing journal clubs and other special groupings such as Midwifery society, Theatre nurse's society etc. can contribute one CEU per hour but no more

than four CEU's per meeting. These groupings must have outcomes that are assessed according to criteria determined by the group (HPCSA, 2006).

5.4 Level 4 (a maximum of 35 CEU's can be obtained in a year)

This level is for professional nurses undertaking formal studies at an accredited institution. This level could earn the required CEU's for a year i.e. 35. CEU's earned are valid for a three year period.

Activities at level four include:

Courses such as nursing postgraduate diplomas, nursing honours degrees and nursing master's degrees that are recognised as additional qualifications by the SANC can earn 35 CEU's on completion of the course. For every academic year passed in all requirements the professional nurse can earn 35 CEU's. Short courses need a minimum of 16 hours contact time to earn a total of 16 CEU's (HPCSA, 2006).

5.5 Clarifying of CPD issues

Any activity that has no professional development purpose will not gain CEU's. Clarity must be obtained from the CPD department at SANC if unsure of the learning activities.

6 Portfolio of evidence

Each professional nurse must keep a record of her or his own learning activity in a lever arch file or other secure file in plastic sleeves. The first page must display the name, surname and SANC registration number. The second page must have the table of contents. The third page must have a copy of the recommended summary of activities. This is the same form that needs to be sent to SANC on a yearly basis with the declaration before registration. The fourth page onwards contains the accreditation certificates as provided by the service providers in a chronological date order. On request for the purpose of an audit by SANC, the professional nurse must forward certified copies of attendance certificates. These certificates

will be validated against the list of activities provided by accredited service providers. The professional nurse must keep the original attendance certificate and must provide it to SANC if required.

The portfolio with its content is the only record that is required to be kept by the professional nurse. The professional nurse has to keep the portfolio for a minimum of six years. The portfolio may be requested by SANC from the professional nurse to do a compliance check when her or his name is drawn for an audit. It must be sent to the CPD department of the council within 21 days of receiving notification of requirement to submit a portfolio.

7 CPD non- compliance

Non-compliance will be investigated. Action may be taken if a professional nurse is found to be guilty of non-compliance:

Firstly a written letter, or other means of communication will be sent to the professional nurse requesting the reasons for the non- compliance. If the written explanation is acceptable, an opportunity will be given to the professional nurse to comply within six months.

Should the professional nurse still not comply then the following actions will be taken:

- No renewal of yearly licence to practise.

- Notification of employer of professional nurses status

- Suspension from practice for a period of time as determined by SANC Professional conduct committee or

- Any other action as recommended by the CPD committee

The professional nurse has to re-apply for restoration of her or his name after he or she has successfully completed a return to practice course (HPCSA,2006).

8 Restoration to register

Restoration will be done once the non-compliant professional nurse has successfully completed the return to practice course and acquired the allocated CPD unit (HPCSA, 2006).

9 Return to practice programme

For every year a person has not been working or not been able to comply with the recommended CEU's per year with an additional 40 CEU's will be required. A maximum of 150 CEU's are required to return to a program (HPCSA, 2006)..

10 Professional nurses abroad

The professional nurse must comply with the CPD requirements of that country. If a CPD system is not in place then the professional nurse should make provision for acknowledgment of courses attended abroad with South African accredited service providers. They can keep all their documents and ask a South African-accredited service provider to accredit their attendance certificates. If the professional nurse cannot provide the needed portfolio will she or he be required to complete the return to practice accreditation programme (HPCSA, 2006).

11 Postponement of CPD requirement's

Professional nurses may apply for postponement of CPD requirement's with a letter of motivation to the CPD committee when necessary. Postponement may be granted depending on the merits of each case. Retired professional nurses and those not practising due to chronic poor health will not be granted postponement (HPCSA, 2006).

12 Professional nurses in non-clinical work settings

Professional nurses not engaged in clinical practice such as nurse managers, nurse educators and others must also comply with CPD requirements (HPCSA, 2006).

13 Appeals against CPD department decisions

A professional nurse has a right of appeal against a decision on a particular request in writing to the CPD committee within 14 days, specifying the grounds on which the appeal is made.

14 Mandatory Community service

Newly qualified professional nurses are not required to comply with CPD requirements during the mandatory community service year but are encouraged to attend CPD offerings at their workplaces to orientate themselves to the way in which the CPD portfolio is to be compiled (HPCSA, 2006).

15 Fees structure for CPD (escalation of 10% per year)

Assessment of the summary will be part of the annual registration fees. A recommended additional fee would be capped at R20.00 per professional nurse. This additional R20 will be sufficient to pay for all operational costs to run the CPD office (R20 x 100 000 nurses = R2 000 000.00). Professional nurses who wish to return to practice or who wish to apply for deferment can be charged additional fees (R200 per case).

16 Resources for CPD department

16.1 Human resources needed for the CPD office.

Category	Number required	Duties
CPD senior manager	1	Operational manager
Receptionist	1	Telephone and reception/postage
Administrator	4	Data capturing, administrative duties
Assessors	4	Assess portfolios
General assistant	1	General office duties e.g. filing

NB: Senior manager and assessors should be nurse educators

16.2 Equipment

Standard office equipment will be needed to allow the CPD office to run effectively.

Some of the items include:

Office furniture for 10 offices

Telephones

Appropriate digital technology

17 Endnote

The proposed guidelines for CPD for professional nurses in South Africa are outlined above. The main aim of the research was to develop a model that could be implemented by SANC. This was achieved after an extensive literature search, studying the CPD systems of national and international countries, conducting a document analysis of government legalisation and policies, assessing the health needs of the community and undertaking a national survey of professional nurses. It is hoped that the SANC will adopt the model for implementation.

8.6 Summary

This chapter has dealt with the development of a model for CPD for professional nurses in South Africa, using the systems theory in an outcomes-based education model. The development of this model was evaluated using the criteria suggested by Chinn and Kramer (2004) and Meleis (1985). The assumptions, propositions and description of the structure of the proposed CPD model for professional nurse have been described in this chapter. The model is depicted in figure 8.2.

Chapter nine

Implications, limitations and recommendations for practice and research

9.1 Introduction

The CPD model for professional nurses in South Africa has been designed on extensive literature analysis and on the needs of professional nurse and is presented in this thesis. The proposed model can be seen as a cornerstone for the validation of a CPD model for professional nurses in the South African context. This model is compliant with the contemporary developments in South Africa such as legislation, policies and principles, health needs and professional nurse CPD needs.

9.2 Implications for Practice

The findings imply that the professional nurse has to maintain and be updated in knowledge, skills, attitudes, and ethical values pertaining to her area of practice. In updating their knowledge and skills it is hoped that nurses will integrate them with the needs of their patients to allow them to practise evidence-based care, supported by the latest scientific evidence. Obsolete and dangerous nursing practices will move to the background as more and more practitioners implement care based on evidence. The community can be assured that the person taking care of them when they are ill is competent in knowledge, skills, attitudes and values. The implication for education is that educators will need to update their knowledge and skills to ensure that they teach practice based on evidence. Educator will learn how to use new technology to their advantage when they facilitate learning activities. They will also learn how to implement adult learning principles in education.

Employers need to take cognisance that participating in CPD is a reciprocal process in that if you have an updated and competent professional nurse the

health service administrator will be assured that a higher standard of service will be delivered and fewer complaints will be received from the patients.

The employers need to make use of the funding for CPD activities from example the skills levy to support employees attending CPD courses. Employers could link performance appraisal of the professional nurse to CPD. Employers should have study leave policies to enable nurses to study further.

9.3 Implications for research

The researcher has developed a proposed model and guideline for the implementation of CPD for professional nurses in South Africa. Currently, there is no CPD model in place for professional nurses in the country. One proposal could be that the researcher requests the SANC's support to evaluate the proposal by implementing it perhaps in one province. As part of the researcher's post- doctoral fellowship the researcher could then evaluate the implementation of the model. If the results are positive, the model can then be adapted and implemented as a model for CPD for South African nurses. Future research could also investigate the CPD requirement of other category nurses.

9.4 Limitations of the research

The study is limited to some extent in that the evaluation and validation of the proposed model have not fallen within the scope of the present thesis. The validation process will only be concluded if SANC approve the concept and allow a trial implementation of the model. The exclusion of the employers or managers of nurses in the study has also been a limitation.

9.5 Conclusions

The research on the development of a model for CPD for professional nurse was set out in various chapters sequentially. Chapter one gave an overall introduction to the thesis. A comprehensive literature review to evaluate the need of

continuous professional development as well as the theoretical framework was discussed in chapter two. Chapter three described the research methodology. Chapter four was a review of literature to evaluate current international and national CPD practices relating to healthcare professionals. A document analysis of relevant government policies and legislation that influence CPD for professional nurse was described in chapter five. The results of health indicators for South Africa were presented in chapter six. A survey was done to assess the continuing professional development needs of professional nurses in South Africa and the results were presented in chapter seven. A proposed model of CPD for professional nurse in South Africa based on all the available information gathered during previous chapters was presented in chapter eight. Implications for research and practice and have been discussed in chapter nine.



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Addendums

Addendum one Higher degrees committee approval

(CHHD 04/12)

**UNIVERSITY OF THE WESTERN CAPE
FACULTY OF COMMUNITY AND HEALTH SCIENCES**

HIGHER DEGREES COMMITTEE

MINUTES OF A MEETING OF THE ABOVE COMMITTEE HELD ON
FRIDAY, 12 NOVEMBER 2004 AT 10H00 IN THE CONFERENCE ROOM,
COMMUNITY AND HEALTH SCIENCES

11.5 Candidate : Sathasivan Arunachallam, CHHD Annex
04/12/11

Student No : 2117347
Degree : PhD (Nursing)
Department : Nursing
Thesis Title : *"The development of an information
technology
system of continuing professional
development for professional nurses in
South Africa"*

Supervisor : Prof C Nikodem
10 Keywords : Academic education, continuous
professional development, continuing competence,
continuing education, information
technology, life-long learning, ongoing
development, professional nurse, staff
development, system.

Reviewer Group : ALL

Referred back with the following comments:

- The researcher should more carefully define the aims and specific objectives.
- In the objectives page 8, the different phases of the IPC system do not appear to feature.
- Regarding objectives – the 3rd objective could be part of the literature review. w.r.t. the 2nd objective, is it a single community? Give the definition.
- Objective 4 is unable to be attained unless, the Nursing Council is centrally involved in the study. This suggests an action research type approach would be required to meet this objective.
- Is the research going to develop a CPD system? If that is not the case then the word "developed" should not appear in the title.

- The researcher should be alerted to CPD in different countries.
- The Health Professionals Council had a problem with the cost, methods and implementation of a CPD. This does not come through in the proposal. The researcher should look at the economic aspects especially i.t.o. non-developed countries.
- The researcher is encouraged to adopt a more critical perspective on CPD systems.
- The researcher has an extremely strong bias. Throughout the proposal there is an implicit and sometimes explicit assumption that a CPD points system is an ideal method of ensuring continuing education and that what is required is simply a good system to implement it.
- Literature review is quite thin. Although the title suggests that the study will develop an IT system for CPD the literature review does not contain anything about IT systems for CPD.
- No literature or critique w.r.t. the value, desirability or appropriateness of a structured CPD points system. This is particularly worrying as the HPCSA has just abandoned its recently launched CPD points system. The student is encouraged to obtain literature from the HPCSA around why it implemented and then abandoned the CPD system.
- The researcher should modify – that he will be assisting or advice in formulating a policy. This reads like action research.
- In the objectives there is no output other than analysis. It looks as though the researcher wants to produce a blueprint – it is not clear.
- In the abstract, the methodology is not properly summarized.
- Editorial errors - some references are not in the referencing list.

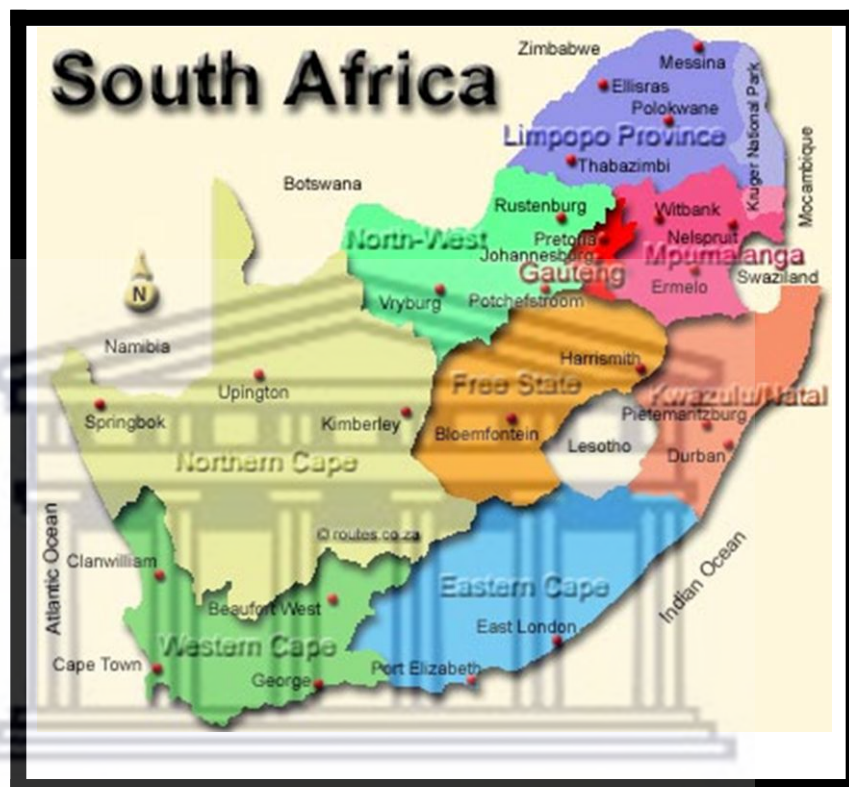
Accepted and recommended to SHD with the following comments:

- The researcher should first establishment whether there is a need for CPD. Give clarity.
- If there is a need, determine what their needs are regarding CPD and then come up with a model to address those needs. (refer to page 8).
- Analyse and gather information about these needs.

Addendum two Questionnaire

CPD for Nurses

Continuing Professional Development for Professional Nurses



A SOUTH AFRICAN SURVEY

This survey is undertaken by S. Arunachallam, a Doctoral candidate at the University of the Western Cape, Department of Nursing.

It will assist in developing a model for CPD for Professional Nurses in South Africa.

This Questionnaire may take approximately 20 - 25 minutes to complete.

Please complete the following questions. If you wish to comment on any question or qualify your answers please use the space provided on the back cover.

**S. Arunachallam
150 King Edward Street
PAROW
Cape Town**

PLEASE USE THE STAMPED ADDRESSED ENVELOPE IN ORDER TO RETURN YOUR QUESTIONNAIRE

021- 930 6319
082 2023206

150 King Edward Street,
Parow 7500
Cape Town

31.7.2005

Dear Participant,

I am a Doctoral (PhD) student from the University of the Western Cape.

Thank you for accepting to participate in the filling of this Questionnaire.

Your name was chosen by the random sampling method from the South African Nursing Council's database of registered professional nurses. The SANC also provided the name and address labels for the envelopes as reflected in their records.

The Title of the Research: The Development of a Model for Continuing Professional Development(CPD) for Professional Nurses in South Africa.

Please complete each question or statement by marking with an (X) in the most appropriate block.

When you have completed the Questionnaire, please use the enclosed stamped, addressed envelope to return it as soon as possible.

Thanking you,

Yours truly,

.....

S.Arunachallam (Researcher)

Continuing Professional Development(CPD) is a method to maintain and enhance a professional career.

Dear participant, please complete each question by marking an X in the appropriate block or by completing the empty spaces.

Q1. Gender

Male	Female
------	--------

Q2. Your age.

<input type="text"/>	<input type="text"/>	years
----------------------	----------------------	-------

Q3. What geographical location best describes where you work?

City	Peri-urban	Town	Rural
------	------------	------	-------

Q4. In which of the following settings do you work now?

4.1	Hospital or Clinic	<input type="text"/>	<input type="text"/>	public-tertiary	public secondary	<input type="text"/>	public-primary	<input type="text"/>	private	<input type="text"/>
-----	--------------------	----------------------	----------------------	-----------------	------------------	----------------------	----------------	----------------------	---------	----------------------

4.2	University department	<input type="text"/>	College department	<input type="text"/>	Technikon department
-----	-----------------------	----------------------	--------------------	----------------------	----------------------

4.3	Research Institution	<input type="text"/>
4.4	Not applicable,not working now.	<input type="text"/>
4.5	Other (specify)	<input type="text"/>

Q5. Which of the following describes your current area of practice?

5.1 Direct Patient Care	<input type="text"/>
5.2 Nursing Education	<input type="text"/>
5.3 Nursing Administration	<input type="text"/>
5.4 Research	<input type="text"/>
5.5 Other (specify)	<input type="text"/>

Q6. In which categories are you registered with the South African Nursing Council?

More than one response can be marked (X)

6.1 Registered General Nurse	<input type="checkbox"/>
6.2 Registered Midwife	<input type="checkbox"/>
6.3 Registered Psychiatric Nurse	<input type="checkbox"/>
6.4 Registered Community Nurse	<input type="checkbox"/>
6.5 Registered Nursing Educator	<input type="checkbox"/>
6.6 Registered Nursing Administrator	<input type="checkbox"/>
6.7 Other (specify)	<input type="checkbox"/>

Q7.List the total number of registered qualifications you have obtained.

Number of:

7.1 Diplomas	<input type="text"/>
--------------	----------------------

- 7.2 Basic Degree.....
 7.3 Masters.....
 7.4 Doctorate.....

Q8. List all other courses that you would like to complete other than those that are formally registered with the SANC. You may include non-nursing human resources.

Q9. How long has it been since you completed your last registered course?

--	--

Number of years

Q10. Please indicate which type of employment contract applies to you?

Mark with an (X)

Permanent		Temporary	
Full-time	Part-time	Full-time	Part-time

Q11. Please read each statement below and mark with an X

		Strongly Agree	Agree	Disagree	Strongly Disagree
11.1	There is a need for continuing Professional Development (CPD) for professional nurses.				
11.2	CPD should be made compulsory in order for a Professional Nurse to re-licence in order to practice.				
11.3	CPD is a way of self-empowerment.				
11.4	CPD can be used to address the needs of the services rendered by the institution				
11.5	CPD should be voluntary.				
11.6	CPD should mandatory.				
11.7	If CPD should become mandatory there should be a penalty for non-compliance with CPD requirements				
11.8	CPD activities should be in a credit bearing format aiming towards a formal qualification				
11.9	CPD should only be provided by an accredited provider approved by the SANC				
11.10	CPD is a way to keep up to date with current health trends				
11.11	CPD is important in terms of maintaining professional standards of practice.				
11.12	CPD can promote job satisfaction.				
11.13	CPD should be able to enhance professional career goals				
11.14	CPD would create positive competitiveness amongst PN's				

Q12. In which manner would you want your CPD credits to be recorded?

More than one response can be marked (X)

- 12.1 Manually
- 12.2 Electronically
- 12.3 Both

Q13. When do you want to submit your CPD for credits?

More than one response can be marked (X)

- 13.1 Annually
- 13.2 Every 2nd year
- 13.3 Every 3rd year
- 13.4 Other (specify)

.....

Q14. What level of health priority should be taken into consideration if CPD becomes mandatory.

Mark with an (X) over the desired block

- 14.1.National
- 14.2.Provincial
- 14.3.Local
- 14.4.Other (specify)

Q15. CPD short courses could be used to improve scarce skills shortages in nursing e.g. ICU, Theatre,Oncology etc.

Q16. CPD update courses can also be effective for those wanting to return to work after a long absence.

Q17. CPD could be applied in human resources development

Q18. A CPD system is long overdue for this country's nurses.

Q19. Continuing Professional Development (CPD) embodies the whole range of learning experiences that lead to improved performance in the delivery of health care.

Mark with an (X) in the blocks,your preferred learning experiences for CPD

- 19.1 Health Care Audits
- 19.2 In-service training.....
- 19.3 On site supervision and guidance by nurse specialists
- 19.4 Journal articles
- 19.5 Team assignments and projects (Task Groups)
- 19.6 Presentations to colleagues.....

- 19.7 Distance learning – Self-study.....
- 19.8 Academic studies.....
- 19.9 Study days during the week.....
- 19.10 Short accredited training courses
- 19.11 Seminars, workshops, conferences, updates.....
- 19.12 Meetings of professional organizations.....
- 19.13 E-learning.....
- 19.14 Staff support groups,problem solving groups.....

Q20.Should your employer fund all CPD activity?

Yes No

Q21. Which of the following would you prefer to be provided by your employer?

(You may choose more than one option)

(You may choose more than one option)		Yes	No
21	Formal policies for study leave		
21	Study leave to attend seminars, workshops, conferences (outside organization)		
21	Formal policies for financial support		

Q22. What specifically may prevent you from engaging in Continuing Professional Development activities?

- 22.1 Family and social commitments
- 22.2 Time constraints
- 22.3 Employer restrictions
- 22.4 Other



Q23. Please tick one box to indicate to what extent you agree or disagree with each of the following statements relating to your future engagement in Continuing Professional Development activities-

23.1	I am self-motivated in relation to CPD activities
23.2	I will plan my activities to progress along a planned career pathway
23.3	CPD will enable me to contribute to developments in my nursing career
23.4	I value education which involves members of the multi-disciplinary team
23.5	CPD will be essential for survival in all nursing practice
23.6	CPD activities will be time consuming and expensive
23.7	CPD will enhance my clinical supervision and mentorship skills
23.8	My career planning will be assisted by my CPD activities
23.9	CPD activities should be dictated by the service needs of the organization in which I am employed
23.10	There should be structured CPD activities within my place of work

Q 24. How will your continuing professional development portfolio be planned?

(You may choose more than one option)

		Yes	No
24.1	Certificates of attendance (short courses, workshops, conferences, seminars) Certificates		
24.2	Written transcripts from course coordinator verifying modules, hours of study and results		
24.3	Copies of unpublished and published work that you have written or contributed to		
24.4	Written references		
24.5	Other (please specify)		

Comments

.....

Please ensure that you have responded to all the Questions

THANK YOU – FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

YOUR CONTRIBUTION IS MUCH APPRECIATED



UNIVERSITY *of the*
WESTERN CAPE

Addendum three Nursing Act

Nursing Act, 2005

Act No. 33 of 2005

NURSING ACT, 2005 (ACT No. 33 OF 2005)

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ACT

To regulate the nursing profession; and to provide for matters connected therewith.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:—

CHAPTER 1

SOUTH AFRICAN NURSING COUNCIL

Definitions

1. In this Act, unless the context indicates otherwise—

"**auxiliary midwife**" means a person who prior to the commencement of this Act was

enrolled or eligible to be enrolled with the Council as such;

"**auxiliary nurse**" means a person registered as such in terms of section 31;

"**code**" means the code of conduct, good practice and any other code made under this

Act;

"**Council**" means the South African Nursing Council contemplated in section 2;

"**database**" means an integrated system of particulars of persons registered under this

Act, nursing education institutions and nursing agencies kept by the Council to meet its

information processing and retrieval requirements in terms of this Act;

"**Director-General**" means the head of the national Department of Health;

"**fruitless and wasteful expenditure**" has the meaning assigned to it in section 1 of the

Public Finance Management Act, 1999 (Act No. 1 of 1999);

"**health care user**" has the meaning assigned to it in section 1 of the National Health

Act, 2003 (Act No. 61 of 2003);

"**health establishment**" has the meaning assigned to it in section 1 of the National

Health Act, 2003 (Act No. 61 of 2003);

"**health services**" has the meaning assigned to it in section 1 of the National Health Act,

2003 (Act No. 61 of 2003);

"**irregular expenditure**" means expenditure, other than unauthorised expenditure—

(a) incurred in contravention of or that is not in accordance with a requirement

of any applicable legislation; or

(b) that falls outside of the scope of the functions of the Council contemplated

in this Act;

"**learner midwife**" means a person registered as such in terms of section 32;

"**learner nurse**" means a person registered as such in terms of section 32;

"**midwife**" means a person registered as such in terms of section 31;

"**midwifery**" refers to a caring profession practised by persons registered under this Act,

which supports and assists the health care user and in particular the mother and baby, to

achieve and maintain optimum health during pregnancy, all stages of labour and the *puerperium*;

"Minister" means the Minister of Health;

"national department" means the national Department of Health;

"nurse" means a person registered in a category under section 31(1) in order to practise nursing or midwifery;

"nursing" means a caring profession practised by a person registered under section 31,

which supports, cares for and treats a health care user to achieve or maintain health and

where this is not possible, cares for a health care user so that he or she lives in comfort

and with dignity until death;

"nursing education institution" means any nursing education institution accredited by

the Council in terms of this Act;

"nursing service" means any service within the scope of practice of a practitioner;

"practitioner" means any person registered in terms of section 31(1) of this Act;

"prescribed" means prescribed by regulation;

"professional nurse" means a person registered as such in terms of section 31;

"register" means a register containing the names and other particulars of all persons

registered in terms of section 31, 32 or 33 and additional qualifications registered in terms of section 34;

"Registrar" means the person appointed in terms of section 18;

"regulation" means any regulation made in terms of section 58;

"rule" means any rule made in terms of section 59;

"scope of practice" means the scope of practice of a practitioner that corresponds to

the level contemplated in section 30 in respect of that practitioner;

"staff nurse" means a person registered as such in terms of section 31;

"this Act" includes the regulations;

"unauthorised expenditure" means expenditure that is not in accordance with the

budget of the Council or that takes place outside of the systems of financial and risk

management and internal control of the Council contemplated in section 29(2);

"unprofessional conduct" means a conduct which, with regard to the profession of a

practitioner, is improper, disgraceful, dishonourable or unworthy.

South African Nursing Council

2. (1) The South African Nursing Council established by section 2 of the Nursing Act, 1978 (Act No. 50 of 1978), continues to exist as a juristic person, notwithstanding the repeal of that Act by this Act.
- (2) The head office of the Council is situated in Pretoria.

Objects of Council

3. The objects of the Council are to—
- (a) serve and protect the public in matters involving health services generally and nursing services in particular;
 - (b) perform its functions in the best interests of the public and in accordance with national health policy as determined by the Minister;
 - (c) promote the provision of nursing services to the inhabitants of the Republic that complies with universal norms and values;
 - (d) establish, improve, control conditions, standards and quality of nursing education and training within the ambit of this Act and any other applicable laws;
 - (e) maintain professional conduct and practice standards for practitioners within the ambit of any applicable law;
 - (f) promote and maintain liaison and communication with all stakeholders regarding nursing standards, and in particular standards of nursing education and training and professional conduct and practice both in and outside the Republic;
 - (g) advise the Minister on the amendment or adaptation of this Act regarding matters pertaining to nursing;
 - (h) be transparent and accountable to the public in achieving its objectives and in performing its functions;
 - (i) uphold and maintain professional and ethical standards within nursing; and
 - (j) promote the strategic objectives of the Council.

Functions of Council

4. (1) The Council must—
- (a) in all its decisions, take cognisance of national health policies as determined by the Minister and implement such policies in respect of nursing;
 - (b) where authorised by this Act, enter, remove from or restore to the register the name of a person;
 - (c) conduct examinations, and appoint examiners and moderators and grant diplomas and certificates in respect of such examinations;

- (d) conduct inspections and investigations of nursing education institutions, nursing education programmes and health establishments, in order to ensure compliance with this Act and the rules and standards determined by the Council in terms of this Act;
- (e) report to the relevant statutory body any non-compliance established after an inspection and investigation referred to in paragraph (d);
- (f) ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to do so;
- (g) investigate complaints against persons registered in terms of this Act and take appropriate disciplinary action against such persons in accordance with the provisions of this Act in order to protect the interests of the public;
- (h) publish in the *Gazette* the details of the unprofessional conduct and the names and qualifications of the persons against whom disciplinary action was taken in terms of this Act within 30 days of the conclusion of such disciplinary action;
- (i) ensure that a register of persons registered in terms of this Act is available to the public as prescribed;
- (j) investigate and take action against non-accredited nursing education institutions;
- (k) withdraw or suspend accreditation of a nursing education institution or nursing education programme if the education or training provided does not comply with the prescribed requirements and inform the relevant licensing authority;
- (l) determine—
- (i) the scope of practice of nurses;
 - (ii) the conditions under which nurses may practise their profession;
 - (iii) the acts or omissions in respect of which the Council may take steps against any person registered in terms of this Act; and
 - (iv) the requirements for any nurse to remain competent in the manner prescribed;
- (m) determine prescribed licence or registration fees, payable under this Act;
- (n) monitor the assessment by education and training providers, including the recognition of prior learning, register constituent assessors and moderators and grant diplomas and certificates in accordance with the requirements of this Act and any other law;
- (o) be regarded as an education and training quality assurer in terms of section 5 of the South African Qualifications Authority Act, 1995 (Act No. 58 of

1995), for all nursing qualifications;

(p) submit to the Minister—

(i) a five-year strategic plan within six months of the Council coming into office which includes details as to how the Council plans to achieve its objectives under this Act;

(ii) a report every six months on the status of nursing and on matters of public importance compiled by the Council in the course of the performance of its functions under this Act; and

(iii) an annual report within six months of the end of the financial year;

(q) ensure that an annual budget is drawn up in terms of sections 23 and 24

and that the Council operates within the parameters of such budget; and

(r) perform such other functions as may be prescribed.

(2) The Council may—

(a) make extracts from the register;

(b) acquire, hire or dispose of property, borrow money on the security of the

assets of the Council, accept or make any donation and administer any trust;

(c) institute or defend any legal action in its name;

(d) appoint experts and advisers as may be required to assist the Council in the

performance of its functions in terms of this Act;

(e) delegate to any person or organisation any function referred to in this section, provided that the Council is not divested of any function so delegated;

(f) accredit nursing education institutions and nursing education programmes

and monitor all assessments by education and training providers in accordance with this Act or any other law;

(g) carry out quality control inspections in accordance with the prescribed conditions;

(h) investigate complaints against any health establishment in respect of its

nursing service;

(i) subject to prescribed conditions and upon payment of a prescribed fee, issue a licence for a professional nurse to conduct a private practice;

(j) consider any matter affecting nursing, and make representations to the Minister and Director-General or take such action in connection therewith as the Council may find advisable;

(k) require nursing education institutions to submit annual returns of learner

nurses and to submit any information that the Council may require;

(l) require employers to submit annual returns of nurses in their employ and

any other information necessary to enable the Council to perform its functions and fulfil its objectives;

(m) in consultation with the Minister of Finance, establish, manage and administer a pension or provident fund for the employees of the Council;

(n) recommend to the Minister regulations relating to any matter under this Act which may be prescribed; and
 (o) generally, do all such things as it may find necessary or expedient to achieve the objects of this Act.

Composition and dissolution of Council

5. (1) (a) The Council consists of not more than 25 members, of whom 14 must be registered in terms of section 31(1)(a) and (b), appointed by the Minister taking into account their expertise in nursing education, nursing, community health, primary health care, occupational health and mental health.

(b) Of the 25 members—

- (i) one person must be an officer of the national department;
- (ii) one person must have special knowledge of the law;
- (iii) one person must have special knowledge of financial matters;
- (iv) one person must have special knowledge of pharmacy;
- (v) one person must have special knowledge of education;
- (vi) one person must have knowledge of consumer affairs;
- (vii) three persons must represent communities;
- (viii) one person must be registered in terms of section 31(1)(c); and
- (ix) one person must be registered in terms of section 31(1)(d).

(2) (a) The members must be appointed by the Minister on the basis of nominations made by interested parties, after publication of a notice in the *Gazette* inviting nominations for new members.

(b) If the Minister receives no nomination or an insufficient number of nominations within the period specified in the invitation, the Minister may appoint the required number of persons who qualify to be appointed in terms of subsection (1).

(3) A member holds office for a period not exceeding five years reckoned from the date of his or her appointment.

(4) The names of the members of the Council, the dates of commencement of their terms of office and the periods for which they have been appointed must be published by the Minister by notice in the *Gazette* as soon as possible after their appointment.

(5) The Minister may reappoint a member whose term of office has expired, for one further period not exceeding five years.

(6) Each member must, on assumption of office, sign an undertaking to abide by the provisions of this Act and the codes.

(7) (a) The Minister may dissolve the Council if the Council fails to comply with any of the provisions of this Act.

(b) All the functions of the Council are vested in the Minister until a new Council is appointed.

(8) (a) The Minister may at any time request copies of the records, including minutes of meetings and financial statements, of the Council in order to ascertain the extent of the Council's compliance with this Act and any codes.

(b) The Registrar must furnish copies of all such records within 15 days of the date of the Minister's written request.

(9) The Minister may appoint one or more persons to investigate the affairs of the Council and to prepare a report after such investigation if there is a reasonable suspicion that the Council is failing to comply with this Act or any code.

Disqualification from membership

6. A person may not be appointed as a member of the Council if he or she—

(a) is an unrehabilitated insolvent or if his or her creditors have accepted an offer of a composition made in terms of section 119 of the Insolvency Act, 1936 (Act No. 24 of 1936);

(b) is disqualified from practising his or her profession under this Act;

(c) is not a South African citizen and ordinarily resident in the Republic;

(d) he or she becomes mentally ill to such a degree that it is necessary that he or she be detained, supervised or controlled;

(e) has been removed from an office of trust on account of misconduct;

(f) has been convicted of—

(i) an offence for which he or she was sentenced to imprisonment without the option of a fine; or

(ii) theft, fraud, forgery or uttering a forged document, perjury, an offence under the Prevention and Combating of Corrupt Activities Act, 2004 (Act No. 12 of 2004), or any other offence involving dishonesty;

(g) has previously been a member of the Council for a period exceeding 10

consecutive years;

(h) has had his or her membership terminated by the Minister in terms of this

Act; or

(i) is, at the time of his or her appointment, or was, during the preceding 12 months—

(i) a member of a municipal council, a provincial legislature or Parliament; or

(ii) a provincial or national office-bearer or employee of any party, organisation or body of a political nature.

Vacation of office

7. A member must vacate his or her office if—

- (a) he or she becomes disqualified in terms of section 6 from being appointed as a member;
- (b) he or she has been absent from more than two consecutive ordinary meetings of the Council without leave of the Council;
- (c) he or she tenders his or her resignation in writing to the Minister and the Minister accepts his or her resignation;
- (d) he or she becomes impaired to the extent that he or she is unable to carry out his or her duties as a member of the Council; or
- (e) he or she ceases to hold any qualification necessary for his or her appointment to the Council.

Termination of membership

8. The Minister may terminate membership of a member of the Council where—

- (a) a member fails to perform the duties of a member in terms of this Act or the codes;
- (b) a member obstructs or impedes the Council in the performance of its functions in terms of this Act or the codes;
- (c) a member fails to declare a conflict of interest between his or her affairs and those of the Council;
- (d) a member acts in a manner that is likely to bring the Council into disrepute;
- (e) a member misuses or misappropriates Council funds or resources;
- (f) a member approves or engages in unauthorised or irregular expenditure or fruitless and wasteful expenditure; or
- (g) such termination is in the interest of the public.

Filling of vacancies

9. Every vacancy on the Council arising from a circumstance referred to in section 7 or 8 and every vacancy caused by the death of a member must be filled by appointment by the Minister in terms of section 5(2), and every member so appointed must hold office for the unexpired portion of the period for which the vacating member was appointed.

Chairperson and vice-chairperson of Council

10. (1) (a) The Minister, after consultation with the Council, must appoint one of the members of the Council appointed in terms of section 5(1)(a) as chairperson of the Council.

(b) At the first meeting of the Council the members must elect a vicechairperson

from the categories mentioned in section 31(1)(a) and (b).

(c) The Minister may withdraw a member's appointment as chairperson or vicechairperson

if it is in the public interest or if the member is for any reason unable to perform or incapable of performing his or her functions as chairperson for a period exceeding three months.

(2) The chairperson and vice-chairperson must hold office for the duration of the term

of office for which he or she has been appointed as a member of the Council

unless the chairperson or vice-chairperson resigns or ceases to be a member of

the Council prior to the expiry of his or her term of office as a member or is removed from office by the Minister in terms of section 8.

(3) In the absence of the chairperson or in the event that the chairperson is for any

reason unable to act as chairperson, the vice-chairperson, subject to the provisions of subsection (1), has the authority to perform all the functions and

exercise all the powers of the chairperson.

(4) If both the chairperson and the vice-chairperson are absent from any meeting, the

members present must elect one of their number to preside at that meeting and,

until the chairperson or vice-chairperson resumes duty, to perform all the functions

and exercise all the powers of the chairperson.

(5) If the office of the chairperson becomes vacant, the Minister must appoint as

chairperson, at his or her discretion, a person from among the remaining members

of the Council, or any other person in terms of section 5(1) and (2), and the person

so appointed must hold office for the unexpired portion of the period for which his

or her predecessor was appointed.

(6) If the office of the vice-chairperson becomes vacant, the members must, at the

first meeting after such vacancy occurs or as soon thereafter as may be convenient, elect from among themselves a new vice-chairperson and the member so elected must hold office for the unexpired portion of the period for

which his or her predecessor was appointed.

(7) The chairperson or vice-chairperson may vacate office as such without terminating

his or her membership of the Council and if such vacation occurs, the Minister

must appoint a new chairperson from amongst the members of the Council in terms of subsection (1).

Duties of chairperson

11. The chairperson of the Council must—

- (a) ensure that every member of the Council has signed the codes made under this Act and adheres to these codes;
- (b) convene meetings of the executive committee;
- (c) liaise with or advise the Minister on issues relating to the Council;
- (d) generally ensure that the Council performs its functions and fulfils its objectives in terms of this Act and complies with the relevant provisions of any other Act; and
- (e) ensure that the budget of the Council is formulated as prescribed and that the Council operates within such budget.

Meetings of Council

12. (1) The Registrar must, in consultation with the chairperson, convene meetings of the Council at the place and time and on the date determined by the Council and must

draw up the agendas and compile documentation for such meetings.

(2) The Council must meet not less than four times annually for the purpose of conducting its business, but the Council may in addition hold such further meetings as it may from time to time determine.

(3) A special meeting of the Council—

- (a) may be convened by the chairperson at any time; or
- (b) must be convened by the chairperson at such place and time and on such date as he or she may determine within 30 days of the receipt of a written request by the Minister or of a written request signed by at least a third of the members.

(4) A written request contemplated in subsection (3)(b) must state clearly the purpose for which the meeting is convened.

Quorum and procedure at meetings

13. (1) A quorum of any meeting of the Council is one half of the total number of members plus one.

(2) At all meetings of the Council each member present must have one vote on a question before the Council.

(3) Any decision taken by the Council must be decided by a majority vote at a meeting of the Council at which a quorum is present and, in the event of an

equality of votes on any matter, the member presiding has a casting vote in addition to his or her deliberative vote.

(4) For the purposes of this Act, a majority vote at a meeting of the Council or of any

of the committees is one half of the total number of members present plus one.

(5) Only members have voting rights on any matter in which the Council is required to make a decision.

(6) A decision taken by the Council or an act performed under the authority of the

Council is not invalid merely by reason of—

(a) an interim vacancy in the Council; or

(b) the fact that a person who is not entitled to sit as a member of the Council,

sat as a member at the time when the decision was taken, if the act was authorised by the required majority of members present at the time and entitled to sit as members of the Council.

Executive committee of Council

14. (1) There is an executive committee of the Council consisting of—

(a) the chairperson;

(b) the vice-chairperson;

(c) three persons appointed in terms of section 5(1)(a);

(d) a person appointed in terms of section 5(1)(b)(i);

(e) a person appointed in terms of section 5(1)(b)(iii); and

(f) a person appointed in terms of section 5(1)(b)(vii).

(2) The members of the executive committee contemplated in subsection (1)(c) and

(f) must be elected by the members of the Council.

(3) In the event that there is an equality of votes on any matter in which the executive

committee is required to take a decision, the chairperson has a casting vote in

addition to his or her deliberative vote.

(4) The term of office of the executive committee is 20 months.

(5) The executive committee may, subject to the directives of the Council, exercise all

the powers, other than a power referred to in Chapter 3, and may perform all the

functions of the Council during periods between meetings of the Council, but does

not have the power to set aside or amend the decisions of the Council, save in so

far as the Council otherwise directs.

(6) Any act performed or decision taken by the executive committee is binding unless,

on good grounds shown, it is set aside or amended by the Council at its next meeting.

Other committees

15. (1) The Council may from time to time establish such committees, including professional conduct committees and education committees, as it may think necessary to investigate and report to the Council on any matter falling within the scope of its functions.
- (2) Each committee appointed in terms of subsection (1) consists of as many persons appointed by the Council as the Council may determine but must, except in the case of a disciplinary appeal committee referred to in subsection (4), include one member of the Council, who must be the chairperson of such committee.
- (3) (a) The Council may, subject to the provisions of subsection (4), delegate to any committee established in terms of subsection (1) or to any person such of its powers as it may determine.
- (b) The Council is not divested of any power so delegated and may amend or set aside any decision of such committee made in the exercise of its delegated power.
- (4) Despite subsection (1), the Council may establish an *ad hoc* disciplinary appeal committee consisting of—
- (a) as chairperson, either a retired judge, retired senior magistrate or an attorney with at least 10 years' experience; and
- (b) not more than two registered persons who have professional qualifications that are the same as those of the person who is subject to the disciplinary proceedings.
- (5) A disciplinary appeal committee referred to in subsection (4) has the power to vary, confirm or set aside a finding of a disciplinary committee established in terms of subsection (1) or to refer the matter back to the disciplinary committee with such instructions as it may consider fit.
- (6) A decision of a disciplinary committee, unless appealed against, is binding from the date determined by that committee but if an appeal is lodged against a penalty of erasure or suspension from practice, such penalty remains effective until the appeal is finalised.
- (7) Where a matter has been considered by a disciplinary appeal committee, its decision is binding from the date determined by the disciplinary appeal committee unless appealed against to the Council.

Remuneration of members of Council and committees

16. (1) The members of the Council and members of the committees of the Council must

be paid remuneration or allowances determined by the Minister in consultation

with the Minister of Finance.

(2) (a) Any person who is not subject to the laws governing the public service shall

be entitled to such remuneration, including allowances for travelling and subsistence expenses incurred by him or her in the exercise, performance or carrying out of the powers, functions and duties conferred upon, assigned to or imposed upon him or her by the Director-General, as the Minister in consultation with the Minister of Finance may determine.

(b) Any other remuneration not referred to in paragraph (a) must be paid by the Council.

(c) Any member who is subject to the laws governing public service must be

entitled to special leave to attend to the functions of the Council.

Minister may rectify defects

17. If anything required to be done under this Act in connection with the appointment of any

member is omitted or not done within the time or in the manner required by this Act, the

Minister may order such steps to be taken as may be necessary to rectify the omission

or error or may validate anything done in an irregular manner or form, in order to give

effect to the objects of this Act.

Appointment of Registrar and staff

18. (1) The Minister must, after consultation with the Council, appoint the Registrar of the

Council to carry out his or her functions under this Act and the Minister may, after

consultation with the Council, dismiss the Registrar.

(2) The appointment of the Registrar is subject to the conclusion of a written

performance agreement entered into between the Council and the Registrar, and

approved by the Minister.

(3) The term of office of a Registrar is five years, but the Minister may, after

consultation with the Council, renew the Registrar's term of office for such further

period as the Minister finds appropriate.

(4) The Registrar may appoint such other persons, subject to the policies and

guidelines of the Council, as he or she may think necessary to perform the

functions specified in this Act and the Registrar may dismiss any such other person.

(5) The staff must include such number of senior managers as the Council may determine, after consultation with the Registrar and the Minister.

Duties of Registrar

19. (1) The Registrar must—

- (a) exercise the powers and perform the functions assigned to the Registrar in terms of this Act;
- (b) keep the registers in respect of practitioners and must on the instructions of the Council enter in the appropriate register the name, physical address, qualifications, date of initial registration and such other particulars, including, where applicable, the details of the category of practitioner, learner midwife or learner nurse, as the Council may determine, of every person whose application for registration in terms of this Act has been granted;
- (c) update the registers correctly and in accordance with the provisions of this Act and remove therefrom the names of all practitioners who have been removed in terms of this Act and must from time to time record changes in the addresses or qualifications of registered persons;
- (d) be the secretary of the Council and maintain the records of its meetings;
- (e) provide guidance and advice on compliance with this Act to the Council and the officials;
- (f) act with fidelity, honesty, integrity and in the best interest of the Council in managing its financial affairs;
- (g) disclose to the Council all material facts and information which in any way might influence the decisions or actions of the Council or the chairperson; and
- (h) prevent any prejudice to the financial and administrative interests of the Council.

(2) The Registrar may not—

- (a) act in a way that is inconsistent with the duties assigned to him or her in terms of this Act; or
- (b) use the position or privileges of, or confidential information obtained as, Registrar for personal gain or to improperly benefit another person.

Accounting duties of Registrar

- 20.** (1) The Registrar must, in a format and for periods as may be prescribed, report to the Council on all revenue received and expenditure incurred by the Council including, but not limited to—
- (a) all fees collected and funds received;
 - (b) salaries and wages;
 - (c) contributions for pensions and medical aid, if any;
 - (d) travel, motor car, accommodation, subsistence and other allowances;
 - (e) housing benefits and allowances;
 - (f) overtime payments;
 - (g) loans and advances; and
 - (h) any type of benefit or allowance related to staff.
- (2) The Registrar must—
- (a) assist the Council in performing the budgetary functions assigned to it in terms of this Act; and
 - (b) provide the chairperson with the administrative support, resources and information necessary for the performance of those functions.
- (3) The Registrar is responsible for implementing the Council's approved budget, including taking all reasonable steps to ensure that—
- (a) the spending of funds is reduced if necessary when revenue is anticipated to be less than projected in the budget; and
 - (b) revenue and expenditure are properly monitored.
- (4) When necessary, the Registrar must prepare an adjustments budget and submit it to the chairperson for consideration and tabling in the Council.
- (5) The Registrar must no later than 14 days after the approval of an annual budget submit to the chairperson—
- (a) a draft service delivery and budget implementation plan for the budget year; and
 - (b) drafts of the annual performance agreements as required for the Registrar and all senior managers.
- (6) The Registrar must report in writing to the Council—
- (a) any impending—
 - (i) shortfalls in budgeted revenue;
 - (ii) overspending of the Council's budget; and
 - (iii) any steps taken to prevent or rectify such shortfalls or overspending.
- (7) The Registrar must by no later than 10 working days after the end of each month submit to the chairperson a statement in the prescribed format on the state of the Council's budget.
- (8) The Registrar must inform the Director-General, in writing, of—

(a) any failure by the Council to adopt or implement a budget-related policy,
 any other policy approved by the Council or a statutory function or responsibility in terms of this Act or any other legislation; or
 (b) any non-compliance by a member or official of the Council with any such policy.

(9) The Registrar must submit to the Council and the Director-General such information, returns, documents, explanations and motivations as may be prescribed or required.

(10) If the Registrar is unable to comply with any of the responsibilities in terms of this Act, he or she must promptly report the inability, together with reasons, to the Council and the Director-General.

(11) Any action taken by the Council or member of the Council against the Registrar solely because of the Registrar's compliance with a provision of this Act is an unfair labour practice for the purposes of the Labour Relations Act, 1995 (Act No. 66 of 1995).

(12) The Registrar may delegate to a staff member or any other official of the Council—

(a) any power or duty assigned to the Registrar in terms of this Act; or
 (b) any power or duty necessary to assist the Registrar in complying with a duty which requires the Registrar to take appropriate steps to ensure the achievement of the aims of a specific provision of this Act.

(13) The Registrar may not delegate to any member of the Council any power or duty assigned to him or her in terms of this Act.

(14) A delegation in terms of subsection (12)—

(a) must be in writing;
 (b) is subject to such limitations and conditions as the Registrar may impose in a specific case;
 (c) may either be to a specific individual or to the holder of a specific post in the Council;
 (d) may, in the case of a delegation to a senior manager, authorise that senior manager to sub-delegate the delegated power or duty to an official or the holder of a specific post in that senior manager's area of responsibility; and
 (e) does not divest the Registrar of the responsibility concerning the exercise of the delegated power or the performance of the delegated duty.

(15) The Registrar may confirm, vary or revoke any decision taken in consequence of a delegation or sub-delegation in terms of this Act, but no such variation or revocation of a decision may detract from any rights that may have accrued as a result of the decision.

Funding of expenditure

21. An annual budget may only be based on—
 (a) anticipated revenue to be collected; and
 (b) accumulated funds from previous years' surpluses not committed for other purposes.

Bank account of Council

22. (1) The Council must open and maintain at least one bank account in the name of the Council.

(2) All money received by the Council must be paid into its bank account promptly and in accordance with this Act and any requirements that may be prescribed.

(3) Money may only be withdrawn from the bank account as prescribed.

(4) The Registrar must submit the name of the bank where the account is held, and

the type and number of the account, to the Auditor-General and the Director-

General within 60 days of opening such bank account.

(5) The Registrar must—

(a) administer the bank account of the Council and must account to the Council

as requested to do so, but the Minister may order the Registrar and the Council to account to him or her regarding anything concerning such bank account; and

(b) ensure compliance with subsections (2) and (3) in the handling and managing of the bank account.

(6) The Registrar may delegate the duties referred to in subsection (5) only to the

manager in charge of finance or the chief financial officer.

Council budget

23. (1) The Council may, except where otherwise provided for in this Act, incur

expenditure only—

(a) in terms of an approved budget; and

(b) within the limits of the amounts appropriated for the different programmes in an approved budget.

(2) The Council must for each financial year approve an annual budget for the Council

before the start of that financial year by adoption of a Council resolution.

(3) In order for the Council to comply with subsection (2), the chairperson must table

the annual budget at a Council meeting at least 90 days before the start of the

budget year.

(4) The chairperson is responsible for the preparation of the budget and must ensure

that the draft budget is linked to the Council's strategic plan and that the annual

budget is approved as prescribed.

(5) The Registrar must submit the approved annual budget to the Director-General

within 30 days of such approval by the Council.

Contents of annual budget and supporting documents

24. (1) An annual budget of the Council must be a schedule in the prescribed format—

(a) setting out anticipated revenue for the budget year from each revenue source;

(b) appropriating expenditure for the budget year under the different programmes of the Council;

(c) setting out indicative revenue per revenue source and projected expenditure by programme for the two financial years following the budget year;

(d) setting out—

(i) estimated revenue and expenditure by programme for the current year; and

(ii) actual revenue and expenditure by programme for the financial year preceding the current year; and

(e) must include a statement containing any other information required, including—

(i) estimates of revenue and expenditure, differentiating between capital and current expenditure;

(ii) proposals for financing any anticipated deficit for the period to which they apply; and

(iii) an indication of intentions regarding borrowing and other forms of liability that will increase the Council debt during the ensuing year.

(2) The annual budget of the Council must be divided into a capital and an operating

budget in accordance with international best practice and as may be prescribed.

(3) When an annual budget is tabled, it must be accompanied by amongst other

things the following documents:

(a) draft resolutions—

(i) approving the budget of the Council;

(ii) imposing any fees as may be required for the budget year or as prescribed; and

(iii) approving any other matter that may be prescribed;

- (b) measurable performance objectives for revenue from each source and for each programme in the budget, taking into account the Council's strategic plan;
- (c) a projection of cash flow for the budget year by revenue source, broken down per month;
- (d) any proposed amendments to the budget-related policies of the Council;
- (e) particulars of the Council's investments;
- (f) the proposed cost to the Council for the budget year of the salary, allowances and benefits of—
 - (i) members of the Council;
 - (ii) the Registrar;
 - (iii) the deputy Registrar, if any; and
 - (iv) senior managers, including the chief financial officer, and other persons appointed by the Registrar; and
- (g) any other supporting documentation as may be prescribed.

Unforeseen and unavoidable expenditure

25. (1) The chairperson may in an emergency or other exceptional circumstances authorise unforeseeable and unavoidable expenditure for which no provision was made in the approved budget.

(2) Any such expenditure—

- (a) must be in accordance with any framework that may be prescribed;
- (b) may not exceed a prescribed percentage of the approved annual budget;
- (c) must be reported by the chairperson to the Council at its next meeting; and
- (d) must be appropriated in an adjustments budget.

(3) If such adjustments budget is not passed within 60 days after the expenditure was incurred, the expenditure is unauthorised and section 26 applies.

Unauthorised, irregular or fruitless and wasteful expenditure

26. (1) Without limiting liability in terms of common law or other legislation—

- (a) a member of the Council is liable for unauthorised expenditure if that member knowingly or after having been advised by the Registrar that the expenditure is likely to result in unauthorised expenditure instructed an official of the Council to incur such expenditure;
- (b) the Registrar is liable for unauthorised expenditure deliberately or negligently incurred by him or her, subject to subsection (3);
- (c) any member or official of the Council who deliberately or negligently made or authorised an irregular expenditure is liable for that expenditure; or
- (d) any member or official of the Council who deliberately or negligently made or authorised a fruitless and wasteful expenditure is liable for that expenditure.

- (2) The Council must recover unauthorised, irregular or fruitless and wasteful expenditure from the person liable for that expenditure, unless the expenditure—
- (a) in the case of unauthorised expenditure, is—
 - (i) authorised in an adjustments budget; or
 - (ii) certified by the Council, after investigation by a Council committee, as irrecoverable and written off by the Council; and
 - (b) in the case of irregular or fruitless and wasteful expenditure, is, after investigation by a Council committee, certified by the Council as irrecoverable and written off by the Council.
- (3) If the Registrar becomes aware that the Council, the chairperson or the executive committee, as the case may be, has taken a decision which, if implemented, is likely to result in unauthorised, irregular or fruitless and wasteful expenditure, the Registrar is not liable for any ensuing unauthorised, irregular or fruitless and wasteful expenditure, provided that the Registrar has informed the Council, the chairperson or the executive committee, in writing, that the expenditure is likely to be unauthorised, irregular or fruitless and wasteful expenditure.
- (4) The Registrar must promptly inform the chairperson, the Director-General and the Auditor-General, in writing—
- (a) of any unauthorised, irregular or fruitless and wasteful expenditure incurred by the Council;
 - (b) whether any person is responsible or under investigation for such unauthorised, irregular or fruitless and wasteful expenditure; and
 - (c) of the steps that have been taken—
 - (i) to recover or rectify such expenditure; and
 - (ii) to prevent a recurrence of such expenditure.
- (5) Criminal or disciplinary proceedings will be instituted against a person charged with the commission of an offence relating to unauthorised, irregular or fruitless and wasteful expenditure whether or not it is written off in terms of subsection (2).
- (6) The Registrar must report to the South African Police Service all cases of alleged—
- (a) irregular expenditure that constitute a criminal offence; and
 - (b) theft and fraud that occur in the Council.
- (7) The Council must take all reasonable steps to ensure that all cases referred to in subsection (6) are reported to the South African Police Service if—
- (a) the charge is against the Registrar; or
 - (b) the Registrar fails to comply with that subsection.

Cash management and investments

27. The Council must set out in writing a policy framework within which the Council must conduct its cash management and investments, and invest money not immediately required.

Disposal of capital assets

28. (1) The Council may only transfer ownership as a result of a sale or other transaction or otherwise permanently dispose of a capital asset after the Council has by resolution decided—

- (a) on reasonable grounds that the asset is not needed for the performance of the Council's functions; and
- (b) that the fair market value of the asset will be received for the asset.

(2) Any transfer or disposal of an asset referred to in subsection (1) must be fair, equitable, transparent, competitive and consistent with the policy framework of the Council contemplated in section 27.

Corporate governance

29. (1) The Registrar is the accounting officer of the Council.

(2) The Registrar must—

- (a) keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of, the Council; and
- (b) ensure that the Council has and maintains—
 - (i) effective, efficient and transparent systems of financial and risk management and internal control;
 - (ii) an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective;
 - (iii) a system for properly evaluating all projects involving expenditure of capital prior to a final decision on the project;
- (c) take effective and appropriate steps to—
 - (i) collect all moneys due to the Council;
 - (ii) prevent unauthorised, irregular or fruitless and wasteful expenditure and losses resulting from criminal conduct; and
 - (iii) manage available working capital efficiently and economically;
- (d) take into account all relevant financial considerations, including issues of propriety, regularity and value for money, when policy proposals affecting the Registrar's responsibilities are considered and, when necessary, bring those considerations to the attention of the Council;
- (e) be responsible for the management, including the safeguarding and the maintenance, of the assets and for the management of the liabilities of the Council;

- (f) settle all contractual obligations and pay all moneys owing by the Council within 30 days of the due date or within a period to which the relevant creditor has agreed;
- (g) ensure that expenditure of the Council is in accordance with the budget and decisions of the Council;
- (h) keep full and proper records of the financial affairs of the Council in accordance with any prescribed norms and standards;
- (i) submit the financial statements of the Council within two months after the end of the financial year to an independent auditor for auditing;
- (j) submit within four months after the end of a financial year to the Council—
- (i) an annual report on the activities of the Council during that financial year;
 - (ii) the financial statements for that financial year after those statements have been audited; and
 - (iii) an independent auditor's report on those statements.
- (3) The Council must ensure that the requirements of subsection (2) are met and properly fulfilled.
- (4) Any person who obstructs the Registrar or the Council in fulfilling the requirements of subsections (2) or (3) is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding two years or to both a fine and such imprisonment.

CHAPTER 2

EDUCATION, TRAINING, RESEARCH, REGISTRATION AND PRACTICE

Scope of profession and practice of nursing

- 30.** (1) A professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice.
- (2) A midwife is a person who is qualified and competent to independently practise midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice.
- (3) A staff nurse is a person educated to practise basic nursing in the manner and to the level prescribed.
- (4) An auxiliary nurse or an auxiliary midwife is a person educated to provide elementary nursing care in the manner and to the level prescribed.

(5) The Minister may prescribe scopes of profession and practice for other categories of nurses contemplated in section 31(2).

Registration as prerequisite to practise

31. (1) Subject to the provisions of section 37, no person may practise as a practitioner unless he or she is registered to practise in at least one of the following categories:

- (a) Professional nurse;
- (b) midwife;
- (c) staff nurse;
- (d) auxiliary nurse; or
- (e) auxiliary midwife.

(2) The Minister, after consultation with the Council, may by notice in the *Gazette*

create such other categories of persons to be registered to practise nursing as he or she considers necessary in the public interest.

(3) An employer must not employ or retain in employment a person to perform the functions pertaining to the profession of nursing, other than a person who holds the necessary qualification and who is registered under subsection (1) or (2).

(4) No person may use as a title any of the categories contemplated in subsection (1) or (2) unless he or she is registered as such in terms of this section.

(5) A practitioner who wishes to register in terms of subsection (1) must apply in the prescribed manner to the Registrar and submit with his or her application—

- (a) proof of identity;
- (b) certificate of good character and standing;
- (c) proof of his or her qualifications;
- (d) the prescribed registration fee; and
- (e) such further documents and information in relation to his or her application

as may be required by the Registrar on the instructions of the Council.

(6) If the Registrar is satisfied that the information and documentation submitted in support of an application for registration meet the requirements of this Act and upon receipt of the prescribed registration fee, the Registrar must issue a registration certificate authorising the applicant, subject to the provisions of this Act, to practise or engage in any of the categories contemplated in subsection (1) within the Republic.

(7) If the Registrar is not satisfied that the information and documentation submitted in support of an application for registration meet the requirements of this Act, he or she must refuse to issue a registration certificate to the applicant and must inform the applicant in writing of the reasons for his or her decision, but must, if so required by the applicant, submit the application to the Council for a decision.

(8) The Registrar may only register a person in terms of subsection (1) if the Registrar is satisfied that the person applying for registration is suitably qualified or if the Council is so satisfied.

(9) Any entry which is proved to the satisfaction of the Council to have been made in error or through misrepresentation or in circumstances not authorised by this Act may be removed from the register and—

(a) a record of the reason for every such removal must be made in the register;

(b) the person in respect of whom such removal has been made must be notified thereof in writing by the Registrar; and

(c) any certificate issued in respect of such registration is considered to have

been cancelled as from the date on which notice has so been given.

(10) The Registrar must delete from the register the name of the practitioner or mark in the register the name of any person removed or suspended, respectively, from

practice and must notify such person in writing accordingly.

(11) A person who contravenes subsection (1), (3) or (4) is guilty of an offence and on

conviction liable to a fine or to imprisonment for a period not exceeding 12 months

or to both a fine and such imprisonment.

(12) A person who has completed a programme qualifying him or her for registration in another category must apply to have his or her entry in the register altered accordingly.

(13) A person who completed a programme leading to registration in a higher category

must, upon application and after evaluation by the Council, have his or her entry in

the register altered accordingly.

(14) A practitioner must notify the Registrar in writing of any change of particulars

within 30 days after such change.

Registration of learners

32. (1) A person undergoing education or training in nursing must apply to the Council to

be registered as a learner nurse or a learner midwife.

(2) The Council must register as a learner nurse or a learner midwife any person who

has complied with the prescribed conditions and has furnished the prescribed

particulars for a training programme at a nursing education institution.

(3) The person in charge of a nursing education institution must, within 30 days, notify

and furnish to the Council information prescribed by the Council in respect of each

learner nurse who has commenced, completed, transferred to or abandoned a

nursing education and training programme.

(4) A person who fails to furnish the Council within a period of 90 days with the

required particulars for the registration of a learner nurse or a learner midwife as

contemplated in subsection (3) or who contravenes the provisions of subsection

(5) is guilty of an offence and liable on conviction to a fine or to imprisonment for a

period not exceeding 12 months or to both a fine and such imprisonment.

(5) A health establishment must not allow access to clinical facilities for training

purposes to anyone who is not registered in terms of this Act.

(6) The Registrar must delete from the register the name of a learner nurse, or mark

in the register the name of any person, suspended from study and must notify

such learner nurse or person accordingly, in writing.

Limited registration

33. (1) The Council may provide limited registration to a person who holds a qualification

other than a qualification contemplated in section 38 to practise as a nurse if he or

she—

(a) has a qualification that does not meet all the required standards of education and training;

(b) has not complied with section 31(5);

(c) does not have all the required professional knowledge, skills and ability; or

(d) is in the Republic for a limited period for the purpose of practice, research

or education.

(2) A person registered under subsection (1) as a nurse may only be entitled to practise—

(a) for such period as the Council may determine, but not exceeding three years; and

(b) under conditions determined by the Council.

(3) A person registered under this section who practises in contravention of the

provisions of subsection (2) is guilty of an offence and liable on conviction to a fine

or to imprisonment for a period not exceeding two years or to both a fine and such

imprisonment.

Registration of additional qualifications

34. (1) Subject to the provisions of subsection (2) and on payment of the prescribed fee,

the Council must register the additional qualification of a person who is registered

under section 31 and who applies in writing for such registration, if he or she

complies with the prescribed conditions and furnishes the prescribed particulars.

(2) Only such qualifications as are prescribed may be registered under this section.

Custody and publication of registers

35. The registers must be kept at the office of the Registrar, and the Council may, at

intervals determined by it, cause copies of the registers or supplementary lists, showing

additions, removals, amendments or revisions effected since the last publication of

copies of the completed registers, to be printed and published or displayed on the

internet as the Council thinks fit.

Register as proof

36. (1) A copy of the last published issue of a register or any supplementary list purporting to be printed and published in terms of section 35 is on the face of it proof of the facts recorded in all legal proceedings, and the absence of the name

of any person from such copy is proof, unless there is credible evidence to the contrary, that such person is not registered in terms of this Act, but that in the case of any person whose name—

(a) does not appear in such copy, or whose name has been added to the register after the date of the last published issue thereof, a certified copy under the hand of the Registrar of the entry of the name of such person in the register is proof that such person is registered under the provisions of this Act; or

(b) has been removed from the register since the date of the last published issue thereof and has not been restored thereto, a certificate under the

hand of the Registrar that the name of such person has been removed from the register is proof that such person is not registered in terms of this Act.

(2) A certificate of registration is proof of registration for a period of one year after its date and thereafter an annual practising certificate, issued upon payment of the prescribed annual fee and the submission of such information as may be required by the Council to keep accurate statistics on human resources in nursing, is proof of registration in the absence of any credible evidence to the contrary.

Receipt as proof

37. A receipt issued by or on behalf of the Council in respect of the payment of registration fees will be proof, in legal proceedings, that such person is registered according to the provisions of this Act, but in the case of any person whose name—
 (a) appears in such register and who is unable to produce such receipt, certification under the hand of the Registrar is proof that such person is registered in terms of this Act; or
 (b) has been removed from the register since the date of issue of such receipt and has not been restored to the register, certification by the Registrar that such name has been removed from the register is proof that such person is not registered in terms of this Act.

Qualifications prescribed for registration

38. The Minister may, on the recommendation of the Council, prescribe qualifications obtained by virtue of examinations conducted by a nursing education institution in the Republic, which, if held singly or conjointly with any other qualification, entitles any holder thereof to registration in terms of this Act if he or she has, before or in connection with or after the acquisition of the qualification in question, complied with such conditions or requirements as may be prescribed.

Conditions relating to continuing professional development

39. The Council may determine—
 (a) conditions relating to continuing professional development to be undergone by practitioners in order to retain such registration;
 (b) the nature and extent of continuing professional development to be undergone by practitioners; and
 (c) the criteria for recognition by the Council of continuing professional development activities and accredited institutions offering such activities.

Community service

40. (1) A person who is a citizen of South Africa intending to register for the first time to

practise a profession in a prescribed category must perform remunerated community service for a period of one year at a public health facility.

(2) A person referred to in subsection (1) must be registered in the category

community service.

(3) The Minister may, after consultation with the Council, make regulations concerning the performance of the service contemplated in subsection (1), including but not limited to—

(a) the place at which such service is to be performed;

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(b) the conditions of employment pertaining to persons who perform such service; and

(c) the categories of registration excluded from such service.

Regulation of research

41. The Council must ensure that the prescribed ethical conduct pertaining to research

related to the practice of nursing is adhered to and may take appropriate disciplinary

action against persons who act in contravention of such rules or any other law.

Education and training

42. (1) An institution intending to conduct a nursing education and training programme in

order to prepare persons for practice in any one of the categories contemplated in

section 31 must first—

(a) apply to the Council in writing for accreditation and submit information on—

(i) the education and training programme to be provided; and

(ii) how it will meet the prescribed standards and conditions for education and training;

(b) furnish the Council with any additional information required by the Council

for purposes of accreditation or approval of the education and training programme; and

(c) pay the prescribed fee.

(2) The Council may refuse any application made in terms of subsection (1) or grant

conditional or provisional accreditation.

(3) Subject to subsections (1) and (2), the Council must issue an accreditation

certificate for a nursing education institution and for each nursing programme

offered by that nursing education institution.

(4) A person who contravenes a provision of this section is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding two years or to both a fine and such imprisonment.

Use of certain titles

43. (1) A person who is registered in one of the categories contemplated in section 31

may use the title "Registered Professional Nurse", "Registered Midwife", "Registered Staff Nurse", "Registered Auxiliary Midwife" or "Registered Auxiliary Nurse", as the case may be, or the abbreviations "RPN", "RM", "RSN", "RAM" or "RAN", respectively.

(2) A person who is following a programme of study in a nursing education and training institution may use the title "Learner Nurse" or "Learner Midwife", as the case may be, or the abbreviations "LN" or "LM", respectively.

(3) A person registered in terms of section 40(2) may use the title "Community Service Practitioner".

Removal from and restoration of name to register

44. (1) The Council may instruct the Registrar to remove from the register the name of

any practitioner—

(a) who has died;

(b) who has ceased to be a citizen or permanent resident of the Republic and

has permanently left the Republic;

(c) who has failed to pay any relevant prescribed fee;

(d) who has failed to notify the Registrar of any change in residential and postal

address or the address of his or her practice within six months after any such change;

(e) who has requested that his or her name be removed from the register, in

which case he or she may be required to lodge with the Registrar an affidavit or affirmation to the effect that no disciplinary or criminal

proceedings are being or are likely to be instituted against him or her;

(f) who has been found guilty of unprofessional conduct and a penalty contemplated in 47(1)(b) or (d) was imposed in terms of this Act;

(g) whose name has been removed from the register, record or roll of any accredited institution or other body from which he or she received the qualification by virtue of which he or she was registered;

(h) who has failed to furnish the Registrar, within a period to be determined by the Council, with such information as the Registrar may require under this Act;

(i) whose registration is proved to the satisfaction of the Council to have been made in error or through fraudulent misrepresentation or concealment of material facts or information or in circumstances not authorised by this Act; or

(j) who, after an inquiry in terms of section 51, is found to be mentally impaired.

(2) The Registrar must give notice of the removal of a person's name from the register in terms of paragraph (b) to paragraph (k) of subsection (1) by registered mail addressed to such person at the address of such person as it appears in the register.

(3) From the date on which notice was given in terms of subsection (2)—
 (a) any registration certificate issued in terms of this Act to the person concerned is considered to have been cancelled; and
 (b) a person whose name has been removed from the register must cease to practise as a practitioner and is precluded from performing any act which he or she, in his or her capacity as a registered person, was entitled to perform.

(4) The Registrar must restore the name of a person whose name has in terms of this section been removed from the register if the person concerned—
 (a) applies on the prescribed form to the Registrar for restoration of his or her name;
 (b) pays the prescribed fee, if any;
 (c) complies with such other requirements as the Council may determine; and
 (d) is otherwise eligible for registration.

Issue of duplicate registration certificate, certificate of status, extract from register or certificate

45. (1) The Registrar may, on application by a practitioner, issue a duplicate certificate of registration if the applicant—
 (a) provides proof of his or her identity to the satisfaction of the Registrar;
 (b) provides an affidavit in which he or she confirms that the certificate of registration has been lost or destroyed; and
 (c) pays the prescribed fee determined by the Council.

(2) The Registrar may, upon payment of the prescribed fee, issue to any registered person a certificate of status containing—
 (a) particulars relating to such person's registration; and
 (b) a statement to the effect that—
 (i) the said person is not disqualified from practising his or her occupation; and

(ii) no disciplinary steps are pending against him or her in terms of this Act.

(3) The Registrar may issue a certified extract from the register or a certificate referred to in subsection (2) under his or her hand to any person upon payment of the prescribed fee.

(4) A certificate may be issued subject to certain conditions imposed by the Council and such conditions shall be indicated on the certificate.

CHAPTER 3

POWERS OF COUNCIL WITH REGARD TO UNPROFESSIONAL CONDUCT

Inquiry by Council into charges of unprofessional conduct

46. (1) The Council may institute an inquiry into any complaint, charge or allegation of unprofessional conduct against a practitioner or a director, manager or owner of an agency registered in terms of this Act, on finding such person guilty of such conduct, may impose any of the penalties contemplated in section 47, but in the case of a complaint, charge or allegation which forms or is likely to form the subject of a criminal case in a court of law, the Council may postpone the holding of an inquiry until such criminal case has been disposed of.

(2) In the absence of a complaint, charge or allegation, the Council may institute an inquiry into any alleged unprofessional conduct that comes to its notice.

(3) If the Council doubts whether an inquiry should be held in connection with a complaint, charge or allegation, it may consult with or seek information from any person, including the person against whom the complaint, charge or allegation has been lodged, to determine whether an inquiry should be held.

Procedure of inquiry by Council

47. (1) A person registered in terms of this Act who, after an inquiry has been held by the Council, is found guilty of unprofessional conduct is liable to one or more of the following penalties:

(a) A caution or a reprimand or both;

(b) suspension for a specified period from practising or, in the case of a learner

nurse or a learner midwife, extension or suspension for a specified period of the prescribed period of education and training;

- (c) removal of his or her name from the register;
 (d) a prescribed fine; or
 (e) payment of the costs of the proceedings.
- (2) The Council must appoint a pro forma complainant to act on behalf of the Council in terms of this Chapter.
- (3) A preliminary investigating committee appointed by the Council may—
 (a) investigate all matters of alleged unprofessional conduct;
 (b) based on evidence, determine whether the case should be referred for a professional conduct inquiry; and
 (c) in the case of a minor offence, recommend a prescribed fine instead of a full professional conduct inquiry.
- (4) The Registrar may then issue a summons on the prescribed form against the defendant carrying an endorsement by the committee of preliminary investigation that the defendant may admit that he or she is guilty of unprofessional conduct and that he or she may pay the fine specified in the summons, without having to appear at an inquiry in terms of section 46.
- (5) If a summons referred to in subsection (4) is issued against a defendant he or she may, without appearing at an inquiry in terms of section 46, admit that he or she is guilty of unprofessional conduct by paying the prescribed admission of guilt fine to the Council on or before the date specified in the summons.
- (6) (a) A penalty imposed under this section, excluding an admission of guilt fine, is effective within 14 days after notification.
 (b) The imposition of a fine under this section has the effect of a judgment in civil proceedings in the magistrate's court of the district in which the inquiry in question under section 46 took place or the district wherein the defendant is subsequently resident or employed.
- (7) A penalty referred to in subsection (1) imposed by a professional conduct committee or the preliminary investigation committee referred to in subsection (3), other than a reprimand, is not effective until confirmed by the Council, but a penalty referred to in subsection (1) imposed by a professional conduct committee or any order made by such committee under subsection (1) must, if such committee so directs in the public interest, come into operation forthwith, and must then lapse after expiry of a period of six months unless confirmed by the Council within that period.

(8) (a) During an inquiry in terms of this section, the defendant must be afforded an opportunity of pleading to the charge and of being heard in his or her defence.

(b) Any party in a professional conduct hearing has the right to be represented by a person of his or her choice, but such representative must adhere to the prescribed procedure pertaining to such inquiry.

(c) Despite a plea of guilty by a defendant, the Council or a professional conduct committee may require the pro forma complainant or defendant to lead evidence.

(9) Any penalty imposed under subsection (1) must be reduced to writing and signed by the chairperson of the Council and dealt with in the prescribed manner.

(10) (a) The Council or a professional conduct committee may—

(i) take evidence from any witness who has been subpoenaed by the Registrar;

(ii) administer an oath to, or take an affirmation from, any witness; and

(iii) examine any book, record, document or thing which a witness has been required to produce.

(b) A subpoena to appear before the Council or a professional conduct committee as a witness or to produce any book, record, document or thing must be in the prescribed form and must be served either by registered post

or in the same manner as a subpoena issued by a magistrate's court.

(c) A person subpoenaed under this subsection who—

(i) refuses or, without sufficient cause, fails to attend and give evidence relevant to the inquiry at the time and place specified in the subpoena;

(ii) refuses to take the oath or to make an affirmation when required by the chairperson to do so;

(iii) refuses to produce any book, record, document or thing which he or she is in terms of the subpoena required to produce;

(iv) wilfully misleads the Council or a professional conduct committee; or

(v) refuses to answer any question that is not self-incriminatory or to answer, to the best of his or her knowledge and belief, any question lawfully put to him or her,

is guilty of an offence and on conviction liable to a prescribed fine.

(d) A person so subpoenaed is entitled to all the privileges to which a witness

subpoenaed to give evidence before a magistrate's court is entitled.

(11) The chairperson of a professional conduct committee may appoint assessors to

advise the Council or such committee on matters of law, procedure or evidence

when holding an inquiry.

Postponement of imposition and suspension of operation of penalty

48. (1) Where a person has been found guilty of unprofessional conduct, a professional

conduct committee may—

(a) postpone the imposition of a penalty for such period and on such conditions

as it may determine; or

(b) impose any penalty mentioned in section 47(1)(b) or (c) but may order the

execution of the penalty to be suspended for such period and on such conditions as it may determine.

(2) If, at the end of the period for which the imposition of a penalty has been

postponed in terms of subsection (1)(a), the Council is satisfied that a registered

person has observed all the relevant conditions of a penalty imposed, the Council

must inform such registered person that the penalty contemplated in section 47

will not be imposed upon him or her.

(3) If the execution of the penalty or any part thereof has been suspended in terms of

subsection (1)(b) and the Council is satisfied that the person concerned has

observed all the relevant conditions throughout the period of suspension, the

Council must inform that person that the penalty contemplated in section 47 will

not be executed.

(4) If the execution of the penalty or any part thereof has been suspended in terms of

subsection (1)(b) and the practitioner concerned fails to comply with one or more

of the conditions of suspension, the Council must put the penalty or part thereof

into operation unless the practitioner satisfies the Council that the failure to comply

with the conditions concerned was due to circumstances beyond his or her control.

Suspension or removal from register related to professional conduct matters

49. (1) A practitioner suspended or whose name is removed from the register in terms of

section 47 is disqualified from practising the profession and his or her registration

certificate is withdrawn until the period of suspension has expired or until his or

her name is restored to the register.

(2) The name of the person removed from the register in terms of section 47(1)(c) or restored to the register in terms of subsection (3)(b) must be published in the *Gazette*.

(3) The Council may on such conditions as it may determine—

(a) terminate any suspension referred to in subsection (1) before the expiry of the specified period; or

(b) restore to the register the name which has been removed, but such restoration may be considered only 12 months after such removal.

Cognisance by Council of conduct of registered persons under certain circumstances

50. (1) If—

(a) a registered practitioner has been convicted of any offence by a court of law; and

(b) the Council is of the opinion that such offence constitutes unprofessional conduct contemplated in section 46, such practitioner may be dealt with by the Council in terms of this Chapter and is liable on conviction to one or more of the penalties contemplated in section 47 but, before imposition of any penalty, such practitioner must be afforded an opportunity to address the Council in extenuation of the conduct in question.

(2) Whenever in the course of any proceedings before any court of law it appears to the court that there is, on the face of it, proof of unprofessional conduct on the part of a person registered in terms of this Act, the court must ensure that a copy of the record of such proceedings, or such portion thereof as is material to the issue, is transmitted to the Council.

Unfitness to practise due to impairment

51. (1) Whenever it appears to the Council that a person registered in terms of the Act is

or may be incapacitated as a result of disability or is or may be impaired, whether mentally or otherwise, to such an extent that—

(a) it would be detrimental to the public interest to allow him or her to continue to practise;

(b) he or she is unable to practise the profession with reasonable skill and safety; or (c) in the case of a learner, has become unfit to continue with the education programme, the Council must appoint a committee to conduct an inquiry in the prescribed manner.

(2) If the Council after holding an inquiry finds the person registered in terms of the Act incapacitated or impaired as referred to in subsection (1), the Council may—

(a) allow that person to continue practising the profession and in the case of a learner to continue with the education programme under such conditions as it may think fit; or

(b) suspend that person for a specified period or stop that person from practising and, in the case of a learner, from continuing with his or her education and training programme.

(3) If a person referred to in subsection (2) applies for re-instatement, the Council

must evaluate the person's ability to continue practising and may extend or withdraw the period of operation of the suspension.

(4) Section 49 must, with the necessary changes, apply in respect of a practitioner suspended in terms of subsection (2).

(5) A practitioner registered under this Act who contravenes or fails to comply with the provisions of subsection (2)(a) or (b) is guilty of an offence.

(6) The committee referred to in subsection (1) may appoint persons with relevant expertise and experience as assessors to advise such committee.

(7) For the purposes of this section "impairment" refers to a condition which renders a practitioner incapable of practising nursing with reasonable skill and safety.

Investigation of matters relating to teaching of learners

52. (1) Despite anything to the contrary contained in any law, any person who has been authorised by the Council in writing may, in the presence of police officer, enter

any institution or premises where learners are trained and confiscate any document or object relevant to such education and training for purposes of—

(a) inspecting such institution or premises for the quality of nursing service in relation to its professional conduct function; or

(b) investigating any matter relating to the education and training of learners for

the qualification to practise the profession of nursing in terms of this Act.

(2) Any person who prevents or hinders an authorised person referred to in

subsection (1) is guilty of an offence.

CHAPTER 4

OFFENCES BY PERSONS NOT REGISTERED

Penalties for practising as professional nurse, midwife, staff nurse, auxiliary nurse or auxiliary midwife while not registered

53. (1) A person registered under this Act who misrepresents that he or she is competent or registered to practise nursing or practises in a capacity that he or she is not registered for is guilty of an offence.

(2) Subsection (1) is not applicable to—

(a) a learner nurse or a learner midwife registered under section 32, while acting in the course of his or her education and training;

(b) a learner nurse or a learner midwife who has taken or will at the first available opportunity take the final examination for a qualification which, if obtained, will entitle him or her to be registered until such time as he or she

is advised on the results of such an examination;

(c) a person rendering assistance in a case of emergency; or

(d) any other class or classes of persons determined by the Council.

Penalty for misrepresentation inducing registration and false entries in register and impersonation

54. (1) A person is guilty of an offence if he or she—

(a) by means of a false representation procures or attempts to procure for himself or herself or any other person registration or any certificate or decision referred to in this Act;

(b) makes or causes to be made any unauthorised entry in, alteration to or removal from a register or a certified copy of or extract from any certificate issued under this Act;

(c) wilfully destroys, damages or renders illegible any entry in the register or,

without the permission of the holder, any certificate issued under this Act;

(d) wilfully omits any information or gives false information to the effect that no

professional misconduct proceedings are being or are likely to be held regarding him or her;

(e) forges or, knowing it to be forged, utters any document purporting to be a

certificate issued under this Act; or

(f) impersonates any person registered in terms of this Act.

(2) A person found guilty of an offence contemplated in subsection (1) is liable on

conviction to a fine or to a period of imprisonment or to both a fine and such

imprisonment.

Penalties

55. (1) A person registered under this Act who in any way takes, uses or publishes any name, title, description or symbol which indicates, or which is calculated to lead persons to infer, that he or she holds a registered professional qualification which is not shown in the register in connection with his or her name is guilty of an offence and liable on conviction to a prescribed fine or to imprisonment for a period not exceeding two years or to both a fine and such imprisonment.

(2) Any person who contravenes or fails to comply with any provision of this Act is guilty of an offence and, save where a penalty is expressly provided, liable on conviction to a prescribed fine or to imprisonment for a period not exceeding three years or to both a fine and such imprisonment.

CHAPTER 5

GENERAL AND SUPPLEMENTARY PROVISIONS

Special provisions relating to certain nurses

56. (1) Despite the provisions of this Act or any other law, the Council may register a person who is registered in terms of section 31(1)(a), (b) or (c) to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions, if such person—

(a) provides proof of completion of prescribed qualification and training;

(b) pays the prescribed registration fee; and

(c) complies with subsection 6.

(2) The Council must issue a registration certificate to a person who complies with the requirements referred to in subsection (1).

(3) The registration certificate referred to in subsection (2) is valid for a period of three years.

(4) The Council may renew a registration certificate referred to in subsection (2) subject to such conditions as the Council may determine.

(5) A person registered in terms of subsection (1) may—

(a) acquire, use, possess or supply medicine subject to the provisions of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965); and

(b) dispense medicines subject to the provisions of the Medicines and Related Substances Act, 1965.

(6) Despite the provisions of this Act, the said Medicines and Related Substances

Act, 1965, the Pharmacy Act, 1974 (Act No. 53 of 1974), and the Health Professions Act, 1974 (Act No. 56 of 1974), a nurse who is in the service of—

- (a) the national department;
- (b) a provincial department of health;
- (c) a municipality; or
- (d) an organisation performing any health service designated by the Director-

General after consultation with the South African Pharmacy Council referred to in section 2 of the Pharmacy Act, 1974, and who has been authorised by the Director-General, the head of such provincial department of health, the medical officer of health of such municipality or the medical practitioner in charge of such organisation, as the case may be, may in

the course of such service perform with reference to—

- (i) the physical examination of any person;
 - (ii) the diagnosing of any physical defect, illness or deficiency in any person; or
 - (iii) the keeping of prescribed medicines and their supply, administering or prescribing on the prescribed conditions;
- any act which the said Director-General, head of provincial department of health, medical officer of health or medical practitioner, as the case may be, may, after

consultation with the Council, determine in general or in a particular case or in

cases of a particular nature, if the services of a medical practitioner or pharmacist, as the circumstances may require, are not available.

(7) A person contemplated in subsection (1) is not entitled to keep an open shop or pharmacy.

(8) For the purpose of subsection (7) "open shop" means a situation where the supply of medicines and scheduled substances to the public is not done by prescription by a person authorised within the scope of practice concerned to prescribe medicine.

Appeal against decisions of Council

57. (1) A person aggrieved by a decision of the Council may within the prescribed period and in the prescribed manner appeal against such decision to an appeal committee contemplated in subsection (2) and appointed by the Minister.

(2) The appeal committee referred to in subsection (1) consists of—

- (a) a retired judge or magistrate or an advocate or attorney of the High Court of

South Africa who has practised as such for a period of at least five years,

and who must be the chairperson of such committee; and

(b) a nurse.

(3) An appeal under subsection (1) must be heard on the date, place and time fixed

by the appeal committee.

(4) The appeal committee must ensure that the appellant as well as the Council are

informed of the date, place and time contemplated in subsection (3) at least 14

days before such appeal is heard.

(5) The appeal committee may for the purposes of an appeal lodged with it—

(a) summon any person who, in its opinion, may be able to give material information concerning the subject of the appeal or who it believes has in his or her possession or custody or under his or her control any document which has any bearing upon the subject of the appeal to appear before it at

a time and place specified in the summons, to be interrogated or to produce

that document, and may retain for examination any document so produced;

and

(b) administer an oath to or accept affirmation from any person called as a witness at the appeal.

(6) The chairperson of the appeal committee must determine the procedure to be

followed during the appeal hearing and notify the appellant and the Council of

such determined procedure.

(7) The appeal committee may after hearing the appeal—

(a) confirm, set aside or vary the relevant decision of the Council; and

(b) direct the Council to execute the decision of the appeal committee in that

regard.

(8) (a) The decision of the appeal committee must be in writing, and a copy must

be furnished to the appellant as well as to the Council.

(b) The decision of the appeal committee contemplated in paragraph (a) must

be conveyed to the appellant and the Council within 14 days of the decision

being reached.

(9) The members of the appeal committee who are not in the full-time employment of

the State may be paid such remuneration and allowances as the Minister may

determine with the concurrence of the Minister of Finance.

Regulations

- 58.** (1) The Minister may, after consultation with the Council, make regulations relating to—
- (a) the appointment of members of the Council in terms of section 5(1) and the requirements for a valid nomination of a candidate for appointment as a member of the Council;
 - (b) the register to be kept, the information which must be recorded in the register and the manner in which alterations may be effected in the register and the diplomas and certificates that may be issued, in terms of this Act;
 - (c) the conditions under which extracts from the register may be made;
 - (d) the particulars to be furnished to the Council to enable it to keep the register;
 - (e) the registration of an additional qualification;
 - (f) the qualifications, and the conditions to be complied with, which entitle a person to be registered under section 31;
 - (g) accreditation of institutions as nursing education institutions;
 - (h) identification symbols provided by the Council that a practitioner may use;
 - (i) the instituting and holding of professional conduct inquiries;
 - (j) the conditions under which private practice may be licenced;
 - (k) the circumstances in which any name may be removed from or restored to a register;
 - (l) the manner of instituting, and the procedure to be followed at, an appeal hearing in terms of section 57 and any other matter incidental thereto;
 - (m) mandatory supplementary training or refresher courses to be undergone or taken by persons registered under this Act, the provision of and control over such training or courses, the intervals between such training or courses and sanctions for failure to undergo such training or take such courses;
 - (n) the performance of community service;
 - (o) ethical conduct for research;
 - (p) conditions for limited registration in terms of section 33;
 - (q) the scope of practice of practitioners;
 - (r) the fees and fines payable in terms of this Act; and
 - (s) generally, any matter which in terms of this Act is required or may be done,
- which the Minister considers necessary or expedient to prescribe in order that the objects of this Act may be achieved.
- (2) The Minister may make regulations regarding—
- (a) procedures for the proper functioning of the Council where, in the opinion of the Minister, the Council is not fulfilling one or more of its functions adequately;

- (b) disciplinary steps that may be taken against a member, the chairperson or the vice-chairperson for failure to perform his or her duties as required in terms of this Act, including the suspension of a member, chairperson or the vice-chairperson from the office pending an investigation into his or her conduct as a member of a profession or as a member, chairperson or vicechairperson of the Council, or a criminal investigation involving such person;
- (c) interim measures for the continued management and functioning of the Council in the event that the Minister terminates membership of 10 or more members simultaneously in terms of section 8 or that the Minister dissolves the Council in terms of section 5(7);
- (d) investigations to be conducted into the affairs of the Council concerning the procedure at Council meetings and meetings of the executive committee of the Council, keeping of records of meetings and resolutions of the Council, the manner in, and extent to, which the Council fulfils its functions in terms of this Act and any other matter which, in the opinion of the Minister, is impeding the Council in the fulfilment of its functions; and
- (e) returns, reports, registers, records, documents and forms to be completed and kept by the Council or to be submitted to the Minister or the Director-General by the Council.
- (3) A regulation made in terms of this Act may prescribe penalties for any contravention thereof or failure to comply therewith.
- (4) A notice issued or regulation or order made under this Act may from time to time be amended or revoked by the authority which issued or made it.
- (5) The Minister must, not less than three months before any regulation is made under subsection (1), publish the regulation in the *Gazette* together with a notice—
- (a) declaring his or her intention to make such regulations; and
- (b) inviting interested persons to comment thereon or to make representations with regard thereto.
- (6) Subsection (5) does not apply in respect of—
- (a) any regulation which, after the provisions of subsection (5) have been complied with, has been amended by the Minister in consequence of representations received by him or her as a result of the notice published in terms of subsection (5); and
- (b) any regulation in respect of which the Council advises the Minister that the public interest requires it to be made without delay.

Rules

59. (1) The Council may make rules relating to—

- (a) conditions relating to continuing professional development to be undergone by practitioners in order to retain such registration;
- (b) the nature and extent of continuing professional development to be undergone by practitioners;
- (c) the criteria for recognition by the Council of continuing professional development activities and of providers offering such activities; and
- (d) any other matter which must be promulgated as rules under this Act.

(2) The Council must, not less than three months before any rule is made under this Act—

- (a) publish such rule in the *Gazette* together with a notice declaring the Council's intention to make such rule; and
- (b) invite interested persons to comment thereon or to make representations with regard thereto.

Repeal of laws

60. (1) The laws set out in the first and second column of the Schedule are repealed to the extent set out in the third column of the Schedule.

(2) The repeal does not affect the transitional arrangements contained in section 61.

Transitional provisions

61. (1) Any proclamation, notice, regulation, authorisation or order issued, made or granted, any registration or enrolment, any removal from a register or roll or any appointment or any other thing done in terms of a provision of any law repealed by section 60(1) is, unless inconsistent with any provision of this Act, deemed to have been issued, made, granted or done under the corresponding provision of this Act.

(2) The members of the Council as constituted immediately prior to the commencement of this Act must continue to be members thereof, and the Council is regarded to be validly constituted in terms of this Act until a date determined by the Minister and published in the *Gazette*.

(3) If any member referred to in subsection (2) vacates his or her office, the Council must, until the date referred to in that subsection, consist of the remaining members.

(4) Despite the provisions of subsection (1) and subject to the provisions of

subsection (5), the Council has the power to institute or conclude disciplinary proceedings under the relevant provisions of the repealed laws in accordance with the procedures as prescribed by regulations made under such repealed laws, against any person who, at any time prior to the first meeting of the Council after the commencement of this Act, is alleged to have committed an act which may have constituted improper or disgraceful conduct in terms of the provisions of the repealed laws or any regulation made thereunder.

(5) The Council may not institute proceedings referred to in subsection (4) against any person unless the nature of the contravention which such person is alleged to have committed in terms of the repealed laws or any regulation made thereunder is substantially the same as that of a contravention referred to in the corresponding provisions of this Act or of any regulation made thereunder.

Short title and commencement

62. This Act is called the Nursing Act, 2005, and comes into operation on a date determined by the President by proclamation in the *Gazette*.

SCHEDULE (SECTION 60)

No. and year Short Title Extent of repeal

No. 50 of 1978 Nursing Act The whole
 No. 71 of 1981 Nursing Amendment Act The whole
 No. 70 of 1982 Nursing Amendment Act The whole
 No. 97 of 1986 Transfer of Powers and Duties of the State President Act
 Section 46
 No. 56 of 1987 Nursing Amendment Act The whole
 No. 21 of 1992 Nursing Amendment Act The whole
 No. 145 of 1993 Nursing Amendment Act The whole
 No. 5 of 1995 Nursing Amendment Act The whole
 No. 88 of 1996 Abolition of Restrictions on the Jurisdiction of Courts Act
 Section 78
 No. 19 of 1997 Nursing Amendment Act The whole
 No. 45 of 1997 Extension of Terms of Office of Members of Certain Councils Act
 Section 6

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While every effort has been made to ensure that this document is error free, should any discrepancy be found, the official version of this Act and any subsequent amendments to this Act, printed in the *Gazette*, will always take precedence over the information in this document.

Nursing Act, 2005 (version 1.0), 2006-05-29



Addendum four List of educational institutions

List of educational institutions.

Currently the following Universities offer undergraduate or postgraduate nursing degrees in South Africa :

Cape Peninsula University of Technology at www.cput.ac.za

Central University of Technology, Free State at www.cut.ac.za

Durban University of Technology at www.dut.ac.za

Mangosuthu University of Technology at www.mantec.ac.za

Nelson Mandela Metropolitan University at www.nmmu.ac.za

North-West University at www.nmu.ac.za.

Rhodes University at www.ru.ac.za

Tshwane University of Technology at www.tut.ac.za

University of Cape Town at www.uct.ac.za

University of KwaZulu-Natal at www.ukzn.ac.za

University of Fort Hare at www.ufh.ac.za

University of Free State at www.uovs.ac.za

University of Johannesburg at www.uj.ac.za

University of Limpopo at www.ul.ac.za

University of Pretoria at www.up.ac.za

University of South Africa at www.unisa.ac.za

University of Stellenbosch at www.sun.ac.za

University of Venda at www.univen.ac.za

University of the Western Cape at www.uwc.ac.za

University of the Witwatersrand at www.wits.ac.za

University of Zululand at www.uzulu.ac.za

Vaal University of Technology at www.vut.ac.za

Walter Sisulu University of Technology at www.wsu.ac.za

Many of the above mentioned providers have departments of continuing education or departments of lifelong learning, which in future could take on the responsibility to offer a variety of courses, workshops and seminars for the purpose of CPD.

In addition to the Universities, nursing education courses are also offered by other institutions such as nursing colleges.

Some of the colleges are:-

Baragwanath Nursing College in Soweto, Johannesburg in the Gauteng province;

Ann Latsky Nursing College in Johannesburg in the Gauteng province

SJ Lourens Nursing College in Pretoria in the Gauteng province

Free State College of Nursing in the Free State province

Excelsior Nursing College in the Northwest province

Venda Nursing College in Limpopo province

KwaZulu - Natal College of Nursing in KwaZulu- Natal province

Eastern Cape College of Nursing in the Eastern Cape province

Western Cape College of Nursing in the Western Cape province

Henrietta Stockdale College of Nursing in the Northern Cape province

All private hospital groups have their own colleges such as: Mediclinic, Netcare and Life Health Group.



Addendum five Summary of CPD activities

SANC

	CPD PORTFOLIO FOR ANNUAL CYCLE ENDING
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Surname		SANC Number
First names		

Level 1 Activities			
Activity	Description	Date	CEU's/Hours

Level 2 Activities			
Activity	Description	Date	CEU's/Hours

Level 3			
Activity	Description	Date	CEU's/Hours

Total CEU's/hours obtained for the Year	
--	--

I, the undersigned, certify that the information contained in this document and the attached certificates is correct

Signature:.....

Date:.....

Addendum six Letter from SANC

Die Suid-Afrikaanse Raad op Verpleging The South African Nursing Council

(Ingestel ingevolge die Wet op Verpleging, 1978)

(Established under the Nursing Act, 1978)

TELEFOON (012) 343-0121
TELEGRAMME "NURSRaad"
PRETORIUSSTRAAT 602
ARCADIA, PRETORIA 0083

FAX (012) 343-5400
POSBUS 1123
PRETORIA
0001



TELEPHONE (012) 343-0121
TELEGRAMS "NURSRaad"
602 PRETORIUS STREET
ARCADIA, PRETORIA 0083

FAX (012) 343-5400
PO BOX 1123
PRETORIA
0001

Vermeld asb. in u antwoord
Please quote in your reply

No. S428

1 February 2001

ATTENTION: Mr S Arunachallam

Professor E Kortenbont
University of Western Cape
Department of Nursing
Private Bag X17
BELLVILLE
7535

Dear Mr Arunachallam

RESEARCH: COMPULSORY PROFESSIONAL DEVELOPMENT IN NURSING

1. Your letter dated 23 January 2001, is acknowledged.
2. The Education Committee is currently engaged in developing a system of continuing professional development for nurses and midwives in South Africa. This process is still in its embryonic stage.
3. I am a contact person. I registered with RAU in the year 2000 for my doctoral studies. I am working with the Education Committee on the development of such a system.
4. The Education Committee is planning to have a national workshop where the profession will be informed about developments with regard to legislative issues, RPL and CPD.

Yours sincerely

MRS E KAYE-PETERSEN
SENIOR MANAGER: PROFESSIONAL DEVELOPMENT SECTION
for REGISTRAR AND CHIEF EXECUTIVE OFFICER

EKPL2001 - qbn(2)