



Valuating a continuous professional development programme for Critical Care nurse practitioners in a private hospital in Gauteng

by

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DECLARATION

I declare that the dissertation titled **EVALUATING A CONTINUOUS PROFESSIONAL DEVELOPMENT PROGRAMME FOR CRITICAL CARE NURSE PRACTITIONERS IN A PRIVATE HOSPITAL IN GAUTENG: AN APPRECIATIVE INQUIRY APPROACH** which I hereby submit for the degree Magister Curationis at the University of Pretoria, is my own work and has not previously been submitted by me for a degree to any other university.

Furthermore I declare that all sources that have been indicated and acknowledged by means of a complete reference list.

Signature

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Date

ABSTRACT

In a hospital environment the focus is on quality patient care. One of the important factors to improve the quality of patient care is the implementation of a continuous professional development programme. In a continuous professional development programme of a hospital three stakeholders namely management, clinical facilitators and the nurse practitioners are identified as partners. When the stakeholders reach a point where it is believed that the continuous professional development programme does not serve its purpose to improve the quality of patient care it is time to evaluate and refine the programme.

This study evaluate the critical care and high care units in a private hospital in Gauteng's continuous professional development programme and the conclusions and recommendations are therefore limited to this specific clinical setting. The refinements recommended cannot be utilised in other clinical setting but the evaluation and research methodology can be utilised to evaluate similar continuous professional development programmes.

Evaluation of a continuous professional development has the potential to negatively influence the nurse practitioners attitude towards continuous professional development. The objective of the research approach chosen namely a 4-D Appreciative Inquiry approach was to gain the collaboration of all the stakeholders in an effort to ensure that the evaluation of the continuous professional development programme of the critical care and high care units in the private hospital in Gauteng does not negatively affect the delivery of quality patient care. The Appreciative Inquiry research approach with its positive approach lends it to be the most appropriate research methodology of the study.

The study utilised a Focus Group Inquiry as data a collection mechanism. From the study *In-service training* emerged as the element that form an important element of an effective continuous professional development programme but that it is of the at most importance that an effective *Workplace learning environment* exists. The supportive role of *Management* for a continuous professional development programme also emerged as one of the main themes required for the implementation of a continuous professional development programme. These findings were utilised in the refinement for the continuous professional development programme for the critical care and high care units in

the private hospital in Gauteng. The research recommends that a steering committee be appointed to implement a pilot continuous professional development programme that incorporate the refinement elements identified. Due to the continuous improvement nature of the Appreciative Inquiry methodology it is also recommended that the pilot continuous professional development programme been re-evaluation to ensure long-term success and improvement.

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LIST OF ABBREVIATIONS

AI	Appreciative Inquiry
AMNCH	The Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital
BC I	Bridging course level 1 (first year)
BC II	Bridging course level 2 (second year)
CCU	Critical Care Unit
CPD	Continuous Professional Development
EFN	European Federation of Nursing Associations
HCU	High Care Unit
NCPD N&M	National Council for the Professional Development of Nursing and Midwifery
PEN I	Pupil enrolled nurse level 1 (first year)
PEN II	Pupil enrolled nurse level 2 (second year)
SANC	South African Nursing Council

1

ORIENTATION TO THE STUDY

“Let us never consider ourselves finished nurses....we must be learning all our lives”

Florence Nightingale

1.1 INTRODUCTION AND BACKGROUND

Nurse practitioners are challenged with high patient turnover, critically ill patients, advanced management interventions and sophisticated technology. Nurse practitioners are required to maintain knowledge and skills in order to be enabled and empowered to deliver quality nursing care. The focus of Continuous Professional Development (CPD) is to empower nurse practitioners and enhance the quality of patient care. This statement is supported by Davids (2006: 1) as well as Forbes, While and Ullman (2005: 78) who indicate that CPD empowers nurse practitioners to provide quality care to their patients. Nurse practitioners have to realise that the expansion and updating of their knowledge and skills is critical to delivering quality patient care.

Continuous Professional Development programmes appear to be under constant pressure due to financial constraints and the time nurse practitioners have available to participate in programmes (Bjork et al. 2009: 1). Further, Munro (2008: 954) emphasises that CPD should be a collaborative effort amongst all stakeholders in order to be successful. Stakeholders in the hospital clinical learning environment include hospital management, clinical facilitators and nurse practitioners. If collaboration between stakeholders does not occur, the successful implementation of a CPD programme becomes extremely difficult. Ineffective or underutilised CPD programmes can jeopardise quality in nursing care (Muller 2002: 202; Muller 2009: 256). In the view of Billings and Halstead (2005: 543), the primary purpose of programme evaluation is to *“judge the merit or worth of the total programme or individual elements of the programme”*. Appreciative Inquiry (AI) offers a positive approach towards evaluation, and facilitates positive change. Appreciative orientated evaluation begins by taking stock of resources, values and strengths on completion of which

aspects those participating in the evaluation feel better equipped to address difficulties and challenges (Preskill & Coghlan 2003:37).

According to Clarke and Aiken (2008: 3317) concerns about quality patient care have been on the increase in recent years. Quality patient care is a challenge for hospital management as it is one of the hospitals main responsibilities. A CPD programme for nurse practitioner is regarded as vital to ensure quality patient care (Uys & Naidoo 2004: 2). Continuous professional development and life-long learning is fundamental in the fast changing nursing practice and clinical environment (Bjork et al. 2009: 1). According to McCormack and Slater (2006: 136) an additional benefit of CPD is higher staff morale, lower burnout, trust amongst professionals and lower patient mortality. Research has shown that development through CPD programme opportunities have a major impact on the job satisfaction of nurse practitioners (Bjork et al. 2009: 2). A CPD system can either be voluntary or mandatory depending on the regulatory requirements of the country. In situations of voluntary CPD systems development activities are undertaken as and when the demand requires it. The international tendency is to move more towards mandatory CPD systems. To ensure quality of development activities regulatory bodies tend to design and operate accreditation systems for CPD activities. There is, however, also a growing emphasis for the recognition of informal CPD activities which is more difficult to accredit (Pharmaceutical Society of Ireland 2010: 4-5).

As emphasised by Frick and Kapp (2006: 2), CPD programmes should be developed for a country's specific health care requirements but should always be internationally acceptable and conform to international trends, standards, and developments. The goal for implementation of a CPD system is to improve the quality of patient care. The overall aim of this study is, by means of AI, to evaluate a CPD programme for critical care nurse practitioners in a private hospital in the Gauteng Province in South Africa.

1.1.1 Continuous Professional Development in a Private Hospital

Traditionally it was accepted that CPD was the responsibility of the individual nurse practitioner. In recent years organisations acknowledge the positive impact of a system that assists the nurse practitioner with continuous career

development (Jooste 2010: 260; Bruce, Klopper & Mellish 2011: 343). In the private hospital in Gauteng where this research was conducted there is a system in place as part of the nurse practitioner's personal development plan. This process identifies specific training needs to improve the quality of nursing care and is acknowledged by the nurse practitioner as being necessary for professional development. Identified topics during performance management interviews are used by the clinical facilitator to provide education and training to the nurse practitioners. These education and training requirements are in line with risk assessments done by the hospital as well as the voice of the customer (Private Hospital 2007: 4).

The stakeholders in the hospital's clinical learning environment are categorised in three groups namely management, clinical facilitators, and nurse practitioners (Disch, Walton & Barnsteiner 2001: 345-346). Figure 1-1 summarises the conceptual framework as developed by the researcher identifying the interdependency between the stakeholders (management, clinical facilitator, nurse practitioner) in the hospital clinical learning environment that is required to ensure quality care for patients and their families.

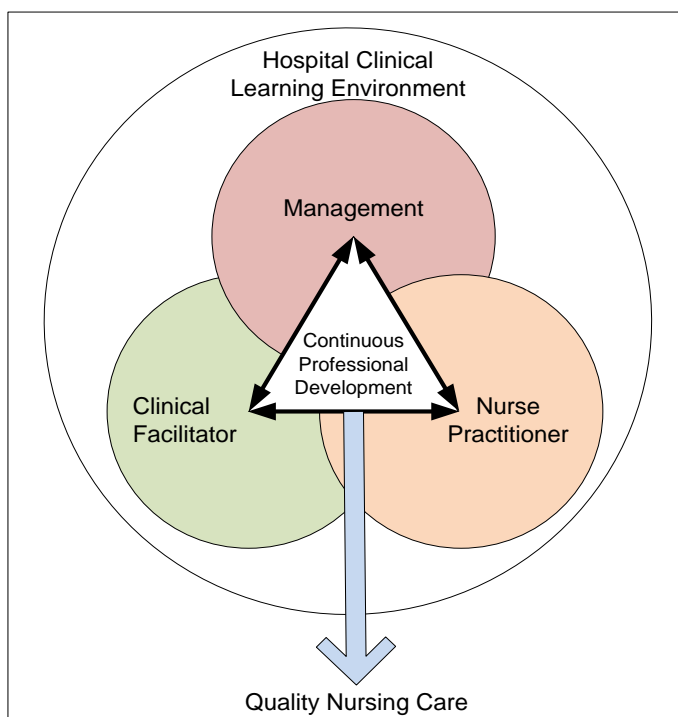


Figure 1-1: Stakeholders involvement in the CPD programme

According to Munro (2008: 954) quality patient care should be a collaborative effort amongst the stakeholders in the healthcare environment. The hospital management, the clinical facilitator, and the nurse practitioners are regarded as being responsible for the CPD programme. If collaboration does not occur, it becomes difficult to implement a CPD programme successfully or to improve the quality of patient care (Muller 2009: 256).

The concepts of Figure 1-1 as identified by the researcher are:

- **Hospital clinical learning environment:** the immediate surroundings of the patient and the stakeholders involved in nursing care;
- **Management:** responsible for the support and resources;
- **Clinical facilitator:** for support in the development of knowledge and skills;
- **Nurse practitioner:** responsible for continuous learning, updating knowledge and skill and take ownership of his/her own development;

Each component of Figure 1-1 is discussed in Sections 1.1.2 and 1.1.3 below.

1.1.2 Hospital Clinical Learning Environment

According to Bruce et al. (2011: 254) "*clinical learning is the acquisition of knowledge, skills and values in clinical practice settings or environments that stimulates clinical practice*". Integration in clinical learning is the demonstration of clinical and/or professional competence (Bruce et al. 2011: 253). The word clinical which has its origin from the Greek *klinikos* meaning bed that refers to the patient's bedside. In the learning context it is the learning of the competence and professional role through practice in a healthcare setting (Uys & Gwele 2005: 79; Bruce et al. 2011: 253).

The hospital where the study is to be conducted emphasises the importance of quality nursing care and nurse practitioner development in its mission and vision statement. The Hospital's mission and vision explicitly state: "*We strive to apply quality leadership and management principles to foster continual employee development.*" (The Hospital 2009:1). According to the Hospital's 2009/2010 business plan two of the main objectives are to develop and retain nurse

practitioners' through a CPD programme and subsequently enhance quality patient care (The Hospital 2009: 4).

Career planning and management is the process where individual nurse practitioners set career goals and objectives. Continuous professional development is therefore a self-directed development process to achieve these goals and objectives. Organisations, however, have their own goals and demands that need to be satisfied. Every nurse practitioner should therefore have a career plan that includes a commitment to continuous professional development (Jooste 2010: 260). The private hospital has an Educational Development Programme that cascades the business objectives down to individual levels to allow individual staff members and managers to manage personal development to achieve the overall business objectives. The Educational Development Programme contract specifies and contracts individual requirements, development areas, and competency profiles with the individual nurse practitioner (Private Hospital Group 2007: 4). The hospital requires nurse practitioners to be self-directed in their development and to come prepared to the Educational Development interviews. The unit manager has three Educational Development interviews with each nurse practitioner over a period of a year that is used to identify the training needs of the unit and the individual nurse practitioners (Muller 2009: 345).

Nurse practitioners working in the Hospital, by means of the hospital's policy statement and Educational Development Programme are obligated to participate in continuous professional development to create an environment of client satisfaction and safe quality nursing care (Private Hospital Group 2007: 4). Within the Hospital the clinical facilitator is responsible to plan and execute the CPD programmes, as well as perform informal training sessions at bedside during quality rounds. These programmes and sessions focus on the improvement of the nurse practitioners' knowledge, skills and attitudes to deliver quality nursing care.

In conclusion Bjork, Torstad, Hansen and Samdal (2009: 8) state that it is in the best interest of both the nursing practitioner and the health organisation to develop competence by means of professional development activities. The current health care environment is fast, ever changing, stressful and complex. A

healthy work environment should be created within this tumultuous environment that ensures a healing environment for patients and family. A healthy work environment can be created through partnerships, between the various stakeholders.

All the stakeholders are collaboratively responsible to ensure the successful implementation of the continuous professional development programme. This can only occur if stakeholders are involved in evaluating and refining the current CPD programme. Within the health care environment evaluation of quality of care, provides a logical basis for the determination of skills development strategies and plans (Uys & Naidoo 2004: 2). There is currently significant emphasis on the demonstration and maintenance of competency of nurse practitioners and CPD. The notion of lifelong learning through CPD is no longer being seen as an option, but as an integral part of the nurse practitioner's career progression and development (McCormack & Slater 2006: 136).

1.1.3 Stakeholders

The three main stakeholders identified to be involved in the CPD programme of the hospital's clinical learning environment are management, the clinical facilitator and nurse practitioners.

1.1.3.1 Management

Management has been defined by Muller (2009: 95) as the group of people responsible for the "*process whereby human, financial, physical and information resources are employed in order to achieve the goals and objectives of the healthcare organisation and the nursing unit by applying the fundamental management activities/elements of planning, organising, leading and control*". Management accepts that safe and quality care is needed in health care organisations and that CPD programmes are required to create a culture of learning (McCormack & Slater 2006: 136). The responsibility for CPD is at most that of the nursing practitioner to participate, self-directed learning, as it is the responsibility of management to create the opportunity for CPD and to facilitate professional development (Jooste 2011: 249, 260).

According to Mellish, Brink and Paton (2001: 279) and Muller (2009: 345) it is the responsibility of hospital management to provide CPD programmes for nurse practitioners that meet the nurse practitioner's development needs. Management should provide the opportunity to nurse practitioners to attend CPD programmes, at the institution as well as with external providers. The necessary training and development departments should be created within the institution which appointed the clinical facilitators for the units. Management should support part-time training and research programmes and allow time for attendance of such programmes.

Continuous professional development requires an investment in human capital and a workplace environment that supports and encourages personal development of the nurse practitioner in the health care environment (Munro 2008: 954).

1.1.3.2 Clinical Facilitator

Facilitation is defined by Bruce, Klopper and Mellish (2011: 112) as the process "concerned with helping people, individually or in groups, to work effectively and efficiently to achieve a particular goal or learning outcome". Facilitation is a "combination of skills, technique and art" used by the clinical facilitator to gain the involvement and interaction to subtract ideas from the nurse practitioners and develop understanding and meaning (Bruce, Klopper and Mellish 2011: 112).

In addition, Potts and Davis (2009: 378) are of the opinion that facilitation and learning teams should ensure continuous engagement with nurse practitioners to support them to be active thinkers and learners. The clinical facilitator's role is supplementary and supportive to the teaching responsibility and role of the professional nurse practitioner in charge of a unit or ward (Mellish, Brink & Paton 2007: 210). The goal of a clinical facilitator is: "The development of a nursing practitioner to be accountable for the continuous improvement of quality nursing care". The benefits of clinical facilitation are that it increases staff morale, improves quality of nursing care, increases the effectiveness of change, and has an input on the recruitment and retention of staff (The Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital (AMNCH) [n.d.]).

Clinical facilitation is one of the critical elements to ensure the realisation, implementation and evaluation of a CPD programme for nurse practitioners. The clinical facilitator has to partner with hospital management and the nurse practitioner when developing a CPD programme. The clinical facilitator focuses on the facilitation of learning and assessment of practical skills and competencies of the nurse practitioner. The objective is to provide safe and quality nursing care while enhancing the quality of learning (Nell 2007: 1).

1.1.3.3 Nurse Practitioner

According to Grindel (2005: 2), it requires much dedication on the part of nurse practitioners to acquire their knowledge and skills. Nurse practitioners therefore own their nursing knowledge and skill and this ownership cannot be taken away from them. However, this places an ethical and professional responsibility on nurse practitioners to ensure that their knowledge and skills are continuously updated resulting in a process of lifelong learning in accordance with regulatory requirements. Although health care management provides the environment for nursing care it does not control the quality of nursing care. The nurse practitioner controls the nursing practice provided on a daily basis and therefore owns the practice (Grindel 2005: 2). Continuous professional development enables the nurse practitioner to contribute to the organisation's objectives and goals through improved quality of nursing care (Muller 2009: 344-345).

Keeping one's knowledge and skills updated through continuous learning remains the responsibility of the nurse practitioner. Failure to accept this responsibility could result in unacceptable nursing care (Davids 2006: 1; Muller 2009: 345). Taking ownership of one's own learning is vital as noted in the following quote by Grindel (2005: 2-3) who states "*I like the notion of owning my professional practice. It is mine. I have worked for it. I am responsible for it. It is mine to give and no one can take it from me*".

1.2 PROBLEM STATEMENT

Continuous professional development is vital for quality patient care and to create knowledgeable nurse practitioners. Hospital management, clinical facilitators and nurse practitioners have to work collaboratively to ensure safe

and quality nursing care (Forbes, While & Ullman 2005: 78). The hospital management has a responsibility to ensure the competency of nurse practitioners employed by the hospital. The implementation of a CPD programme was initiated by the hospital management and facilitated by the clinical facilitator (The Hospital 2010:1).

Currently the stakeholders of the CPD programme in the private hospital in Gauteng believe that the CPD programme does not achieve the objective of quality patient care by presenting knowledgeable nurse practitioners. The following are some aspects that emerged:

- Management in the private hospital felt that although currently six hours are allowed for training, management did not see a reduction in the number of complaints received from doctors and patients in the hospital.
- The clinical facilitator, on the other hand, felt that the hospital follows a top down approach in the identification and presentation of training opportunities because the clinical facilitator receives a summary of training needs from the unit manager that have to be addressed and one of the unit's managers made attendance compulsory for nurse practitioners.
- The nurse practitioners indicated that the training topics were not what were formulated by the nurse practitioners during the Educational Development programme interviews. The nurse practitioners also point out that no distinction is made between novice and expert nurse practitioners in the attendance of training programmes. Therefore the nurse practitioners believe it is a waste of time to attend the CPD programme. Attendance by nurse practitioners at educational sessions presented as part of the CPD programme was thus unsatisfactory.

As researcher the clinical facilitator acknowledged that the CPD programme was not evaluated or refined by the nurse practitioners in the past. For this reasons the researcher decided to utilise an Appreciative Inquiry as a positive evaluation process to guide the evaluation and refine the CPD programme. By evaluating the CPD programme and providing an opportunity for nurse practitioners to give inputs pertaining to the evaluation and refinement of the CPD programme should give the nurse practitioners a sense of responsibility and ownership. This in turn

should increase participation in the CPD programme and may contribute to the enhancement of knowledge and skills of the nurse practitioners working in the Critical Care (CCU) and High Care (HCU) units of the private hospital in Gauteng. Evaluating the CPD programme collaboratively is regarded by the researcher as a positive attempt to address these concerns and to ensure continuous safe and quality nursing care.

1.3 RESEARCH QUESTION

In view of the background and problem statement, the following research question was formulated:

How do nurse practitioners working in the critical care and high care units evaluate the current continuous professional development programme in a private hospital in Gauteng?

1.4 AIM AND OBJECTIVES

The overall aim of this research is to evaluate the CPD programme for critical care nurse practitioners in a private hospital.

In order to achieve this aim, the objectives are guided by the 4-D cycle of Appreciative Inquiry:

Objective 1: Explore and describe the views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng;

Objective 2: Make recommendations to refine the current CPD programme in the private hospital to the hospital management.

1.5 RESEARCHERS FRAME OF REFERENCE

The frame of reference of the study may be described in terms of the setting in which the study was conducted, the role of the researcher, the paradigm and

core assumptions underpinning the study, the theoretical framework as well as the clarification of key definitions.

1.5.1 The Setting

The research is to be performed in the Critical Care (CCU) and High Care (HCU) units of a private hospital in Gauteng. The hospital is a modern 358-bed hospital licensed as a Level II medical facility. The hospital is classified as a level II because it is equipped only with a heli-stop. Table 1-1 summarises the maximum number of beds allowed by the licence of the private hospital in Gauteng to be occupied at any time. The Table also indicates the allocated number of critical care and high care beds in the critical and high care units where the nurse practitioners work in the private hospital in Gauteng that form the subject of this study.

Table 1-1: Summary of beds in the hospital's clinical working environment

Type of beds	Number
Maximum number of patients permitted to be accommodated simultaneously in the hospital	358
Critical care	
• Adult	21
• Paediatric	2
High care	
• Adult	29
Total	52

As reflected in Table 1-1 the private hospital has 52 beds that are allocated to critical and high care patient where the nurse practitioners work which form the subject of this study.

The various stakeholders related to the hospital's clinical working environment that participate in this study are summarised in Table 1-2. The stakeholders are divided into the three stakeholder categories identified in the conceptual framework namely management, clinical facilitators and nurse practitioners as described by Figure 1-1 in Section 1.1.1. Table 1-2 summarised the different

categories with the number of staff working during June 2011 in the CCU and HCU of the private hospital in Gauteng. The researcher forms part of the Clinical Facilitator/Clinical Nursing Specialist category.

Table 1-2: Summary of nurse practitioners in the CCU and HCU

Nursing Category	Medical Surgical CCU	Neuro Trauma CCU	Medical Surgical HC	Neuro Trauma HC	Total
Deputy Matron	1				3
Unit Manager	1	1	0	0	
Clinical Facilitator	1				4
Clinical Nursing Specialist	0	1	0	2	
Trained critical care nurse practitioner	3	5	0	0	8
Experienced critical care nurse practitioner	12	12	7	6	37
Enrolled nurse	4	4	5	9	22

As reflected in Table 1-2 a total of 67 critical care nurse practitioners form the participants of this study.

1.5.2 Role of the Researcher

In the opinion of Creswell (2003: 184), qualitative research is interpretive research, where the researcher is typically involved in a sustained and intensive experience with the stakeholders as research participants. Four elements of the researcher's role as identified by Creswell (2003: 184) are applied in this study:

- Past experience:** The researcher is a nurse practitioner and has a post-basic qualification in critical care nursing. The researcher has worked as a nurse practitioner for approximately 31 years, of which 12 years were as a trained critical care nurse practitioner and two and a half years as a clinical facilitator in the Hospital. As suggested by Creswell (2003: 184)

the clinical and educational experience of the researcher enhanced the researcher's role in the research.

- **Gain access:** The researcher is a clinical facilitator at the Hospital and therefore regarded as an "insider" enhancing acceptance of the researcher by the participants. Ethical approval will be obtained to conduct the study (see Annexure A).
- **Connection with participants:** There is a direct connection between the researcher and the participants with regards to the research setting as indicated (see Figure 1-2). This relates to a professional relationship concerning CPD.
- **Ethical considerations:** The participants are encouraged to participate and were assured that their comments would not be used against them by the clinical facilitator and/or management (see Annexure B). Finally, comments regarding sensitive ethical issues that might arise during the research were documented.

The researcher is currently working as a clinical facilitator responsible for the clinical facilitation of the short course in critical care as well as the diploma in Critical Care programme. The researcher is furthermore responsible for the clinical education and facilitation of the CPD of nurse practitioners working in the CCU and HCU in the private hospital for the past two-and-a-half years.

The current organisation diagram for the Education and training department of the private hospital in Gauteng is presented in Figure 1-2.

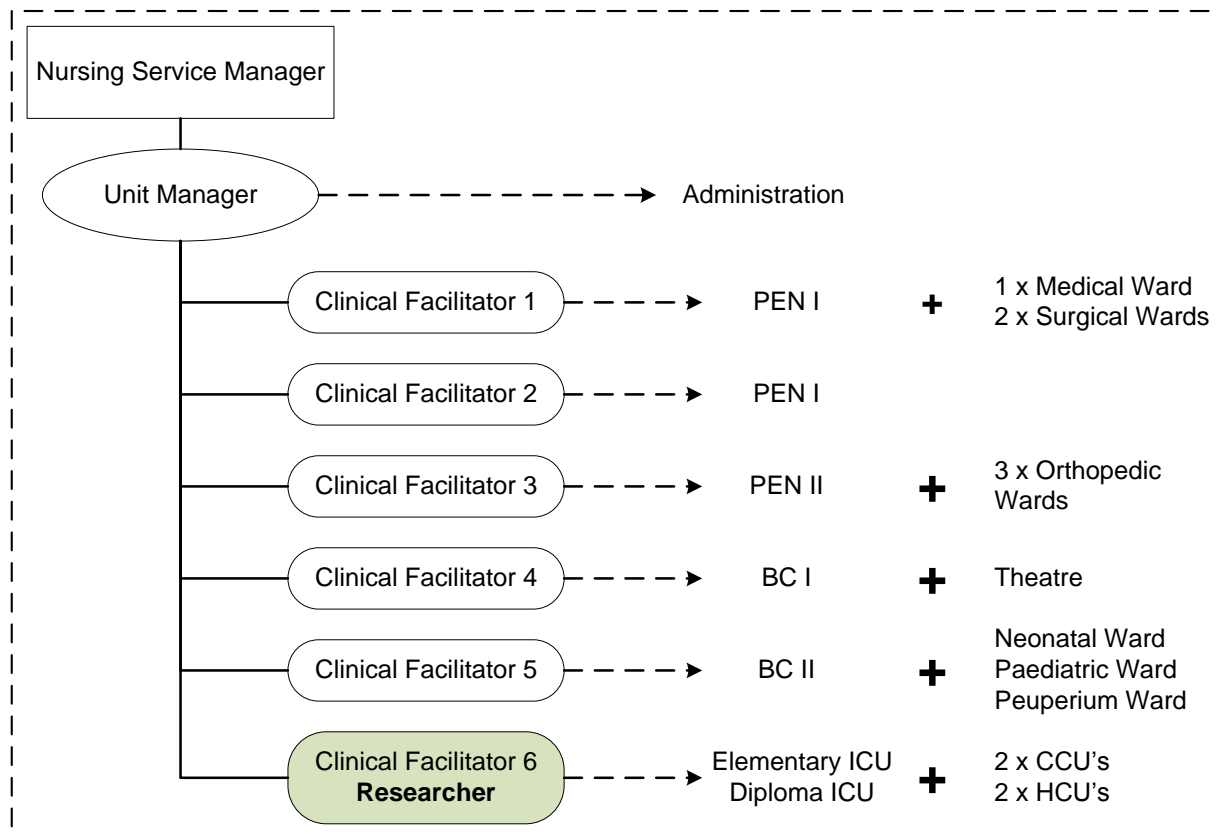


Figure 1-2: Organisation diagram of the Education and Training Department

List of abbreviation utilised in Figure 1-2

PEN I:	Pupil enrolled nurse level 1 (first year)
PEN II:	Pupil enrolled nurse level 2 (second year)
BC I:	Bridging course level 1 (first year)
BC II:	Bridging course level 2 (second year)

The current organisation diagram for the Education and Training department of the private hospital as presented in Figure 1-2, also indicating the relationship of the researcher relative to her colleagues and superior while defining the clinical facilitator's areas of responsibility for the in-service training programmes that focuses on the improvement of the nurse practitioners knowledge, skills and attitudes to deliver quality nursing care as well as informal training sessions at bedside during quality rounds.

1.6 PARADIGM

Paradigm has been defined by Polit and Beck (2008:761) as *"a way of looking at natural phenomena that encompass a set of philosophical assumptions and that guide one's approach to enquiry"*. According to Burns and Grove (2009: 712) a paradigm is a *"particular way of viewing a phenomenon in the world"*.

Appreciative Inquiry is imbedded in the social constructivist paradigm (Watkins & Mohr 2001: 26). The social constructivism paradigm as defined by Polit and Beck (2008: 759) is *"An alternative paradigm to the traditional positivist paradigm that holds that there are multiple interpretations of reality, and that the goal of research is to understand how individuals construct reality within their context; often associated with qualitative research"*. When using constructivism in Appreciative Inquiry reality is not fixed and varies with the individual's participation in the research. Reality exists within the relative context of the research environment and might lead to a number of possible results (Polit & Beck 2008: 15).

Appreciative Inquiry looks at organisational issues, challenges and concerns in a significantly different way. Instead of focusing on problems, organisational members first discover what is working particularly well in their organisation. Then, instead of analysing possible causes and solutions, they envision what it might be like if *"the best of what is"* occurred more frequently. The power of AI is the way in which stakeholders become engaged and inspired by focusing on their own positive experiences (Yballe & O`Conner 2004: 171).

As pointed out by Coghlan, Preskill & Catsambas (2003: 6) the proponents of AI argue that it is *"not just another organisation development tool or technique"* but *"a philosophy and orientation to change that can fundamentally reshape the practice of organisational learning, design and development"*. Although the positive focus of AI is useful it is not the purpose of AI. The purpose of AI is to generate a new and improved future (Bushe 2007: 4)

Appreciative Inquiry was utilised as the methodology in this study because the foundation of AI is focused on a positive discovery model to evaluate the current CPD programme and to generate a new and improved future CPD programme

within the CCU and HCU of the private hospital in Gauteng. Appreciative Inquiry is both a theory of change and a methodology of discovering, understanding and fostering innovation. This approach has the capacity to heighten positive potential for change. For the purpose of this study the current CPD programme is to be evaluated and refined using the Appreciative Inquiry approach by firstly focusing on what works well and what members want more of in the programme utilising this information to improve and refine the CPD programme in the private hospital in Gauteng.

1.7 ASSUMPTIONS

According to Hall and Hammond (2000: 1) "*Appreciative Inquiry works on the assumption that whatever you want more of, already exists in all organisations*". According to Hall and Hammond (2000: 2-3) and Hammond (1998: 20) Appreciative Inquiry generally assumes the following in research situations that needs to be researched:

- In every group or organisation there is something that works;
- If a group or organisation focuses on something, it becomes reality for them;
- In a moment reality can be created and several realities are created;
- By asking questions a group or organisation can be influenced in some way;
- A group or organisation has more confidence to move forward if they can take something from the past to build on;
- A group or organisation should carry the best from the past to the future;
- In a group or organisation differences exist that should be valued;
- Language helps us to create our reality.

1.8 KEY CONCEPTS

The key concepts underlying the study are described in Sections 1.8.1 to 1.8.5.

1.8.1 Clinical Facilitator

According to Disch, Walton and Barnsteiner (2001: 345) the essence of the clinical facilitator's role is "*based on the application of expert clinical and systems knowledge that should result in improved patient outcomes and staff satisfaction*". Mellish, Brink and Paton (2007: 75) emphasise the clinical facilitator's role as a teacher and someone who has the ability to facilitate learning. Furthermore according to McCormack and Slater (2006: 136), a clinical facilitator has to co-ordinate education and training and should ensure that nurse practitioners maintain appropriate levels of competence.

McKinley (2007:25) states that an expert "*is an individual who has achieved a level of role maturity*". These individuals, either a clinical facilitator or a clinical nursing specialist are viewed to be team players and "doers" who help others through mentorship and empowerment to grow in their jobs and careers. Literature uses the term clinical facilitator, clinical nursing expert and supervisor interchangeably in some instances.

For the purpose of this study a clinical facilitator refers to a registered nurse and nursing educator who has achieved a level of clinical practice and knowledge as well as role maturity in the field of safe patient care. The clinical facilitator is appointed by the private hospital to support staff development in the two CCU and two HCU in the private hospital in Gauteng with the objective and responsibility to improve patient care that should result in improved patient outcomes.

1.8.2 Continuous Professional Development

Continuous Professional Development is defined by Vasuthevan and Viljoen (2003: 94) as "*lifelong learning that takes place in a professional career after the point of qualification and or registration*". Continuous professional development is further defined as "*learning activities for developing and*

maintaining the capabilities to perform competently in the professional environment” (Vasuthevan & Viljoen 2003: 94).

Continuous professional development is defined by Earley and Bubb (2004: 4) as *“any professional development activities engaged in which enhance knowledge and skills and enable the professional to consider their attitudes and approaches to the practice with the view to improve the quality of the service and practices. CPD is an on-going process building upon initial training and induction, including development and training opportunities throughout a career and concluding with preparation for retirement”.*

The concept of CPD as summarised by Bruce, Klopper and Mellish (2011: 342) is based on a *“cycle in which individual practitioners reflect on their practice and assess their knowledge and skills, identify learning needs, create a personal learning plan, implement the learning plan, and evaluate the effectiveness of the educational interventions and the plan in relation to their practice”.* Quinn and Hughes (2007: 435) pointed out that regardless of the term used, the aim of CPD is to ensure that *“the knowledge and skills are kept up to date and remain relevant, both in terms of subject and educational expertise”.*

For the purpose of this study CPD is an on-going, self-directed, structured, outcome-focused cycle that leads to professional and personal improvement to the quality of nursing practice in the private hospital in Gauteng.

1.8.3 Evaluation

Evaluation is defined by Cross et al. (2006:181) as *“the activity by which we as educators find out how successful we have been in realising our educational aims, enabling learners to fulfil their learning needs”* and therefore reaching objectives and goals of the organisation through the successful planning, providing and facilitation of the learning experience. Evaluation is therefore not only concerned with the learning experience of the individual but with the experience of all the stakeholders involved (Cross et al. 2006:181).

Although various writers offer a wide variety of definitions for evaluation most agree with the summary as adopted from Preskill & Catsambas (2006:40-41) that evaluation:

- Is a systematic process;
- Is a purposeful and planned process;
- Involves the collection of data in organisations, programmes and society regarding issues and questions at hand;
- Offers to increase knowledge and improved individuals, organisations, processes or programmes and whether to continue or expand a programme;
- Involves a large amount of resources and time and should therefore only be engaged in when the outcomes will be positively used;
- Concerns issues that arise out of everyday activities and practice;
- Is a means to an end with the objective to gain understanding of what we do and what affects the outcomes.

1.8.4 Lifelong Learning

Lifelong learning is defined by Quinn and Hughes (2007:437) and Hinchliff (1998) as follows: "*... often used to refer to learning that occurs throughout the (usually working) life of an individual, which may be planned or not.*" Lifelong learning as defined by Bruce et al. (2011: 100) focuses on the development and learning of new skills and competencies required by the professional in the work situation or personal development and growth.

The Pharmaceutical Society of Ireland (2010: 25) defines lifelong learning as "*all learning activities undertaken throughout life, with the aim of improving knowledge, skills and competence, within a personal, civic, social and/or employment-related perspective.*"

For the purpose of this study lifelong learning is considered to be all personal and professional learning activities that the nurse practitioner engages in for personal and professional development.

1.8.5 Nurse Practitioner

"Nurse" means a person registered in a category under section 31(1) of the Nursing Act no. 33, 2005 in order to practise nursing or midwifery. "Practitioner" means any person registered in terms of section 31(1) of the Nursing Act no. 33, 2005. Section 31(1) of The Nursing Act (2005) stipulates: "*Subject to the*

provisions of section 37, no person may practice as a practitioner unless he or she is registered to practice”.

For the purpose of this study a nurse practitioner is considered to be any Professional nurse or Enrolled nurse registered with the South African Nursing Council under Section 31(1) of the Nursing Act (2005) working in one of the CCU or HCU in the specific private hospital.

1.9 THE RESEARCH DESIGN AND METHODS

According to Polit and Beck, (2008: 765) research method *“is the technique used to structure a study and to gather and analyse information in a systematic fashion”*. For the purpose of this study the method refers to the research design and research methodology used to address the research question.

1.9.1 Research Design

Research design is defined by Polit and Beck (2008: 66) as *“the overall plan for obtaining answers to questions being studied and for handling some of the difficulties encountered during the research process”*. Hofstee (2009: 113) further explains research design as *“the section where one names and discusses the overall approach to be used when testing the thesis statement”*. For the purpose of this study qualitative, contextual, explorative and descriptive research designs are to be utilised.

1.9.1.1 Qualitative

Qualitative research is referred to by Polit and Beck (2008: 70) as an emergent design that emerges during the course of data collection. These authors further explain that an emergent design is a reflection of the researcher’s desire to have an enquiry based on the realities and viewpoints of those under study. Qualitative design is guided by different disciplines (Polit & Beck 2008: 219) and each has developed different methods for addressing questions of particular interest.

Furthermore Polit and Beck (2008: 15) indicate that the objective of most qualitative studies is to describe and understand a phenomenon within a real

environmental setup where it exists as created by the individual in relativism of their world (2008: 220). Reality for the qualitative researcher is not a fixed entity. Reality within the qualitative research concerned always exists within a specific context. For the purpose of this study the phenomenon the researcher wishes to explore and describe is to determine what the components of a CPD programme should be for nurse practitioners working in the CCU and HCU of a specific private hospital.

1.9.1.2 Contextual

It is stated by Babbie and Mouton (2001: 272) that research should be conducted in the natural context in which the phenomenon occurs, and that the researcher should aim to understand the phenomenon as it occurs in this context.

The context of this study is a specific private hospital's CCU and HCU where critical care nurse practitioners work on a daily basis and participate in the CPD programme.

1.9.1.3 Explorative

According to Polit and Beck (2008: 20) an exploratory research, like a descriptive research begins with a phenomenon of interest but it investigates the phenomenon in full. An exploratory research not only describes the phenomenon but also investigate the way it manifests as well as other factors that it relates to. Burns and Grove (2009: 359) conclude that exploratory research studies are not intended to be extrapolated to large populations. Exploratory research is aimed to expand the knowledge within the field of study.

For the purpose of this study the researcher will explore (identify) what the components should be that must be included in a CPD programme, based on the inputs from participants.

1.9.1.4 Descriptive

Descriptive research is defined by Burns and Grove (2009: 696) as "*Provides an accurate portrayal or account of the characteristics of a particular individual,*

event, or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information". According to Jooste (2011: 299; Polit & Beck 2008: 274) a descriptive research design is used "when there are no variables to be manipulated" and when the researcher wants to gain more information regarding a particular phenomenon. This study aims to describe the components that should be included in a CPD programme for critical care nurse practitioners working in the CCU and HCU of a private hospital.

1.9.2 Methodology

Research methods are defined as "the steps, procedure, and strategies for gathering and analysing data in a study" (Polit & Beck 2008: 758; Silverman 2005: 379). Methodology on the other hand is a plan of action that includes the techniques to be employed when conducting the study. These techniques are sampling, data collection and analysis (Hofstee 2008: 115).

Qualitative research methodology is both flexible and develops as the researcher explores the depth and complexity of the information. This should enable the researcher to identify and describe the components that should be included in the CPD programme of nurse practitioners working in CCU and HCU in the private hospital.

The research methodology use in this study is summarised in Table 1-3 below. The steps utilised during the research methodology identifying the techniques employed in the study, are identified and summarised.

Table 1-3: Summary of the research methodology

Phase 1: Evaluation current CPD programme			
Objective: Explore and describe views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng.			
Methodology components			
Population	Sampling	Data collection	Data analysis
All critical care nurse practitioners working in the two CCUs and two HC units of the private hospital in Gauteng	Sampling Non-probability <ul style="list-style-type: none"> • Purposive Sample size 20 participants	Focus Group discussion. Step 1: Question 1 of AI 4-D cycle - What is best Step 2: Question 2 of AI 4-D cycle - What challenges/wishes Step 3: Question 1 of AI 4-D cycle - What will change	Content analysis <ul style="list-style-type: none"> • Data coding • Tabulated • Reorganised
Phase 2: Refine the current CPD programme			
Objective: Make recommendations to refine the current CPD programme in the private hospital to the hospital management based on the data obtained from Phase 1.			
Methodology components			
Population	Sampling	Data collection	Data analysis
All critical care nurse practitioners working in the two CCUs and two HC units of the private hospital in Gauteng	Sampling Non-probability <ul style="list-style-type: none"> • Purposive Sample size 20 participants	Focus Group discussion using AI Destiny approach – Question 4	Content analysis <ul style="list-style-type: none"> • Data coding • Tabulated • Reorganised

1.10 TRUSTWORTHINESS

Trustworthiness is defined by Polit and Beck (2008: 768) as “*The degree of confidence qualitative researchers have in their data, assessed using the criteria*

of credibility, transferability, dependability, confirmability and authenticity". For the purpose of this study the researcher will use the methods of addressing these criteria in the study as summarise in Table 1-4 below. These actions are discussed in more detail in Section 3.4.

Table 1-4: Summary of actions to ensure quality in research for this study

Trustworthiness Criteria	Method of Addressing Criteria in this Study
<p>Credibility Confidence that can be drawn relating to the truth of the data and the interpretation based upon the data. (Polit & Beck 2008: 539)</p>	<ul style="list-style-type: none"> • Focus Group Inquiry where participants can verbalise and describe their experience • Researcher an experienced nurse educator • Experienced independent Focus Group facilitator • Strict adherence to research process and procedure
<p>Dependability Refers to the reliability or stability of data over a period of time and various conditions. (Merriam 2009: 220)</p>	<ul style="list-style-type: none"> • Audit trail from data collection to study findings • Data open for scrutiny by participants
<p>Confirmability The degree that the findings and results of the study are the product of the inquiries data. (Graneheim & Lunman 2004: 109)</p>	<ul style="list-style-type: none"> • Focus Group where participants can verbalise and describe their experience • Experienced, independent Focus Group facilitator • Data interpreted by experienced nurse educator and practitioner • Recorded AI interview schedule • Focus Group discussion recorded on flipcharts and audio-taped
<p>Transferability The extent of applicability of the results and findings to other groups or settings. (Polit & Beck 2008: 539)</p>	<ul style="list-style-type: none"> • Detailed process and procedure of data collection process
<p>Authenticity The degree that the research results reflect the views of the participant and the conclusion are considered to be fair. (Daymon & Holloway 2011: 84)</p>	<ul style="list-style-type: none"> • Experienced, independent Focus Group facilitator • Guided by predetermine AI interview schedule • Findings recorded guided by the AI interview schedule

1.11 ETHICAL CONSIDERATIONS

Research studies should consider the rights of the individual that participate in the study. The three primary principles that the researcher should comply with are that of justice, beneficence and respect for the human dignity of the research participants (Polit & Beck 2008: 170; Burns & Grove 2009: 189). The application of the primary principles and concepts to this study is described in Chapter Three Section 3.5.

The principle of justice includes the right to fair treatment and the right to privacy of the participants in a research study. Fair treatment does not only apply to issues of subject selection that must not be biased against certain groups but also covers aspects like the fair treatment of participants who wants to withdraw from the study and differences in beliefs, lifestyles and habits of individuals with different cultures or backgrounds (Polit & Beck 2008: 173-174; Burns & Grove 2009: 189).

As stated by Holloway (2005: 65) it is very difficult to ensure this principle in a focus group discussion because the researcher does not have control over the individual participants' outside of the focus group. However, this can be addressed by setting up ground rules pertaining not only to the focus group but that also apply after the conclusion of the activities of the focus group.

The researcher therefore should ensure that all reasonable steps are taken to limit intrusion. Participants have the right to expect that information and data shared and provided will be handled in the strictest confidence (Polit & Beck 2008: 174). In this study the researcher will ensure privacy through the specific actions and mechanisms as described in sections addressing the issues of the right to privacy, confidentiality and anonymity, and the right to fairness ensuring that the information given by them is handled in the strictest manner.

Research participants have the right to protection from exploitation. The researcher should give participants the assurance that they will not be exploited or that information provided by them will not be used against them, either professionally or personally because they enter into a special relationship during the research with the researcher (Polit & Beck 2008: 171).

Participants have the right to expect that information and data shared and provide will be handled in the strictest confidence (Polit & Beck 2008: 174; Burns & Grove 2009: 194). During this study the researcher will utilise an independent facilitator and a process of anonymity of questionnaires during the data collection process protecting the participants from identification and exploitation.

The ethical dimensions of confidentiality and consent concerning data collection needs to be addressed in a research study. Consent refers to the steps to ensure that participants are informed of what they are agreeing to when they agree to take part in the study. Confidentiality refers to that fact that details shared in the study should remain private and that participants should remain anonymous (Reed 2007: 122; Polit & Beck 2008: 172). For the purpose of this study the researcher signs an informed consent agreement with each of the research participants' guarantees the right to confidentiality and the right to withdraw at any time if a participant prefers not to continue.

1.12 LIMITATIONS

The study is subject to a number of limitations that the researcher has to take into consideration. Firstly, the study is limited to the care nurse practitioners of the private hospital working in the CCU and HCU that limits the use and extrapolation of the results to other clinical settings. Within the private hospital the research only sample nursing practitioners for High Care and Critical Care units that is a relatively small population. Therefore the refined CPD programme cannot be utilised by other units in the same hospital or be generalised.

The lack of a formal recognition process for CPD in South Africa by the South African Nursing Council (SANC) limits the understanding and requirement for CPD by the participants in this study. Participants therefore did not always understand the necessity of CPD. This lack of formal recognition created an environment where there are not any consequences for the participants, directly or indirectly, if they do or do not participate in CPD activities. This lack also limits hospital management's enthusiasm and support to ensure participation in CPD activities.

1.13 LAYOUT

This study utilise the layout as shown below in Figure 1-3.

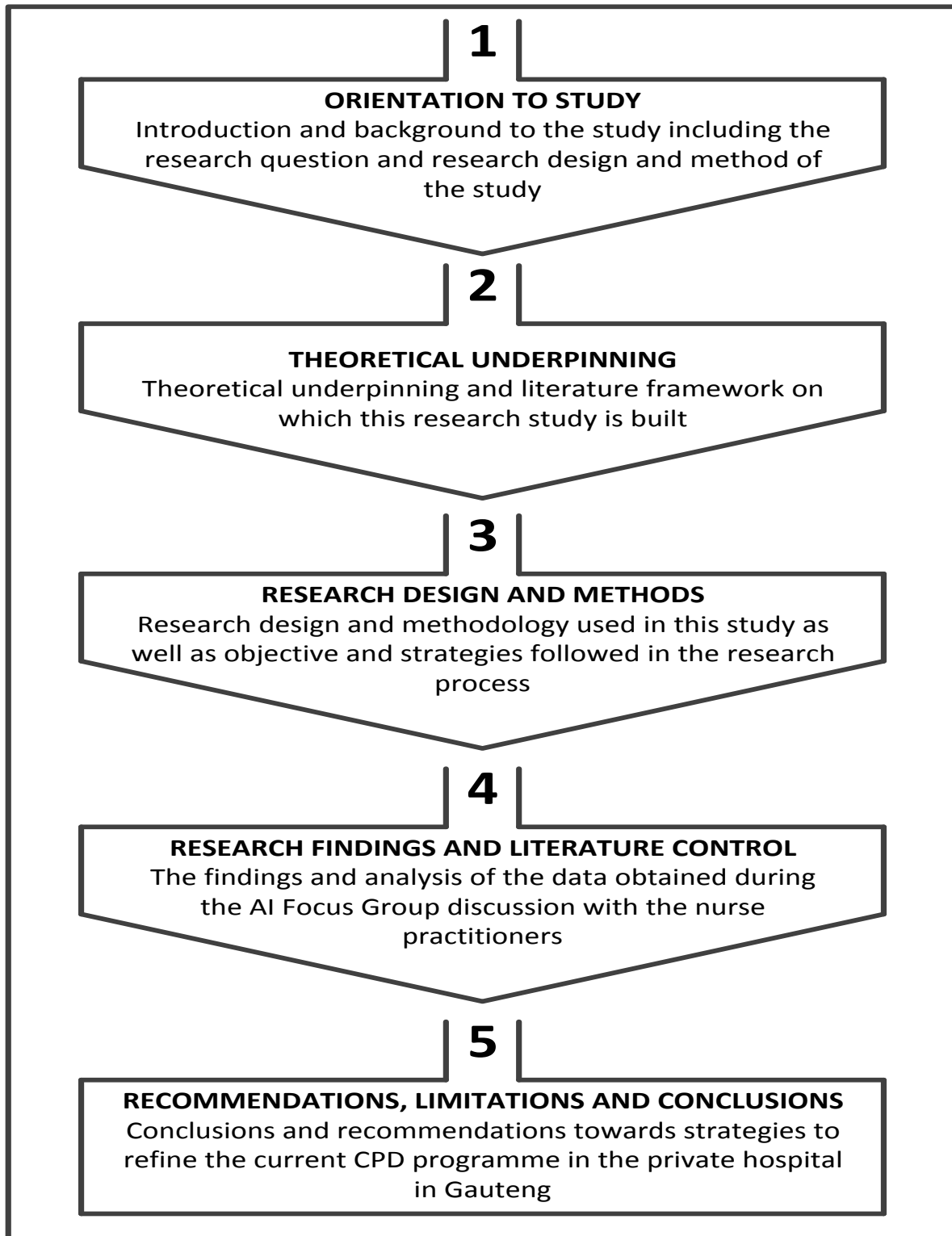


Figure 1-3: Layout of the chapters

1.14 CONCLUSION

Chapter 1 provided an orientation to the study including the research question and research design and method used during the research process. The chapter covered the utilising of AI as a positive and participatory approach to evaluate the current CPD programme. The nurse practitioners will have an opportunity to give inputs and refine the CPD programme to meet their specific educational needs. By appreciating what works well pertaining to the CPD programme, the change process is initiated. In order to maximise the impact of CPD development on staff development the participants should have buy-in into the CPD programme.

Chapter 2 investigates the theoretical underpinning and literature framework utilised in this study.

2**THEORETICAL UNDERPINNING**

“Remember the old saying, ‘You can take a horse to the water but you can’t make it drink’? Our response to that is to say that CPD is becoming thirsty – thirsty for new knowledge, thirsty for new skills, thirsty for new experiences.”

David Megginson and Vivien Whitaker

2.1 INTRODUCTION

In Chapter 1 the researcher provides an overview of the background that leads to the research question. The overall aim of the research study is, by means of Appreciative Inquiry (AI), to evaluate and refine a Continuous Professional Development Programme (CPD) for critical care nurse practitioners in a private hospital in the Gauteng province of South Africa.

The objective of Chapter 2 is to orientate the reader to the theoretical underpinning and literature framework of the components of continuous professional development, the evaluation of a continuous professional development programme utilising Appreciative Inquiry.

2.2 CONTINUOUS PROFESSIONAL DEVELOPMENT

Professionals acknowledge that it is no longer possible to build a career purely on what was learnt in the beginning of their career and then spend the rest of their working life using only that knowledge (Chong et.al. 2011: 39). The “*sell-by date*” of knowledge and practice has become shorter and shorter. This implies that a professional’s assets do not keep their value if they do not maintain, refresh it and acquire new knowledge and practice (Megginson & Whitaker 2007: 6; Pharmaceutical Society of Ireland 2010:25). It is widely recognised by health service providers that CPD is one of the important mechanisms to achieve the quality care and service that is expected from nurse practitioners (Yfantis, Tiniakou & Yfanti 2010: 194).

Literature confirms the fact that individuals should take control of their own development and learning during CPD through engaging development in an on-going process (McDonnell & Zutshi 2006: 3; Pharmaceutical Society of Ireland 2010: 25; Yfantis, Tiniakou & Yfanti 2010: 194). Continuous professional development, however, does not only provide for the needs of the individual but also the needs of the employer, the profession as a whole as well as society (Yfantis, Tiniakou & Yfanti 2010: 194). Continuous professional development as one of the elements of lifelong learning is increasingly considered and recognised in both the professional as well as the personal arena of development (Pharmaceutical Society of Ireland 2010: 25; Yfantis, Tiniakou and Yfanti 2010: 194, 198).

Development is a systematic structured process utilised by the professional through formal and informal education processes to acquire new knowledge and skills that is required by the professional's practice. A key element, however, in the development is through the practice of the profession itself and the influence from the professional environment. The implication of this is that professional development and professional practice is interdependent. The one will not develop without the other (Jasper 2007: 2; Yfantis, Tiniakou and Yfanti 2010: 194; Bruce, Klopper and Mellish, 2011: 343). The professional should be open to all and new challenges are to be utilised as developmental opportunities to grow and develop the professional's practice and profession (Jasper, 2007: 40).

The British Association of Social Workers concludes that CPD is an *"on-going, planned learning and development process, which improves practice, contributes to life-long learning and enables career progression"*. The British Association of Social Workers summarises that CPD *"is the process through which professionals maintain and develop their knowledge and skills throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice"* (Bruce, Klopper and Mellish 2011: 342; Coetzee, Botha, Kiley and Truman 2012: 48; McDonnell 2012: 5).

It is argued by Earley and Bubb (2004: 3) that one of the characteristics to be identified as a professional is the ability to continue to learn during and throughout one's career and by means of self-improvement. The reason for this continuous learning should, however, not be for one's own sake but should be to

ensure that clients or beneficiaries are supplied with the best possible service. Continuous professional development includes all formal and informal learning and development to enable the individual to improve service and practice (Earley and Bubb 2004: 3; National Council for the Professional Development of Nursing and Midwifery (NCPD N&M) 2004: 16; McDennell and Zutshi 2006: 3; Bruce, Klopper and Mellish 2011:343).

Literature concludes that CPD's functions can be summarised as the improvement of competencies benefiting both professional as well as personal roles through professional and personal effectiveness and increased job satisfaction through training for changes and expansion in responsibilities and roles for e.g. new areas of competencies associated with promotion.

The importance to update and renew knowledge and skills due to development in knowledge and practice of the profession is highlighted to ensure continuing competence in the profession's current role. Continuous professional development support newly qualified nurse practitioners to consolidate the newly acquired competencies obtained during their training while supporting the retraining of nurse practitioners who were out of nursing for a long time (Earley & Bubb 2004: 4; Quinn & Hughes 2007: 441; Jooste, 2010: 250 Bruce; Klopper & Mellish 2011:338).

2.2.1 Continuous Professional Development Concepts

According to Attwood, Curtis, Pitts and While (2005: 5) before a researcher can evaluate continuous professional development it is important to understand what is meant by professional development. To understand continuous professional development the following concepts should be understood:

- Lifelong learning;
- Self-directed learning;
- Professional practice;
- Professional knowledge; and
- The natural process of professional change.

2.2.1.1 Lifelong Learning

Professionals require high levels of the ability to be adaptable, flexible and responsive to change in order to survive and maintain a satisfied professional career (Cross et al. 2006: 131). Lifelong learning is defined by Quinn and Hughes (2007:437) as follows: “... *often used to refer to learning that occurs throughout the (usually working) life of an individual, which may be planned or not.*” The notion of lifelong learning through CPD is no longer being seen as an option, but as an integral part of the nurse practitioner’s career progression and development (McCormack & Slater 2006: 136).

According to Quinn and Hughes (2007: 440), the requirement for continuing professional development will be reduced if lifelong learning can be fostered in nursing education. They continue to define lifelong learning as “*any planned series of incidents at any time in the lifespan, having a humanistic basis, directed towards the participants’ learning and understanding*”. Literature concludes that continuous professional development is a “*functional component that lies along the continuum of lifelong learning*” (Quinn & Hughes 2007: 442; Bruce, Klopper & Mellish 2011:338).

Lifelong learning is characterised by the fact that it is intentional while focusing on specific needs and objectives. The objective of lifelong learning is long-term learning and retention of the knowledge or skills driven by a motivation to achieve. Lifelong learning focuses on the knowledge, skills, values and understanding beyond the individuals personal needs (National Council for the Professional Development of Nursing and Midwifery 2004: 15).

2.2.1.2 Self-directed Learning

Nurse practitioners have the personal responsibility to develop and maintain skills and knowledge to ensure competence throughout the nurse practitioner’s career (Bruce et al. 2011: 344). There is no guarantee that nurse practitioners have learned if they are not actively involved in the process of seeking knowledge. Active self-directed learning is concerned with the process through which nurse practitioners construct new knowledge and understanding. This self-

directedness is one of the key principles of CPD (Cross et al. 2006: 76; Pharmaceutical Society of Ireland, 2010:28).

Three fundamental characteristics of self-directed learning are identified by Cross et al. (2006: 77) as well as Pharmaceutical Society of Ireland (2010:28):

- (i) The ability to acquire skills and knowledge with the minimum interference and assistance from others through a process where the individual set for himself goals and identifies and uses resources;
- (ii) The level of self-awareness and courage; and
- (iii) An internal driven perspective on knowledge, development and educational relationships.

In the concept of self-directed learning the nurse practitioner takes the initiative for the determination of training needs and goals, resources required to ensure successful learning and the evaluation to determine whether training is successful or not. Self-directed learning forms the basis of adult learning or andragogy where learners are responsible for their own learning (Bruce, Klopper & Mellish 2011: 199-200; Meyer et al. 2009: 104).

2.2.1.3 Professional Practice

According to Attwood et al. (2005: 5) professional practice means "*dealing with difficult, complex problems*" that are often not determinate. It involves the reading of the situation, being flexible and improvising. The meaning of practice in the medical field according to Gawanda (2002: 7) as quoted by Attwood et al. (2005: 5) is defined as follows: "*We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do but also habit, intuition and sometimes plain old guessing. The gap between what we know and what we aim for persist. And this gap complicates everything we do [Medicine is] what happens when the simplicities of science come up against the complexities of individual lives*" (Gawande 2002: 7-8).

This impacts on how protocols, which is the way professionals should do things in routine situations and cases, are developed. What Attwood et al. (2005: 6) therefore concludes is that the expert practice of professionals came into play when protocols, which are focused on the routine situations, no longer apply. Professional practice in healthcare fundamentally involves the ability of a healthcare professional to engage the “correct” action in the situation. There is often no absolute right answer. Clinical competence involves the knowledge, values, attitudes and skills demonstrated during practice by the nurse practitioner. Professional practice therefore can be defined as the ability of a nurse practitioner to integrate the knowledge, values, attitudes and skills during critical thinking and clinical judgement to ensure performance (Bruce et al. 2011: 263-264).

Expert nurse practitioners with their advanced and comprehensive knowledge base act as the critical thinkers expressing their role as professional practitioners in the absence of complete information or protocols. These experts normally take a leading role in their area of practice. The professional practice role of the expert nurse practitioner includes source of authority, leadership, mentorship, change agents and influencing policy and practice (Jasper 2007: 30).

2.2.1.4 Professional Knowledge

Different kinds of professional knowledge are distinguished between by Attwood et al. (2005: 6) noting that propositional knowledge is part of what informs professionals’ actions. Professionals, however, also have “*personal knowledge*” which is acquired through personal experience (Attwood et al. 2005: 6). It is important to distinguish between technical knowledge, the knowledge to make something, practical wisdom, and the ability to make moral judgement (Attwood et al. 2005: 6). Professional knowledge therefore is not resolving technical problems where there is a correct solution but rather resolving the moral dilemmas that have more than one different course of action (Attwood et al. 2005: 6-7).

2.2.1.5 Natural Process of Professional Change

Much of the practical knowledge that professionals have is acquired from natural learning and experience through the community of practice (Attwood et al. 2005: 7). The most common mechanism is the day-to-day communications that occurs between professionals and during social events where professionals are involved. However, this does not mean that professional practice is merely passed on from one generation to the other without critically re-assessing it. It is argued by Attwood et al. (2005: 7) that professionals in principle constantly re-interpret the practice through discussion and dialogue. Attwood et al. (2005: 7) continue that this ability by a professional to change their practice occurs through what is called "*critical reconstruction*".

Therefore it can be argued that the aim of professional development is not only technically to update competencies but the constant renewal of capacity to make professional decisions and judgements. This is at the heart of the definition of a professional i.e. the drive to constantly refine practice (Attwood et al. 2005: 7).

2.2.2 International Perspective on Continuous Professional Development

Professional bodies all over the world have the responsibility to determine who is eligible to practice in the profession as well as to outline the requirements for skills and knowledge to remain competent in the profession. As part of this responsibility the professional body should determine continuous professional development programmes and processes (Bruce et al. 2011: 284). Emphasis is placed by Frick and Kapp (2006: 2) on the fact that CPD programmes should be developed for a country's specific health care requirements but should always be internationally acceptable and conform to international trends, standards, and developments.

The European Federation of Nursing Associations demands that all health professionals including nurse practitioners demonstrate their commitment to keep up to date with new knowledge practice and techniques related to their field of expertise. In Australia, the United Kingdom and the United States of America CPD programmes for nurse practitioners are implemented to enhance

quality patient care. According to Kaye-Petersen (2004: 22) these CPD programmes should continuously be evaluated and refined by all stakeholders involved.

2.2.2.1 Australia

The Australian Nursing and Midwife Council were established in 2009 with a primary objective to protect the Australian public and to oversee that the registered nurse practitioners maintain their knowledge and skills. Australian registered nurse practitioners should complete at least 20 hours of relevant CPD activities per year to remain registered (Nursing and Midwifery Board of Australia, 2010: 1). Nursing practitioners must keep a portfolio of evidence ready for random audit by the Nursing and Midwifery Regulatory Authorities. The regulatory authority is committed to audit at least 2% of the nursing practitioners annually. If a nursing practitioner is found to be non-compliant they are given a three-month window to correct the situation before de-registration. An appeal procedure exists if the nursing practitioner does not agree with the cancellation of registration (Nursing and Midwifery Board of Australia 2010: 1).

2.2.2.2 United Kingdom

The United Kingdom established the Nursing and Midwifery Council in 2002 to improve the standard of nursing care in the United Kingdom as well as to protect the public (Jasper 2007: 14). One of the important aspects of the United Kingdom's CPD programme is that learning must be relevant to the practitioner's practice but they do not prescribe specific learning activities (Jasper 2007: 16). The council requires 35 hours of developmental activities over a three-year period supported by a portfolio of evidence (Jasper 2007: 16).

2.2.2.3 United States of America

The United States of America established the National Quality Forum in the late 1990's and strives to deliver quality health care. The National Quality Forum became one of the most influential organisations in the field of quality improvement in the United States of America (Sebellus 2005: 214). Each state in the United States of America has its own CPD requirements. For this study the

requirements of Texas is given as an example. Nursing practitioners are required to show development activities of 20 hours over a two-year period. Quality assurance is done through a random audit of nursing practitioners' portfolio of evidence.

2.2.2.4 South Africa

In South Africa, there is no formal CPD system for nurse practitioners. Yet, the public of South Africa has a commitment from the South African Nursing Council (SANC) that they will receive knowledgeable, competent, ethical and safe nursing care. This will only occur once a formal CPD system is in place.

The newly published National Nursing Strategy, however, does promote the concept of professional development for nursing in South Africa (Kaye-Petersen 2004: 246; Bruce, Klopper & Mellish 2011:341). In 2008 the South African Nursing Council, however, included the possibility of a CPD programme for South Africa in their strategy for safe nursing practice. They stress the fact that the development and implementation of an effective, appropriate and relevant CPD process is critical for those already practising nursing practitioners. However, the SANC lacks the commitment to an implementation programme and time scale (Nursing Strategy for South Africa 2008: 13-14). Quality of nursing care is currently controlled only by an annual registration with no portfolio of evidence of continuing development.

According to the Skills Development (Act 97 of 1998) development of the employees in South Africa is compulsory. The Skills Development Levies Act 69 of 1999 provides mechanisms to fund the skills and competency development of nurse practitioners in South Africa. A professional is most effective within an environment and culture of learning and evaluation in terms of outcomes (McDonnell 2012: 5; McDonnell & Zutshi 2006: 3). Within the hospital where the study is being conducted it is required that all training longer than half an hour must be recorded by the unit manager and that nursing practitioners must be exposed to at least 18 hours of development activities per year.

2.2.3 Need-focused Continuous Professional Development

Any CPD programme needs to clearly identify the needs to be met with the involvement and agreement of all stakeholders. Needs for development are identified in the shortfall in meeting of standards, changes in service delivery requirements, individual development, changes in technology and changes in equipment.

Literature stresses the fact that development and learning must be linked to the collaborated needs identified from the requirements for service delivery, the needs of the team and the individual (NHS 2010: 7; Coetzee et al. 2007: 80).

2.2.3.1 Management

What professionals say they want to learn is not always what they need to learn? The CPD learning targets should reflect and articulate the employers, clients and individual's professional needs and goals clearly (Megginson & Whitaker 2007:6-7; Hansen 2008: 6; Bruce, Klopper & Mellish 2011: 345). For the organisation it is a means to better service delivery through the support of their staff in their personal development because they can keep their knowledge and skills fresh and relevant (Megginson & Whitaker 2007: 8). An organisation which focuses on quality service delivery and improvement is in an excellent position to provide practice-based learning opportunities and an environment for professional practitioners who mutually support the identification of development needs to meet organisational and personal goals (Council on Credentialing in Pharmacy 2004: 20; NCPD N&M 2004: 18).

Organisations often link CPD activities to organisational targets and objectives as well as personal development plans. This creates an environment where an appropriate balance can be retained and agreed upon between the organisation's and the professional's personal and professional needs (Earley & Bubb 2004: 35; NHS 2010: 11). Continuous professional development activities should be planned and budgeted for by the organisation (Earley & Bubb 2004: 10; Pharmaceutical Society of Ireland 2010: 28).

2.2.3.2 Clinical Facilitator

Professional healthcare facilitators often tend to overload nurse practitioners with information because they attempted to bring the nurse practitioners to their level of skills and competence. These practitioners who normally have a wealth of practical experience-based knowledge battle to associate with the needs of the nurse practitioners. As a result of this their expectations may be inappropriate or unrealistic (Cross et al. 2006: 76). On the other hand the constraints and demands of the practice environment make it difficult and inappropriate for practical facilitators to focus excessively on the nurse practitioner's needs (Cross et al. 2006: 76).

Facilitators should be very careful not to see nurse practitioners as passive recipients of information because they can compromise the learner's personal and professional development. The clinical facilitator supports the unit manager by identifying needs through assessment of the staff. The clinical facilitator is jointly responsible with the unit manager for the planning and execution of the continuous development programme. The clinical facilitator has to identify the goals, solutions, priorities and strategies to implement the CPD programme (Coetzee et al. 2007: 330; NHS 2010: 11)

2.2.3.3 Nurse Practitioner

Continuous professional development not only reminds professionals' about the dreams that they had for their career and life but also helps them to take active steps to not only realise but also to keep those dreams alive. The professional owes it to himself to create and utilise the opportunity to apply for the ideal job and then develop himself further through developmental courses and new tasks to develop skills and knowledge (Megginson & Whitaker 2007: 6).

Professionals should decide and plan their learning needs and determine how to execute them for themselves. Each individual walks a unique path. Colleagues, friends and family may walk with and alongside some for the way but each individual must live his own life. Most professionals experience a range of jobs/careers during their working lifetime. A professional chooses consciously and sometimes unconsciously their work and employer. Exploring CPD creates

the opportunity for the professional to become aware of it and to prepare for such changes. Continuous professional development gives the professional growth and a path through learning to a fulfilled life and career.

Historically the role of the professional in the process to identify their needs has often been down-played against that of the organisation. There is evidence that professionals when given the opportunity do not follow a structured process to identify their developmental needs which lead to random and ad hoc choices of development activities. The process normally involves the professional glancing through advertised lists of courses based on their preference and interests, when and where these are being held or at what cost. There tend to be a very limited link between their actual professional development need and their choices (Earley & Bubb 2004: 51; Hansen 2008: 6).

Professionals CPD opportunities and activities should be based on the individual's self-directed focus. These development activities should be related to the professional's personal needs as identified in support of their professional career and/or development goals. Relevant CPD activities include activities like mentoring, coaching, attending courses, exchanging ideas (professional networking) and good practice with colleagues and exchange visits (Earley & Bubb 2004: 10; Pharmaceutical Society of Ireland 2010:28).

The best learning results occur if the nurse practitioner identifies areas where they need improvement of professional knowledge, understanding and practice to more effectively perform their current job tasks. Nurse practitioners show commitment to reflect on their own professional development by taking steps to develop their own needs (Earley & Bubb 2004: 11).

The hospital in which the study will be done has a performance review process where nurse practitioners are allowed to discuss and record their development needs. The unit manager generates and prioritises a combined list of the identified needs by the nursing practitioners and integrates it with client (patients and doctors) expectations and risk assessment. This combined list does not necessarily address all of the nurse practitioners' identified needs.

2.2.4 Principles of Continuous Professional Development

All the stakeholders responsible for the delivery of quality nursing care are, however, collaboratively responsible to ensure the successful implementation of the continuous professional development programme. This can only occur if stakeholders collaborate and nurse practitioners are involved in evaluating and refining the CPD programme. Professionals need to be conscious of how they continuously interact with their environment to ensure that they are successful as professional practitioners. They have to continuously build on their knowledge base (NCPD N&M 2004: 16; Jasper 2006: 40; Bruce, Klopper & Mellish 2011: 343).

The principles of CPD are summarised by Megginson and Whitaker (2007: 5) as a systematic on-going, self-directed learning process planned by the professional throughout the professional's working life. The responsibility for professional development lies with the individual but organisations have a responsibility to support the professional and to meet the needs of the nurse practitioner. The nurse practitioner and the organisation should partner to ensure that the needs of both have been met. CPD should cover all learning requirements to improve the effectiveness of the nurse practitioner. The learning process, formal and informal is most effective when it is acknowledged as being part of the work-environment. Continuous professional development focuses in a hospital learning environment on the improvement of quality patient care. (Council of Credentialing in Pharmacy 2004: 15; NCPD N&M 2004: 16; Bruce, Klopper & Mellish 2011: 343).

2.2.4.1 Adult Learning

Adult learning is defined by Meyer et al. (2009: 104) as a learner whose life is "*characterised by many roles, such as work, employer, spouse or parent*". The learning environment has been affected by the fact that learners tend to bring these roles with them to the learning setting. Because adults are normally responsible for their own learning they use previous experience and knowledge as a foundation for new skills and knowledge (Meyer et al. 2009: 104; Coetzee et al. 2007: 56). The teaching and learning of adults are described in literature by the term "*andragogy*". The American educationalist Malcolm S. Knowles was

one of the foremost contributors in this area. One of the main arguments from Knowles are that traditional educational methods cause learners rather to react to educator stimuli instead of actively searching for knowledge which is the skill set required for life-long learning (Quinn & Hughes 2007: 27).

Work done by Knowles in the field of his process model for human resource development and the use of learning contracts particularly focus on the nurse education curriculum. The term "*human resource development*" is used by Knowles to cover the range of continuing training and education during the development of professional staff (Quinn & Hughes 2007: 28-29). The andragogical "*process model*" as opposed to the pedagogical "*content model*" consists of a number of elements. The andragogical "*process model*" establishes an environment and climate conducive for learning. The model involves mutual planning involving all stakeholders in the process of needs assessment and diagnoses acknowledged learning experience patterns and self-directed learning. Clear learning programme objectives, operational and evaluation requirements and processes should be established and agreed upon (Quinn & Hughes 2007: 29-30; Coetzee et al. 2007: 54).

In conclusion Knowles pointed out that due to the need for self-directed learning in andragogy the need for a clear learning contract that focuses on the nurse practitioner's needs for professional development and maintenance as well as that of the employer and the professional body exists. Such a learning contract provides useful ways to manage conflict that might develop due to contradictory objectives and priorities between the needs of the nurse practitioner and those of the employer (Quinn & Hughes 2007: 30, 32).

The following characteristics differentiate andragogy from pedagogy:

- **Self-concept** because adults take responsibility for their own lives and development;
- Adult learners draw from wide **past experience** during learning situations;
- The **relevance of learning** as well as practice theory correlation become more evident to adult learners;

- **Orientation and time perspective** are more evident to adult learners and they should be given the opportunity to immediately apply the newly gained knowledge;
- For adults it is important to recognise the advantage of the learning to **motivate** them to learn (Quinn & Hughes 2007: 28; Meyer et al. 2009: 104-105; Coetzee et al. 2007: 54-55).

Literature identifies a number of key aspects to enhance adult learning. The aspects that should be considered are the individuality, motivation and active involvement of the learners, the fact that learning implies change, relevance and clarity of content and the requirement in andragogy for immediate practical application, and the fact that the learning environment tends to be more informal (Gravett 2008: 16; Meyer et al. 2009: 105-106).

2.2.5 Benefits of Continuous Professional Development

CPD is an essential element to manage an organisation's workforce and adapt to changes in technology and service delivery requirements (McDonnell & Zutshi 2006: 4). Continuous professional development allows workers to expand their knowledge and skills to fulfil their potential. Continuous professional development includes all activities performed by workers which improved performance and built competence and confidence as roles and responsibilities develop and change (McDonnell & Zutshi 2006: 2).

This ensures that individuals have the required and relevant knowledge, skills, attitudes and understanding to execute a particular task to an agreed standard. CPD is not limited to normal workers but also includes management as well as all types of learning (McDonnell & Zutshi 2006: 2). One of the major benefits of CPD for the employer is the focus of CPD activities to improve the quality of service delivery. This includes development activities and opportunities such as in-house courses, mentoring, job-shadowing, coaching and secondment (McDonnell & Zutshi 2006: 3).

Employers can use CPD opportunities creatively in the development of people to prepare them for changes in existing jobs and roles (McDonnell & Zutshi 2006: 3). Employers/managers know that their workforce is critical to service delivery.

Developing the workforce is the most effective way to improve the quality of service delivery. Investment in on-going development and learning process should therefore have a direct positive impact on the abilities of the workforce to continue to deliver quality practice and service (NCPD N&M 2004: 20; McDonnell & Zutshi 2006: 3).

A CPD strategy is an essential tool in the development and management of people's performance. A clear and well-defined CPD programme contributes positively to the recruitment and retention of employees and provides a working environment conducive for employees to stay. Continuous professional development programmes develop an organisational learning culture resulting in more nurse practitioners that are competent to meet the requirements to ensure quality patient care. A well-structured CPD programme ensures that nurse practitioners comply with regulatory bodies, like SANC's, requirements for registration while ensuring that an organisations learning cost are effectively utilised and are relevant to the organisation (McDonnell & Zutshi 2006: 3-4).

Continuous professional development as a mechanism to address the quality of service delivery by professionals has an important implication for the public, is the recipient of service delivery by professionals, have the right to have access to health care professionals who have up-to-date skills, knowledge and abilities applicable in their sphere of practice (Royal College of Nursing 2007: 5). Continual demand for a wider range of skills from professionals requires efficient and effective supported and structured CPD programmes (Royal College of Nursing 2007: 5). The conscious updating of one's knowledge and skills leads to key benefits for the individual, the organisation and the community one serves.

In Table 2-1 the benefits that the different stakeholders in the hospital environment receive from CPD as discussed above are summarised.

Table 2-1: Summary of benefits to the individual, organisation and community

Benefits	Nurse Practitioner	Management	Patient ↓ Quality care
Positive impact on working environment and job satisfaction	X	X	
Continual improvement and refining of skills	X		X
Expansion of both general and specialist capabilities and skills in the organisation	X	X	X
Improved productivity	X	X	X
Empowers individuals to take responsibility for their own development	X	X	
Creates credibility as a professional with governing bodies	X	X	X
Create credibility for the profession within the organisation		X	
Enhances and promote the organisation as an employer		X	

Adopted from Government Science and Engineering (GSE) (c.a. 2008: 7)

2.2.6 Criticisms of Continuous Professional Development

Although change is natural for professionals it does not always happen. Reasons given by Attwood et al. (2005: 7) are that professional education and development are not always rewarded or valued by management and there is often pressure of service delivery and inappropriate work tasks given due to staff shortages. The professional development point system causes professional to chase the points instead of addressing real development needs. The limited opportunity to apply and review feedback from learning activities tends to demotivate participants especially when this is not met with the same

enthusiasm on the part of colleagues and co-workers (NCPD N&M 2004: 18; Hughes 2005: 46). The lack of time and financial resources has also been identified by Hughes (2005: 49) as reasons why CPD frustrates and disempowers nurse practitioners (Yfantis, Tiniakou & Ytanti 2010: 198).

New CPD interventions should not just re-invent the same old system. According to Attwood et al. (2005: 8) refinements to CPD programmes should maintain a balance between professional, private and working life while acknowledging the needs of all stakeholders. Continuous professional development programmes should provide for recognition of professional development. Support should be given by the organisation to the individual nurse practitioner to participate in CPD activities and development of the nurse practitioner's mentor skills and abilities to transfer the learned knowledge and skills to colleagues. However, organisations should refrain from relating CPD to accreditation, monitoring, remuneration or promotion. Organisations should evaluate CPD programmes on a regular basis to ensure effectiveness and create an environment that allows natural development and is supportive to CPD arrangements.

2.3 EVALUATING OF A CPD PROGRAMME

Continuous professional development normally does not happen by itself. To ensure that CPD presents good value for money and has a positive impact it needs to be managed and led effectively (Earley & Babb 2004:80). Increased competitiveness and globalisation, however, has created an environment where organisations struggle to adapt quickly enough (Preskill & Donaldson 2007: 3). This has forced them to shift the responsibility of career development from the organisation to the individual. It is now viewed that continuous professional development is a partnership between the organisation and the professional. This has led to the design and implementation of a wide variety of development activities and programmes. Despite this investment organisations have little evidence of the evaluation and success of these interventions and investments (Preskill & Donaldson 2007: 3-4). Organisations should implement quality assurance systems through which the process from training needs analysis through which the implementation and evaluation of the success and

effectiveness of CPD programmes are assessed (McKimm & Swanwick 2010:234).

2.3.1 Evaluation in a CPD Programme

Evaluation is necessary to ensure a sound basis for the reason to improve and upgrade processes and programmes but should be relatively simple and not expensive to implement otherwise management might consider utilising scarce resources that are more needed in other areas (Earley & Babb 2004: 77). Monitoring of staff developmental activities is the most basic level to check that what should have happened actually happens. (Earley & Babb 2004: 77; Preskill & Catsambas 2006: 42).

Evaluating staff continuous professional development is, however, not always a simple process. Evaluation includes the long chain of involvement and impact between the training programme, the individual and the benefits of the impact on the organisation and individual's personal development and growth. An understanding of the impact that CPD has on the investment in people and the related impact on the performance is fundamental for the evaluation (Earley & Babb 2004: 78).

Appreciative Inquiry as evaluation approach goal is to engage nurse practitioners' hearts and spirits with the aim to generate buy-in and passion by the stakeholders in the CPD programme (Thibodeau 2011: 122). The researcher must understand that AI and evaluation is not the same thing. Appreciative Inquiry does not necessary address all the responsibilities that an evaluator has to ensure a quality evaluation. Appreciative Inquiry, however, offers evaluators a different perspective, an alternative approach to shape and conceptualise an evaluation with a toolbox for conducting the various phases of an evaluation (Preskill & Catsambas 2006: 46).

Appreciative Inquiry evaluation works best when there is fear or scepticism surrounding the evaluation or in an environment that is subjected to frequent and fast changes. Appreciative Inquiry is also useful in situations of limited knowledge between stakeholders and stakeholder working and decision making environment. In environments where dialogue is specifically critical or

relationships between groups have deteriorated to a level of “*a sense of hopelessness*” AI is particularly useful as an evaluation approach helping to rebuild a desire to learn and become a community of practice (Fynn 2011: 29).

Appreciative Inquiry as an overarching philosophy, method or approach for evaluation should provide positive, useful and meaningful results. The way AI approach participation shows a lot of similarity with evaluation is in the way questions are asked, viewing inquiry as a continuing process and integrating it in the organisation through structured processes and findings (Coghlan, Preskill, & Catsambas 2003: 19)

2.3.2 Negative perspective of Evaluating

Evaluating someone on only one level does not ensure that they have grown or that the development has indeed effected any change. The impact should be evaluated on all levels before success can be attributed to a professional development programme (Earley & Babb 2004: 77). Evaluation may, however, be very negative in nature. Evaluation is often charged with a negative association and connotation. A number of misconceptions are associated with these activities. One such misconception is that evaluation equates to enormous amounts of work with very little results or outcomes and that it generates information that is seldom or never used. It is also believed that evaluation’s only concern is failure or success and that it is something that needs to be done by experts (Preskill & Donaldson 2007: 12; Kahan 2008: 57).

There are therefore a number of reasons why institutions avoid evaluation of CPD programmes. These include reasons like a lack of emphasis from top management on the importance of evaluation resulting in a situation where they simply accept that the training that is performed as part of the CPD programme is valid and effective. Another reason is that there is uncertainty as to what should be evaluated given the wide range of models and training performed as part of the CPD programme. Finally evaluation is viewed as risky and expensive where the cost overweighs the benefits. Evaluation might also focus negative attention on the training programme (Coetzee et al. 2007: 282).

2.4 APPRECIATIVE INQUIRY

The strength of Appreciative Inquiry lies in the engagement and inspiration that participants draw from their personal positive experience. The fact that AI's fundamentals are imbedded in the participants' actual experience creates a confidence, affirmation and commitment to their personal success. This creates an environment where they believe that they can contribute to more success (Coghlan, Preskill & Catsambas 2003: 6).

Appreciative Inquiry is therefore an alternative methodology, framework, approach or mind-set that highlights individuals' personal success or power in collaboration with standard organisational development processes such as organisational redesign, restructuring and strategic planning (Coghlan, Preskill & Catsambas 2003: 6).

2.4.1 Defining Appreciative Inquiry

Appreciative Inquiry has been defined by Preskill and Catsambas (2006: 2) based on Watkins and Cooperrider (2000: 3) as *"seeks what is "right" in an organisation. It is a habit of mind, heart, and imagination that searches for the success, the life-giving force, the incidence of joy. It moves toward what the organisation is doing right and provides a frame for creating an imagined future that builds on and expands the joyful and life-giving realities as the metaphor and organising of the organisation."* It is therefore concluded by Preskill and Catsambas (2006: 2) that AI is both a philosophy and a process used to create an environment and organisation where people would like to live and work. Appreciative Inquiry, however, follows a different significant approach to organisational change by focusing on what works particularly well instead of focusing on problems and what is not working. Since the late 1980s AI has been used for various organisational improvement applications. Appreciative Inquiry is being used to improve organisations through "discovery and valuing", dialogue, envisioning and co-constructing the future (Preskill and Catsambas 2006: 2).

On the other hand Appreciative Inquiry is defined by Cooperrider, Whitney & Stravros (2008: xv) as *"an exciting way to embrace organizational change. Its assumption is simple: Every organization has something that works right—things*

that give it life when it is most alive, effective, successful, and connected in healthy ways to its stakeholders and communities. AI begins by identifying what is positive and connecting to it in ways that heighten energy, vision, and action for change." They conclude that *"AI begins as an adventure."* Many people have experienced this adventure and many will still explore this emergent paradigm (Cooperrider, Whitney & Stravros 2008: xv).

As stated by Reed (2007: 2) AI *"is a simple but radical approach to understanding the social world. Put simply, AI concentrates on exploring ideas that people have about what is valuable in what they do and then tries to work out ways in which this can be built on – the emphasis is firmly on appreciating the activities and responses of people, rather than concentrating on their problems."* Reed (2007: 2) continues to stress that the radical aspect of AI lies in the way that AI challenges members of the organisation to rethink ideas on the way people work, how changes happen and the way research can be used in this process.

2.4.2 Principles of Appreciative Inquiry

According to Watkins and Mohr (2001: 36) it is important to understand what the essential components of the approach used by the researcher are. To understand AI it is necessary to describe and understand the five core principles and processes that form the core fundamentals of AI. Understanding of these principles and processes allows the researcher to adapt and create the necessary activities and steps to address almost any situation where human beings are involved (Watkins & Mohr 2001: 37).

The following five principles of AI were first described by Cooperrider, Whitney & Stavros (2008: 8) and will be discussed briefly in Sections 2.4.2.1 to 2.4.2.5. Although these five principles are quite abstract, they are important in AI to make the connection between the theoretical development and starting point of the AI (Watkins & Mohr 2001: 37-38; Reed 2007: 26-27).

The original five principles were later extended to eight principles in an effort to improve the effectiveness of AI as a whole. The three additional principles that were added will be discussed in Section 2.4.2.6 to 2.4.2.8.

2.4.2.1 The Constructivist Principle

Constructivism is based on the principle of interpretation and construction of a phenomenon and not on simply recording it. Different people experience and interpret situations differently. Appreciative Inquiry focused on the processes of construction to use the past and present to affect the future positively. Appreciative Inquiry therefore encourages the challenging of assumptions and the asking of questions about how things work in the programme. The constructivist principle acknowledges the existence of different but equal types of knowledge (Watkins & Mohr 2001: 37-38; Reed 2007: 26-27; Cooperrider et al. 2008: 9; Fynn 2011:116).

2.4.2.2 The Principle of Simultaneity

The principle of simultaneity refers to the fact that inquiry and change occur simultaneously and are not sequential steps in the process. Appreciative Inquiry acknowledges the fact that inquiry generates reflection on the situation and the way people see and act (Watkins & Mohr 2001: 37-38; Reed 2007: 26-27; Cooperrider et al. 2008: 9).

2.4.2.3 The Poetic Principle

Different people verbalise situations differently according to what is of interest to them at that specific time (Watkins & Mohr 2001: 37-38; Reed 2007: 26-27). The AI process, however, should ensure that the participants are guided by the process to stay engaged in the authoring process in a way that makes it accessible to all (Cooperrider et al. 2008: 9; Fynn 2011:118).

2.4.2.4 The Anticipatory Principle

This principle suggests that the way people move toward the future is being shaped by the way they think about it. AI uses this principle to direct drive and energy in the development of ideas for the future based on what works well (Watkins & Mohr 2001: 37-38; Reed 2007: 26-27; Cooperrider et al. 2008: 9).

2.4.2.5 The Positive Principle

People tend to react more effectively when confronted with positive explorative questions. Appreciative Inquiry uses the positive principle in the way questions are asked (Watkins & Mohr 2001: 37-38; Reed 2007: 26-27; Bushe 2007: 3; Cooperrider et al. 2008: 9). This leads to creating an appreciative mind-set with the participants (Bushe 2007: 3).

2.4.2.6 The wholeness principle

This principle suggested that wholeness allows people to belong and therefore bring out the best in them. The involvement of all of the stakeholders creates an environment of collective capacity. The wholeness principle helps to understand the whole story while engaging with the whole system and person (Preskill & Catsambas 2006: 10; Fynn 2011: 118).

2.4.2.7 The Enactment Principle

For positive change to occur and to be sustainable each stakeholder should be the role model for the ideal future and therefore live this ideal future. The future is not tomorrow but now, the moment that we create it (Preskill & Catsambas 2006: 10; Fynn 2011: 118).

2.4.2.8 The free choice Principle

It is believed that people will perform better when they have the freedom of choice on how and what they can and will contribute. Free choice stimulates positive change and organisational excellence because it liberates both organisational and personal power (Preskill & Catsambas 2006: 11; Fynn 2011: 119).

2.4.3 Theoretical Framework of Appreciative Enquiry

Appreciative Inquiry as defined by Cooperrider & Whitney (2001: 3) "*is about co-evolutionary search for the best in people, their organisations, and the relevant world around them*".

Cooperrider and colleagues describe the four phases of the AI process by means of the 4-D model that they have developed. The AI process consists out of four phases i.e. Discovery, Dream, Design and Destiny (Cooperrider et al. 2000: 2; Preskill & Catsambas 2006: 15). According to Oren (2002: 5) Frank Barrett, however, used a fifth phase of Defining before the Discovery phase while Cooperrider includes the defining phase into the Discovery phase. Feedback and experience from AI practitioners and their clients has tended to impel them to use a different, more descriptive and/or accessible set of labels for the four AI phases. The selected labels are Inquire, Imagine, Innovate and Implement (Preskill & Catsambas 2006:15; Preskill & Donaldson 2007: 12).

This is an on-going phase with continuing dialogue, updating and revisiting of positions based on the images from previous phases, specifically the Discovery phase during which possibilities and solutions were created for the future based on successes and achievements from the past (Reed 2007: 33).

Figure 2-1 reflects the theoretical framework of the AI process. The 5th D of Defining, as suggested by Frank Barrett is covered by most authors within the definition of the need for the research (Oren 2002: 5). In this study the need to refine the CPD programme was defined as part of the study definition, aims and objectives.

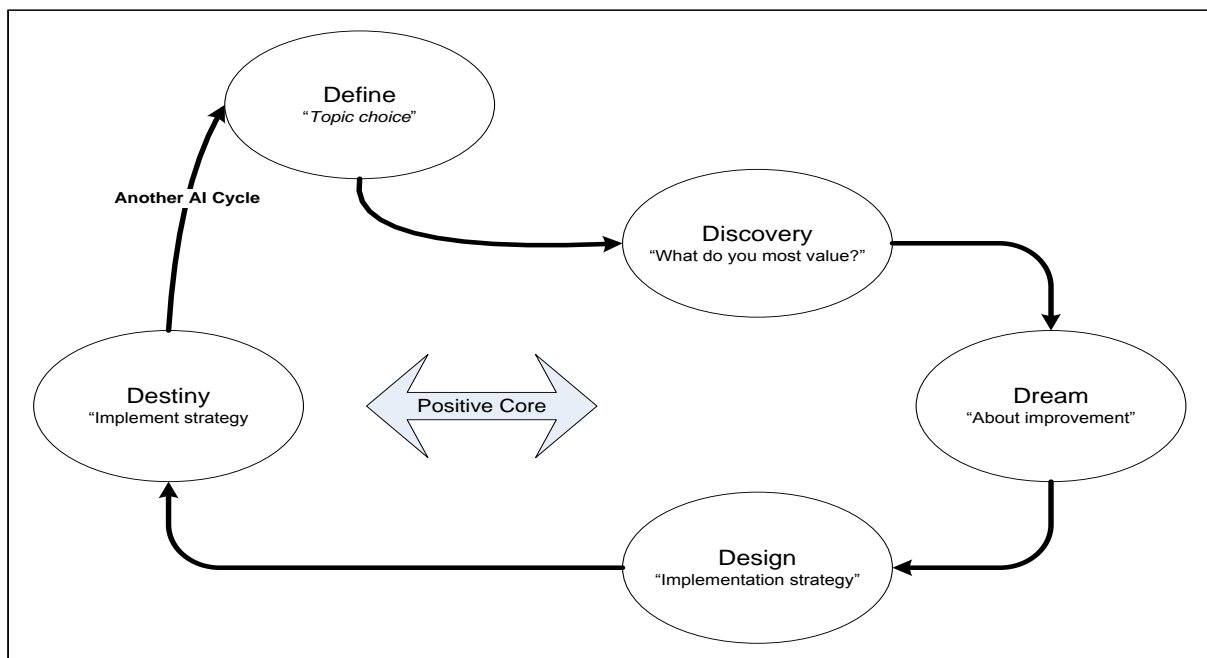


Figure 2-1: Adapted Appreciative Inquiry 4-D Cycle

2.4.4 Discovery

During the Discovery phase the researcher must lead the organisation to explore the best within the organisation of “*what is*”. The researcher should focus on periods of organisational excellence (Watkins & Mohr 2001: 43). A number of core questions can be asked for example “What assets of the organisation will you protect in the future?” or “Name two to three things that you will change to improve the organisation?” These generic questions need to be adapted by the researcher to address the specific topics that are being researched (Orem 2010: 5). This phase is identified by Reed (2007: 33) as the phase during which positive conversation should be established in the organisation.

2.4.5 Dream

The Dream phase is used to develop a new focus point uncovered in the Discovery phase. From the Discovery phase the employees identified what is needed and what must be improved within the organisation (Orem 2010: 5). During this phase opportunities were created to develop great thoughts and possibilities for the organisation (Watkins & Mohr 2001: 44). Throughout the Dream phase participants were given unrestricted freedom to create ideas based on the results of the Discovery phase. It is important to drop the traditional resources and relationship restrictions to prevent limitations on possible ideas (Reed 2007: 33).

2.4.6 Designing

The Designing phase designs a strategy to realise the dream expressed by the participants during the dream phase of the research process. Existing positive aspects that were identified during the Discovery phase were strengthened (Orem 2010: 6). During the Design phase plans for the future were crafted by participants. True to the challenging nature of AI, provocative propositions may be produced. Participants were requested to think from a position of confidence and in an assertive way during the development of these propositions (Reed 2007: 33).

2.4.7 Delivery

The Delivery phase is used to implement or deliver the strategy. This strategy represents the new image that was designed for the future of the organisation. Appreciative Inquiry requires that continuous learning and adjustment with improvisation to address change is the order of day. The shared positive images of the future involved everybody in the creation of the organisation's future (Watkins & Mohr 2001: 45). This is an on-going phase with continuing dialogue, updating and revisiting of positions based on the images from previous phases, specifically the Discovery phase during which possibilities and solutions were created for the future based on successes and achievements from the past (Reed 2007: 33).

2.4.8 Criticisms towards Appreciative Inquiry

The primary criticism to Appreciative Inquiry comes from practitioners that felt that AI is only being used as an alternative strategy to alleviate the tension and anxiety that participants associate with an evaluating programme (Fynn 2011: 126). Those opposed to AI argue that AI is nothing but a method to deceive the stakeholders into participating in an evaluation without knowing it.

Evaluation is being seen by most organisations as a negative activity because people are judged and assessed. This often led to implications for non-performers and penalisation of non-compliance (Fynn 2011: 126). Appreciative Inquiry is being seen by some as a strategy how to co-opt those who do not want to participate in evaluation by emphasising the positive nature of the approach (Cooperrider, Whitney & Stavros 2008: 3).

Because AI focuses on the positive and tends to ignore the negative, some criticised it to be uncritical and unbalanced to the point of only focusing on the positive (Preskill & Donaldson 2007: 6; Reed 2007: 39; Fynn 2011: 126). This approach may be seen as discouraging constructive criticism that is necessary to investigate alternative solutions (Coghlan, Preskill & Catsambas 2003: 6; Fynn 2011: 126).

The AI approach has also been criticised that there tends to be a delay between the AI summit and the impact of the intervention (Reed 2007: 40). AI focuses to

bring sustainable change about involving the stakeholders responsible for change management. The implication of this is that there is often a misalignment between the timescale deadline of the stakeholders and that of those who conduct the impact assessment. Another reason is that changes in different organisations happen at a different pace and rate (Reed 2007: 40). Change within an organisation does not always happen on the level of processes, policies and procedures but often consists of implicit changes like relationships, perceptions and interpersonal interaction which is harder to measure and observe if the evaluator does not specifically observe these changes.

2.4.9 Application of Appreciative Inquiry

As suggested by Preskill & Catsambas (2006: 46) Appreciative Inquiry can be utilised in a variety of evaluation contexts and for a number of different purposes. Appreciative Inquiry is specifically successful when organisations and researchers focus on participatory and collaborative approaches to evaluate.

Where time and cost is particularly important in the evaluation, AI is considered to be well positioned. Organisations value innovation. In learning organisations that strive to continuously improve on patient care innovative ideas is always welcome (Preskill & Catsambas 2006: 46).

In conclusion Muller (2009: 275) states that the purpose of programmes such as CPD is the improvement of quality nursing care. To achieve this it is important to promote ownership for the CPD programme amongst the nurse practitioners.

2.5 CONCLUSION

In Chapter 2 a theoretical underpinning and literature framework was used to orientate the reader to the evaluation of a CPD programme and the research method of AI used in this study.

Chapter 3 discusses the research design and methods in detail that were utilised and applied to this study.

3

RESEARCH DESIGN AND METHODS

“I am what I study; what I focus on, what I question. Inquiry and change are a simultaneous moment”

David Cooperrider

3.1 INTRODUCTION

Chapter 2 was dedicated to the theoretical underpinning of Continuing Professional Development and the theoretical background of Appreciative Inquiry that will be used as evaluation methodology within this study.

The overall aim of this research was to evaluate the CPD programme for critical care nurse practitioners in a private hospital. To achieve this aim, the research was guided by the Appreciative Inquiry approach to evaluate the CPD programme in the private hospital to achieve the objectives as stated in Chapter 1 Section 1.4.

Objective 1: Explore and describe views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng;

Objective 2: Make recommendations to refine the current CPD programme in the private hospital to the hospital management.

Chapter 3 discussed the research design and methods used in this research study in greater depth.

3.2 RESEARCH DESIGN

The research design must not be confused with the research methodology. These are two totally different aspects of the research study (Mouton 2001: 55). In addition, Polit and Beck (2008: 66) define the research design as *“the overall plan for obtaining answers to questions being studied and for handling some of the difficulties encountered during the research process”*. As explained further by

Hofstee (2009: 113), the research design is “*the section where one names and discusses the overall approach to be used when testing the thesis statement*”. The research design therefore provides the instructions, steps, and guidelines to be followed in addressing the research problem. The research design can therefore be seen as the plan or blueprint of how you intend to execute the research (Mouton 2001: 55; Daymon & Holloway 2011: 365).

Research is divided into basic and applied research. Basic research investigates the intellectual interest of a phenomenon with the objective to extend the body of knowledge (Merriam 2009: 4). On the other hand applied research tries to improve the quality of practice and hopes that the work will be used to improve practices and the way things are done (Merriam 2009: 4). Evaluation qualitative research collects evidence and or data on the value of process, programme or techniques that can be used as basis for decision-making (Merriam 2009: 4). For the purpose of this study a qualitative and descriptive research design was utilised using qualitative methodology to investigate how a CPD programme can be evaluated by critical care nurse practitioners utilising the Appreciative Inquiry process. The AI process as a qualitative and descriptive research design provides the opportunity to the researcher to explore and utilise the views of the participating nurse practitioners working in the CCU and HCU to evaluate the current CPD programme. Utilising the positive outcome from the current CPD programme is thereafter used in the AI focus group inquiry to generate recommendation for the future CPD programme in the CCU and HCU of the private hospital in Gauteng.

The research designs utilised in this research was qualitative and descriptive research designs. In Section 3.2.1 to Section 3.2.2 the rationale for the use of these designs is discussed.

3.2.1 Qualitative

Qualitative research design is referred to by Polit and Beck (2008: 70) as an emergent design that appears during the course of data collection. These authors further explain that an emergent design is a reflection of the researcher’s desire to have an enquiry based on the realities and viewpoints of those under study. In conclusion Denzin and Lincoln (2005: 3) argue that

qualitative researchers “*study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them*”. An older definition by Van Maanen (1979: 520) however, still defines qualitative research in its broader sense. According to this definition qualitative research is “*an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world*”.

Qualitative design is guided by different disciplines and each has developed various methods for addressing questions of particular interest (Polit & Beck 2008: 219). However, Polit and Beck (2008: 219) delineate the general principles of the qualitative research design as it applies across the disciplines. It is stressed by Keegan (2006:607) that qualitative research’s greatest strength is its rigorous, intuitive, reflexive, reflective contextualised subjectivity embodied in the research. Furthermore Polit and Beck (2008: 15) indicate that the objective of most qualitative studies is to describe and understand a phenomenon within a real environmental set up where it exists and as created by the individual in relativism of their world (Polit and Beck 2008: 220). Reality for the qualitative researcher is not a fixed entity. Reality within the qualitative research always exists within a specific context (Griffiths & Bridges 2010: 158).

Four basic methodological attitudes are outlined by Holloway (2005: 4) that define the **characteristics of qualitative** research methods. As stated by Yin (2011: 7), literature prefers to define qualitative research in terms of five features. Both these two authors, however, capture the essence of qualitative research in the following characteristics:

- Qualitative research relies on **interaction** with the people that are being studied under **real-world conditions**. The people studied are therefore not simply passive subjects but active participants in the study. Data is thus produced/collected through interaction with the people while they are performing their daily activities. They are allowed to say what they felt was appropriated in the situation (Holloway 2005: 5; Yin 2011: 8).
- Qualitative research represents the **views of people** within a textual data framework. This simply means that the method of inquiry is used

that produces data in the form of text instead of numbers. Data is captured through transcripts of conversations or interviews, diary entries, case history, comments on questionnaires, observation notes or entries in nursing or medical notes (Holloway 2005: 4; Keele 2011: 36; Yin 2011: 8).

- Qualitative research usually uses **flexible plans of inquiry with multiple sources** of evidence. The complexity of the real world warrants the use of various techniques like observations, interviews or the inspection of documents. The plan employed normally evolves as the research study progresses. Study conclusions are based on the triangulation of data from different methods and sources (Holloway 2005: 4; Keele 2011: 36; Yin 2011: 8).
- Qualitative research studies the participants in their **contextual conditions**. This includes the social, work, and environmental setting within which the participants live and operate naturally (Holloway 2005: 4; Keele 2011: 36; Yin 2011: 9).
- As stated by Yin (2011: 8) it is preferred to add that qualitative research is not just a chronicle of everyday events related to the participants but that research should strive to explain the events through **emerging concepts** (Yin 2011: 8).

In conclusion Creswell (2007: 37) states that in his view "*Qualitative Research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem.*" Qualitative research focuses on the description and observation whenever the researcher wants to describe people and reality. The objective in this study was to create an environment that fosters disclosure from the participating nurse practitioners in the CCU and HCU of the private hospital in Gauteng.

The definition of qualitative research is been **extended** by Creswell (2007: 37-39) to include the following **characteristics** of qualitative research:

- The **researcher** is considered to be a **key instrument** in the qualitative research process. Researchers are directly involved in the collection of

the data through the process of interviews, examining of documents or behavioural observation;

- Qualitative research follows an **inductive, interactive and recursive** data analysis processes;
- The qualitative researcher focuses on the **meaning that the participants hold** in relation to the issues at hand and not on the meaning that the researcher brings to the research;
- Qualitative research tends to follow a process of **emergent design**. This means that the phases of the research might change and shift during the research and cannot be tightly prescribed during the initial planning of the research;
- Qualitative researchers from time to time use a specific **theoretical view** to organise the context of the problem or issue being researched;
- Qualitative research makes use of **interpretive inquiry**. During qualitative research researchers often interpret what they hear, see or understand. This also applies to almost every-one involved or reading the research report;
- The researcher in qualitative research tries to build a complex **holistic picture** of the issue or problem under research.

In summary, qualitative researchers as in this research study, try to make sense of how people construct meaning within the context of their world and experiences (Merriam 2009: 13). The application of these characteristics to this study is summarised in Table 3-1.

Table 3-1: Application of qualitative research characteristics to this study

Characteristic	Application
View of people within a textual data framework	Focus Group Inquiry Open-ended questions Confidential written contextualisation of feelings/inputs
Multiple source of evidence	Small group discussions and part of Focus Group Inquiry Confidential written contextualisation of feelings/inputs Summarised group discussions
Contextual conditions	All participants are nurse practitioners working in the specific CCUs and HC units of the private hospital
Emerging concepts	An AI approach was followed
Meaning that the participants hold	Feedback from the participant will be used to formulate recommendations and strategies
Interpretive inquiry	Data will be coded and grouped into themes, categories and sub-categories, the specific recommendations as well as strategies identified for the refined CPD programme in the private hospital
Holistic picture	The impact of all stakeholders on the current CPD programme will be evaluated as viewed by the nurse practitioners in the CCUs and HC units of the private hospital

For the purpose of this study the phenomenon the researcher explored and described was to determine what the components of a CPD programme should be for nurse practitioners working in the critical care and HCU of a specific private hospital.

3.2.2 Descriptive

Appreciative Inquiry is a reform-focused research methodology that utilises descriptive methods within a process to evaluate and identify what works best in an environment or system in order to use these strengths to build and generate practical developmental opportunities in an effort to create change (O'Connor & Netting 2005: 8)

Descriptive research is defined by Burns and Grove (2009: 696) as follows: *“Provides an accurate portrayal or account of the characteristics of a particular individual, event, or group in real-life situations for the purpose of discovering*

new meaning, describing what exists, determining the frequency with which something occurs, and categorising information". According to Babbie and Mouton (2001: 80) one of the main purposes of social scientific studies is the description of events and situations. Descriptive research focuses on describing something as people experience it (Polit & Beck 2008: 228; Daymon & Holloway 2011: 149). Descriptive research is used when the researcher knows little about the phenomenon under study (Burns & Grove 2009: 25). Descriptive research according to Polit and Beck (2008: 228) often includes the steps of bracketing, intuiting, analysing and describing.

Bracketing refers to the process used by researchers to bracket out the environment and world in an effort to analyse and confront the data in a pure and unbiased manner. It is not possible to bracket out all external influences but researchers strive to bracket out the world (Polit & Beck 2008: 228; Daymon & Holloway 2011: 184). Bracketing is an iterative process using evaluation and feedback on the effectiveness of the bracketing (Polit & Beck 2008: 228). In this study data collection was done through a Focus Group Inquiry in a conducive setting with the required aids under the control of an independent focus group facilitator.

The second step of descriptive research is **intuiting** which occurs when the researcher remains open to the interpretation of those who have experienced the phenomenon (Polit & Beck 2008: 228; Burns & Grove 2009: 529). During this study the views of the nurse practitioners directly involved in the current CPD programme in the CCU and HCU of the private hospital, which is the subject of this study, were the participants in the data collection and exploitation of future strategies design process.

The next step is to **analyse** the data through extraction of significant statements, categorising the statements and making sense from the data (Polit & Beck 2008: 228; Burns & Grove 2009: 529). This study utilised a data analysis process of coding through which themes, categories and sub-categories were identified directing the refinement of recommendations and strategies for the future CPD programme in the CCU and HCU of the private hospital.

The researcher then moved to the **descriptive** phase during which the researcher came to understand the phenomenon (Polit & Beck 2008: 228; Burns & Grove 2009: 529). In this study the researcher utilised a descriptive research approach to describe the refinements that should be included in a CPD programme for critical care nurse practitioners working in the CCU and HCU of the private hospital.

3.3 RESEARCH METHODS

According to Polit and Beck (2008: 765) research method "*is the technique used to structure a study and to gather and analyse information in a systematic fashion*". Research design on the other hand refers to systematic techniques that the researcher applies in a step-by-step process to do the research (Daymon & Holloway 2011: 100).

Research methods as "*the steps, procedure, and strategies for gathering and analysing data in a study*" (Silverman 2005: 379; Polit and Beck 2008: 758). The research method is therefore a plan of action that includes the techniques employed when conducting the study. As a minimum, the research methods should include the techniques used for sampling, sample size, selection and collection of the sample, data collection and analysis as well as steps to ensure reliability and validity (Hofstee 2008: 115; Merriam 2009: 246; Daymon & Holloway 2011: 100).

Qualitative research methodology is both flexible and developing as the researcher explores the depth and complexity of the information. This enabled the researcher to identify and describe the refinements that were included in the CPD programme of nurse practitioners working in CCU and HCU in a specific private hospital as suggested by Burns & Grove (2005: 52).

3.3.1 Population

Population is defined by Burns and Grove (2009: 714) as "*All elements (individuals, objects, events, or substances) that meet the sample criteria for inclusion in a study; sometimes referred to as a target population*". This

definition is confirmed by Polit & Beck (2010: 67) as "*all individuals or objects with common, defining characteristics*" (Daymon & Holloway 2011: 209).

During a research study data is typically collected from a sample that is only part or a subset of the population. The reason for this is related to practicality and being financially aware, but it contains risk in the fact that the researcher might miss important data or that the sample does not adequately reflect the original population's traits (Polit & Beck 2010: 67; Daymon & Holloway 2011: 209).

The target population for this study are the critical care nurse practitioners working in any one of the CCU and/or HCU of the private hospital in Gauteng.

3.3.2 Sample

According to Burns and Grove (2009: 721) a sample is a subset of the population that is selected by the researcher for the study. The researcher therefore collects data only from a portion of the population that is of interest (Daymon & Holloway 2011: 209). The three primary non-probability sampling techniques are quota, convenience and purposiveness (Polit & Beck 2008: 341; Daymon & Holloway 2011: 209).

A sample plan is called purposeful because the purpose of the study directs the sampling that needs to be done in a qualitative research study. It is also called purposive sampling or alternatively, judgmental or theoretical sampling (Keele 2011: 45; Tappen 2011: 115). The sampling process involves a conscious selection of the participants used for the study. The goal in qualitative research is not to generalise the findings of the study to a larger population (Creswell 2003: 185; Polit & Beck 2010: 343; Keele 2011: 45).

For the purpose of this study purposive sampling was utilised. The idea behind qualitative research is to purposefully select participants at sites that best help the researcher understand the problem and the research question (Creswell 2003: 185; Polit & Beck 2010: 343).

The target population for this study is small with a specific focus and therefore the whole population was sampled for this study (Daymon & Holloway 2011:

209). The sample consists of all the critical care nurse practitioners working the CCU and/ or the HCU of the private hospital. All the nurse practitioners of the various critical care units as well as the high care units in the private hospital were invited personally via written invitation (see Annexure B) to participate in the study.

Due to the fact that the research setting as described in Section 1.5.1 is part of a 24-hour operation, the researcher was limited for practical reasons to a sample 13 participants.

3.3.3 Data Collection

Emphasis is placed by Burns and Grove (2009: 431) on the fact that consistency across data collection is paramount during the research process. The researcher developed an AI interview schedule based on the 4-D cycle of Appreciative Inquiry (view Annexure C). Focus Groups foster an environment and culture rich in storytelling and sharing of ideas and information. This environment provides an opportunity for collaboration between stakeholder groups and creates a profile for the organisation's or the unit's positive core. Focus Groups create a non-threatening setting where the research participants can openly share their views and feelings with the researcher (Glasgow 2008: 52).

A number of benefits using Focus Group Inquiry in an Appreciative Inquiry evaluation are highlighted by Preskill and Catsambas (2006: 58-59). A Focus Group Inquiry generates a common understanding about the programme leading to greater understanding by the participants and therefore creates commitment to the evaluation process. During a Focus Group Inquiry an environment is provided that stimulate the participant's innovation and creativity in addressing the evaluation topic while investigating more in-depth information related to the topic. This increases the likelihood that the evaluation findings are used. Focus Group Inquiries are normally more time and cost efficient due to the fact that a large number of participants are involved at the same time while a structured process is followed allowing for good time management.

This study utilised a Focus Group Inquiry to collect the data utilising an Appreciative Inquiry approach (see Figure 3-1). The activities leading to and during the Focus Group Inquiry are discussed in Sections 3.3.3.1 and 3.3.3.6.

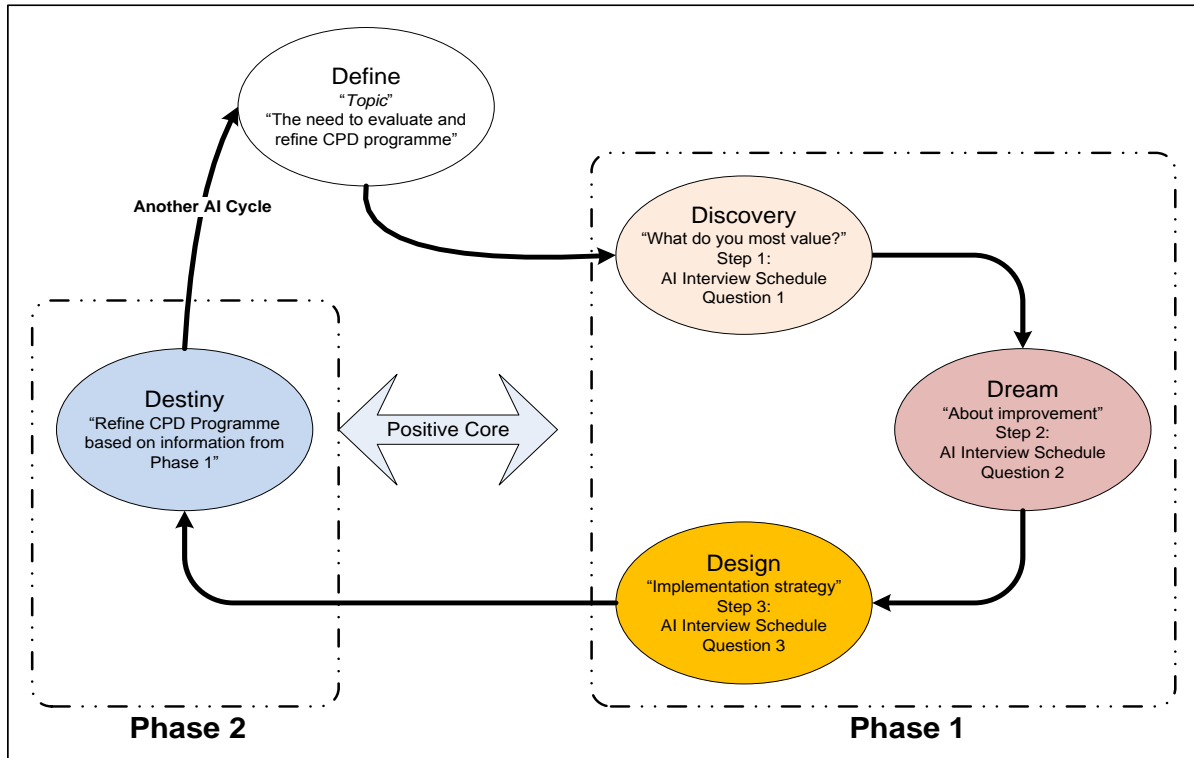


Figure 3-1: Adapted Appreciative Inquiry 4-D Cycle as utilised in the study

The Focus Group Inquiry was divided into two phases. The first phase, Phase 1, utilised the Discovery, Dream and Design phases of the AI process to elicit the data required to refine the current CPD programme in the hospital during Phase 2 of the Focus Group Inquiry which utilised the Destiny phase of the AI approach. The application of the Focus Group Inquiry for each of the phases of the 4-D cycle will be briefly discussed in Sections 3.3.3.1 to 3.3.3.4.

3.3.3.1 *Discovery*

The Discovery question was utilised to explore the participants' understanding of the peak experiences of the current CPD programme in the private hospital in Gauteng.

During the Discovery step the independent facilitator asked Question 1 as part of the Focus Group Inquiry related to the current CPD programme (see Annexure

C, Question 1). The aim of this question was to identify the aspects of the CPD programme that work well and are perceived as positive by the participants.

3.3.3.2 Dream

During the Dream question the participants were allowed to dream freely and explored what they believe would be the ideal CPD programme if there were no limitations in the design or implementation.

During the Dream step the independent facilitator asked Question 2 as part of the Focus Group Inquiry related to the current CPD programme (see Annexure C, Question 2). The aim of this question was to enable the participants to indicate their dreams and wishes to be implemented into the CPD programme to move the programme towards excellence.

3.3.3.3 Designing

In the Design question the participants were given the opportunity to identify aspects that they feel will be challenges in the refinement of the CPD programme that requires action.

During the Design step the independent facilitator asked Question 3 as part of the Focus Group Inquiry related to the current CPD programme (see Annexure C, Question 3). The aim of this question was to enable the participants to indicate what the specific aspects/components are that they would like to be included into the future refined CPD programme in the private hospital.

3.3.3.4 Delivery

The Delivery phase is used to refine the current CPD programme based on the findings from Phase 1 during which the AI Dream, Discovery and Design step were utilised to explore the current CPD programme.

During the Delivery step the independent facilitator asked Question 4 as part of the Focus Group Inquiry related to the current CPD programme (see Annexure C, Question 4). The aim of this step was to enable the participants to refine the specific elements required for the future CPD programme in the CCU and HCU of the private hospital.

3.3.3.5 Preparation for Focus Group Inquiry

The researcher started the preparation process with visiting the Deputy Nursing Service Manager responsible for the CCU and HCU in the private hospital to create understanding for the research and to negotiate for the attendance hours of the participating nurse practitioners. Due to the Deputy Nursing Service Manager's commitment towards the improvement of quality patient care the request was granted allowing the participants to attend the Focus Group Inquiry during working hours.

The invitation to the 20 available (not allocated on the duty roster for the specific day) nurse practitioners was distributed three weeks prior to the Focus Group Inquiry by the researcher. The Focus Group Inquiry was held on the 14th of June 2012 from 08h00 to 12h00 in the Skills Lab of the private hospital. The venue was the old Skill Lab of the private hospital and was booked in advance to ensure availability. The setting supplies a safe and conducive environment where the participants can share inputs and experiences. The venue was big enough to allow for three smaller group discussions and equipped with aids such as a data projector, white board, and flip charts.

The researcher arranges two weeks in advance with the experienced independent focus group facilitator for the facilitation of the Focus Group Inquiry. The commitment was confirmed telephonically two days before the Focus Group Inquiry.

The researcher did not directly participate in the Focus Group Inquiry although she was theoretically grounded in the research method the researcher has never before taken part in an Focus Group Inquiry and has therefore no practical experience to lead and facilitate an Focus Group Inquiry. The reason for this decision was to prevent any bias because researcher had previously worked as a clinical facilitator with most of the participants in the private hospital that was the subject of the research.

The objectives and activities related to the Focus Group Inquiry are presented in Table 3-2 below.

Table 3-2: Summary of the Focus Group Inquiry

	Discovery	Dream	Design	Destiny
Objective of Focus Group Inquiry question	Explore the views of the critical care nurse practitioners, pertaining to the current CPD programme in the CCUs and HCU in the private hospital in Gauteng	Identify the desired CPD programme for the CCUs and HCU in the private hospital in Gauteng	Identify specific aspects that need to be addressed within the current CPD programme in the CCUs and HCU in the private hospital in Gauteng	Develop strategies to refine the current CPD programme in the private hospital as a recommendation to the hospital management
Activity	Reflecting back on the CPD programme in the private hospital that was the most satisfying/peak experience	Brainstorm what are the wishes for an ideal CPD programme in a private hospital that ensures quality nursing care	Formulate a collaborative strategy to address the challenges of a CPD programme that ensures quality nursing care	Creation of a collaborative action plan to implement changes to the CPD programme in the private hospital
	Phase 1			Phase 2
Duration of session	One 4-hour session			

3.3.3.6 Focus Group Inquiry

The Focus Group Inquiry utilised in this research to collect the data, was structured with a welcome, introduction and administrative phase followed by two phases of data collection. The Focus Group Inquiry was concluded with a closure phase.

The researcher prepares the venue the previous evening to be ready on the morning of the 14th of June 2012 for the Focus group Inquiry. The venue was set-up with three tables in a lecture room style. Sufficient space was allowed between the tables to provide for the individual tables also to be utilised during the Focus Group Inquiry to accommodate small group discussions.

On each table different colour sticky notes and colour pens were provided for the use of the participants during the Focus Group Inquiry. At each seating the researcher provided a file containing the Participation Leaflet and Consent Form and the AI Interview Schedule (see Annexure B and C).

A flipchart and different colour pens was supply for use during the Focus Group Inquiry by the facilitator and the participants.

Figure 3-2 summarised the process followed during the Focus Group Inquiry. The Focus Group Inquiry was facilitated by the focus group facilitator and observed by the researcher.

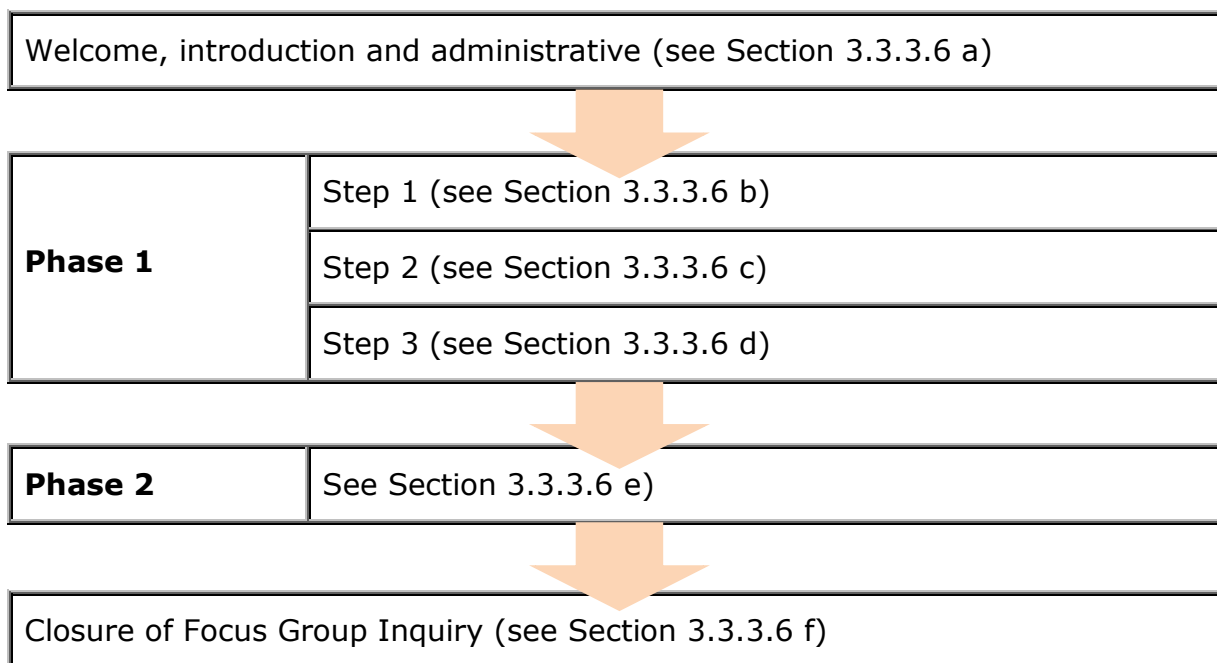


Figure 3-2: Process flow utilised during the Focus Group Inquiry

a) Welcome, Introduction and Administration

On 14 June 2012 only 13 of the 20 nurse practitioners invited from the CCU and HCU in the private hospital attended the Focus Group Inquiry. On the morning of the Focus Group Inquiry the researcher allowed sufficient time for the participants to arrive while coffee, tea and rusks were provided.

The researcher started the Focus Group inquiry at 08h30 welcoming everybody. After the welcome the researcher introduced the focus group facilitator explaining the role of the facilitator as an experience, independent person and

that of the researcher will observe the proceedings. At this stage the researcher utilised the opportunity to discuss and agreed the ground rules with all present in the Focus Group Inquiry (see Annexure K).

The researcher explained the administrative arrangements of the Focus group Inquiry namely that there will be a 15 minutes tea break after completion of question 2 and that the session will end at 12h00. The researchers gave a background to the study, discussing the objectives and explain the positive nature of the AI approach using a Power Point presentation and quotations from Belva Davis and an unknown author (see Annexure J).

The participants were referred to the Participation Leaflet in the file containing the Informed Consent form. Each participant was requested to complete and sign the Informed Consent Form. Opportunity was given for participants to withdraw at this stage or at any stage during the Focus Group Inquiry if they feel to do so. None of the participant withdraws from the Focus group Inquiry. Participants were given the assurance that the participants do not have to supply their names on any of the recorded data and that no data through which they can be identified will be supplied to anybody without their consent.

After the welcoming, introduction and administrative arrangements of the Focus Group Inquiry were completed the group was handed over to the focus group facilitator who firstly puts the group at ease before starting with the questions as per the AI interview schedule (See Annexure D for the curriculum vitae of the experienced independent facilitator).

b) Focus Group Inquiry Phase 1: Step 1

The group was asked to divide into paired groups of two participants each. The participants were asked to discuss Question 1 of the AI Interview Schedule and to share their experiences with each other while recording the discussion on the AI Interview Schedule. The focus group facilitator did not set a specific time for the process but monitored the discussions of the paired groups and as soon as the participants started to discuss other unrelated topics terminate the paired group discussions.

The focus group facilitator gave opportunity for volunteers to give feedback from the paired group discussions. The focus group facilitator summarised and recorded the outcomes on the flip chart (see Annexure E).

c) Focus Group Inquiry Phase 1: Step 2

The participants were asked to discuss Question 2 of the AI Interview Schedule during Step 2. The group was divided into three smaller groups of four each discussing the second question. No specific team leader was identified in the groups.

The focus group facilitator did not set a specific time for the process but monitored the discussions of the groups and as soon as the participants started to discuss other unrelated topics terminate the group discussions.

The focus group facilitator gave opportunity for volunteers to give feedback from the paired group discussions. The focus group facilitator summarised and recorded the outcomes on the flip chart (see Annexure E).

The group was given a 15 minute break during tea, coffee and refreshments were served before continuing with Question 3.

d) Focus Group Inquiry Phase 1: Step 3

The participants were asked to discuss Question 3 of the AI Interview Schedule during Step 3. The group was divided into three smaller groups of four participants each discussing the third question. No specific team leader was identified in the groups.

The focus group facilitator did not set a specific time for the process but monitored the discussions of the groups and as soon as the participants started to discuss other unrelated topics terminate the group discussions.

The focus group facilitator gave opportunity for volunteers to give feedback from the paired group discussions. The focus group facilitator summarised and recorded the outcomes on the flip chart (see Annexure E).

e) Focus Group Inquiry Phase 2

Question 4, however, was handled as a single group discussion facilitated by the focus group facilitator while recording and summarising the outcome for the entire group on the flip chart.

During the feedback sessions only two out of the 13 participants did not participate actively. However, it was observed that during the group discussion sessions these two participants did participate.

f) Focus Group Inquiry Closure

After completion of Question 4 the focus group facilitator concluded the Focus Group Inquiry. The express their positive experience of the Focus Group Inquiry to the extent that they wanted to give the future actions that a name with which they could identify and take ownership of. The researcher thanks everybody for their positive and constructed contribution before ending at 12h30.

3.3.4 Data Analysis

Literature expresses the view that it is of key importance that the analysis accurately reflects on the data for the research. The researcher should always refer back to the data in order to confirm the fit between the data and the analytical themes and categories that were developed (Daymon & Holloway 2011: 160). The researcher should start with a description of the data. During the initial phases of the data analysis everything is observed and described but as the appreciative aspects for the setting develop the researcher starts to focus on only what is important and relevant to the research. Some interactions and events are disregarded in favour of others based on their relevance to the research study.

The analysis will, as the research progresses become a story that reflects the sense or feeling and understanding of what is going on (Daymon & Holloway 2011: 160).

The qualitative data collected during the Focus Group Inquiry was analysed utilising thematic content analysis. The following six steps provided by Creswell

(2003: 191) were used in this study by the researcher during the data analysis process.

Step 1: Data was organised and prepared for analysis. This involved sorting and organising the data into different types depending on the sources of information. Data in this study was in the form of the records from the Focus Group Inquiry session. The data was sorted according to the AI interview schedule's questions per stakeholder grouping.

Step 2: The next step involves reading through the data to obtain the general sense of the information and to reflect on its overall meaning. It is important to get a feeling for the credibility, depth and usefulness of the data. Researchers sometimes start to organise data during this stage by means of side notes to capture general thoughts about the data. In this study the researcher read through the records and notes from the Focus Group Inquiry session facilitated by the experienced independent facilitator to identify emerging themes. These thoughts are noted in the records as side and margin notes as reminders for later processing.

Step 3: Detailed analysis begins with a coding process performed by the researcher in this study. According to Creswell (2003: 192) "*Coding is the process of organizing the material into "chunks" before bringing meaning to those "chunks".* The text data was categorised and labelled with a term. Creswell in Tesch (1990: 142-145) delineates the eight steps of the coding process as follows:

- Firstly, the researcher reads through all the interview schedules carefully in order to get a sense of the whole.
- The researcher identifies each participant interview schedule with a number and reads through it to get the underlying meaning while identifying generic topics.
- The researcher then makes a list of all the topics from the documents, clusters similar topics and forms these topics into columns that might be arranged as major topics, unique topics, and leftovers.
- The most descriptive wording for the topics was found and these turned into categories.

- There after the researcher reduces the total list of categories by grouping topics that relate to each other and emerge as themes.
- The data material belonging to each category is assembled in one place and a preliminary analysis performed.
- The existing data was recoded if necessary.

These steps engage the researcher in a systematic data analysis process. The researcher utilises this process, step by step, during the analysis of the data from the Focus Group Inquiry (Holloway 2005: 154-155).

Step 4: Evolves from the data using the coding process to generate a description of the setting or people as well as categories or themes. This involves a detailed rendering of information about people, places, or events in a setting. Afterwards the coding is used to generate a smaller practical number of themes, categories, and sub-categories for the research study. These themes appear as major findings in the qualitative study and are stated under separate headings in the findings sections of the study.

Step 5: Proceeds to reveal how the description and themes are to be represented in the qualitative narrative. This might be a discussion that mentions a chronology of events, at detailed discussion of several themes or a discussion with interconnecting themes. The researcher uses visuals, figures, or tables as adjuncts to the discussion. They convey descriptive information about each participant in a Table. The researcher gives a detailed description of each theme and how it has emerged from the data. This explanation and description are covered in Chapter Four Section 4.3.1.1 to 4.3.3.1.

Step 6: The final step in data analysis involves making an interpretation or finding a meaning in the data. It involves feedback on the outcomes of the study, or the lessons learned. It could also be a meaning derived from a comparison of the findings with information gleaned from the literature.

Once the data was analysed the researcher makes recommendations for the refinement of the CPD programme. These suggestions were formulated in recommendations for implementation by the private hospital for the refinement of the CPD programme as detailed in Chapter Five.

3.4 QUALITY IN RESEARCH

Professionals in applied fields should be able to trust research especially if they intervene in people's lives. To ensure reliability and validity in qualitative research requires that the research has been conducted in an ethical manner (Merriam 2009: 209; Keele 2011: 48). Research is judged by its quality and integrity which is an indication of the extent it conforms to the expected quality criteria. There is, however, a lack of consensus and agreement on how to define the notion of quality in qualitative research (Daymon & Holloway 2011: 77). Various researchers embark on three different perspectives:

- **Traditional:** Traditionalists argue that both quantitative as well as qualitative research should be judged against the same criteria and standards of reliability and validity.
- **Alternative:** Researchers argue that different criteria like authenticity and trustworthiness should be used for qualitative research.
- **Radical:** It is argued by some researchers that each research study should be judged against its own most appropriate characteristic such as intrinsically, intuitively or the research community in which it is situated (Daymon & Holloway 2011: 77-78).

Many researchers argue that reliability and validity in quantitative research is similar to trustworthiness/rigor in qualitative research (Merriam 2009: 209; Keele 2011: 48). As stated by Polit & Beck (2008: 539) a high-quality qualitative research study should be both descriptively explicit and sound. It should, however, also be interpretively innovative and rich, to ensure trustworthiness of a qualitative research.

The **Alternative** perspective of authenticity and trustworthiness is now the preferred criteria for the demonstration and judgement of quality in qualitative research (Daymon & Holloway 2011: 84). The integrity or how good the research is, is characterised through the concepts of authenticity and trustworthiness. These concepts are proven through researchers careful and accurate documentation of the research processes and decisions made and derived from the research (Daymon & Holloway 2011: 84). Furthermore Polit and Beck (2008: 539) suggested the use of Lincoln and Guba's framework of

four criteria i.e. credibility, dependability, conformability and transferability to ensure the quality of the research and research findings that was later adapted to include the fifth criteria of authenticity (Merriam 2009: 211; Daymon & Holloway 2011: 84).

3.4.1 Trustworthiness

The Appreciative Inquiry approach as a qualitative research design is designed to stimulate improvements through discovery and valuing, dialogue, envisioning and co-constructing the future resulting in a high level of dynamic participation by the participants (Preskill and Catsambas 2006: 2). Within this framework the researcher should, however, still ensure that systematic and rigorous processes are followed and maintained. Although various opinions are found in the literature regarding the use of the terms rigour or trustworthiness the most important issue for the researcher to remember is that independent of which terminology is used the researcher must show the truth-value of the research (Holloway 2005: 276). Appreciative Inquiry is a qualitative research and rigour is therefore based on checks and balances to ensure that the outcome of the research is trustworthy and authentic. For the purpose of this study the concepts of **credibility**, **dependability**, **conformability**, **transferability** and **authenticity** are used to ensure rigour and trustworthiness of the research outcomes and results.

The actions identified in Sections 3.4.1.1 to 3.4.1.5 to ensure rigor and trustworthiness in this study are summarised in Chapter One Table 1-4: Summary of actions to ensure quality in research for this study.

3.4.1.1 Credibility

Credibility refers to the confidence that can be drawn on the truth of the data and the interpretation based upon the data. Credibility is considered an overriding objective of qualitative research. The research should strive to establish credibility through confidence in the truth of the results and findings for the participants and within the context of the research. To establish credibility in a research study it is firstly important to carry the research out in such a way that belief in the results and findings is enhanced and secondly, through steps

that demonstrate credibility to readers (Polit & Beck 2008: 539; Merriam 2009: 210).

The researcher should formulate the research findings in such a way that it “*makes sense*” to the reader. The way the researcher designs the study and applies well-developed standards accepted by the scientific community, ensures the trustworthiness of the research (Merriam 2009: 210). Credibility hinges on what reality means. Merriam (2009: 213) concludes that reality is “*what we choose not to question at the moment*”. Merriam (2009: 213) continues to say that “*data do not speak for themselves; there is always an interpreter, or a translator*”. It is therefore clear that credibility is not measured in terms of reality but something else. It is pointed out by Maxwell (2005: 105) that reality cannot really be captured. Credibility is therefore a goal rather than a result and is relative. In conclusion Merriam (2009: 213), according to Lincoln and Guba (1985) states that “*something else*” is the question. “*Are the findings credible given the data presented?*”

The researcher is an experienced nurse educator and to ensure creditability followed the research process and data collection process in a strict manner as indicated in the study. The research findings were co-coded by experienced supervisors pertaining to qualitative data analysis before the findings were concluded.

3.4.1.2 Dependability

Dependability refers to the reliability or stability of data over a period of time and under various conditions. Dependability should be able to ensure that if the research is repeated with the same research set up and participants within the same context, the same results and findings would be reached. Dependability is a pre-requisite to ensure credibility (Polit & Beck 2008: 539; Merriam 2009: 220).

As pointed out by Merriam (2009: 221) dependability is problematic in the social sciences purely because of the fact that human behaviour is never static. It is also a fact that what many experience is not necessary more dependable than what one individual experiences. The more valid question is whether the results

and conclusions are consistent with the collected data. When the research results make sense in terms of the data collected the results and conclusions are consistent and dependable (Merriam 2009: 221). To ensure dependability the researcher must be able to account for the data used while conforming to process and procedure (Holloway 2005: 143).

The researcher maintained all documentation from the research process to be available for auditing to ensure dependability. The researcher also ensures that an audit trail has been established to show how decisions are related and derived from the data collected. By doing so the findings derived from the data are open for scrutiny (Holloway 2005: 143).

3.4.1.3 Confirmability

Confirmability relates to the fact that the data is representative of the information provided by the research participants and not figments of the research inquirer's imagination. Confirmability touches on objectivity of the interpretation of data and the data's relevance, accuracy, or meaning. This criterion is all about representation of the participants and not about the bias, perspective or motivation of the researcher (Polit & Beck 2008: 539). In addition Melnyk and Fineout-Overholt (2005: 151) continue to conclude that confirmability in research is the ability to prove substantiation that the interpretation and findings of the research study are founded on the data collected.

Confirmability therefore refers to the degree that the findings and results of the research study are the product of the inquiry data (Graneheim & Lunman 2004: 109; Steubert-Speziale & Carpenter 2007: 49). Simultaneous data collection and analysis during qualitative inquiry normally lead to excellent confirmability (Polit & Beck 2010: 500).

To ensure confirmability, the researcher used an Focus Group Inquiry supported by an AI interview schedule facilitated by an experienced independent facilitator during the data collection process, and the data from the Focus group Inquiry was documented on the AI interview schedule and flip charts provided during Phase 1. Phase 2 of the Focus Group Inquiry was also recorded on the flip chart

and audio recorded to ensure that the essence of the action plan was captured. This ensured that the data from the Focus Group Inquiry is always available to be verified by the participants.

3.4.1.4 Transferability

Transferability primarily deals with the generalisability of data and the extent of transferability or applicability of the results and findings to other groups or settings (Polit & Beck 2008: 539; Merriam 2009: 223). The researcher should provide sufficient data of a descriptive nature in the research report to allow other researchers or users to evaluate the research findings for applicability to other research settings or context. Although the researcher cannot specify the external validity of a study, he can supply sufficient description for interesting parties to make an assessment of the possibility to transfer research findings (Polit & Beck 2008: 539). In qualitative research the researcher is often not interested whether the results can be utilised or applied in more settings but in understanding the particular phenomenon in depth (Merriam 2009: 224).

The study was limited to the specific private hospital where the study was done, but the researcher compiled the detailed report on the process followed to conduct the research, which provides other researchers with data to use in order to replicate the study for other settings.

3.4.1.5 Authenticity

The concept of authenticity includes the concepts of fairness, sharing of knowledge and action (Daymon & Holloway 2011: 84). Authenticity reflects the mood, experience, feeling, language and context of the lives of the research participants when the researcher is fair and faithful in his range of reality. When the research text is authentic, readers are able to assess and understand the lives of those participating in the research (Polit & Beck 2008: 540).

A research study can also be judged authentic when the strategies that were used by the researcher are appropriate for the correct and accurate reporting of the participants' description and ideas. When the study is fair and when it helps and supports research participants as well as similar groups to understand their environment to improve it (Daymon & Holloway 2011: 84). Authenticity is

usually of high importance in participatory research studies where the researcher and participants' objectives are to collaboratively build strategies to bring about change (Daymon & Holloway 2011: 84).

In this research study a Focus Group Inquiry under the leadership and facilitation of the experienced independent practitioners was used to capture the mood, experience and feeling of the research participants to ensure authenticity. The Focus Group Inquiry was guided by a predetermined AI Interview Schedule and recorded against the specific questions (see Annexure C and E).

3.5 SPECIFIC ETHICAL CONSIDERATIONS

The credibility and dependability of a qualitative research study depends to a large extent on the ethics of the researcher (Merriam 2009:228). Research studies should consider the rights of the individual that participate in the study. In this study the researcher uses the three primary principles from the Belmont Report of beneficence, respect for human dignity and justice as the standard of ethical conduct (Polit & Beck 2008: 170). Table 3-3 summarises the specific application utilised in this study to ensure that the researcher complies with the requirements from the Belmont Report on ethical considerations.

Table 3-3: Application of ethical considerations in this study

Beneficence	
The objective is to minimise harm and maximise benefit for the participant and the society (Holloway 2005: 26; Polit & Beck 2008: 170; Burns & Grove 2009: 198)	
Application in this study	
<ul style="list-style-type: none"> • Right to freedom from harm and discomfort 	<ul style="list-style-type: none"> • Participants were given the assurance that information will be handled confidentially • Participants names will not be disclosed in the research report or findings • The Focus Group Inquiry was held in a comfortable and safe setting • The data collection was conducted according to the rules and requirements of the University of Pretoria and the selected hospital under study • Participants attended the focus group discussion during working hours (all received pay for the hours by the hospital) • An experienced independent facilitator was utilise by the researcher
<ul style="list-style-type: none"> • Right to protection from exploitation 	<ul style="list-style-type: none"> • Participants were given the assurance that information will be handled confidentially and will not be utilised against any participant • Although the researcher has a special relationship with the participants due to the researcher’s position as Clinical Facilitator, attendance was voluntary. Only 13 of the 20 invited nurse practitioners attended the Focus Group Inquiry

Respect for human dignity	
The objective is to assure confidentiality and consent during the research process (Polit & Beck 2008: 171; Burns & Grove 2009: 189)	
Application in this study	
<ul style="list-style-type: none"> • Right to self-determination 	<ul style="list-style-type: none"> • Participants received a full background to the study in the invitation letter to participate. View Annexure B • Participants received an introduction to the study in the beginning of the data collection Focus Group Inquiry before the participants were requested to sign an informed consent letter. View Annexure B
<ul style="list-style-type: none"> • Right to full disclosure 	<ul style="list-style-type: none"> • The researcher fully disclosed the objectives and aims of the study to the hospital management and received approval from the hospital to conduct the study • Participants were given the right not to attend or withdraw from the study at any time without interference from the researcher to prevent the participant to withdraw • The researcher maintained an audit trail during the data collection and analysis process to assure auditability of the process to prevent bias.

Justice	
The principle of justice refers to receiving fair and equitable treatment and that privacy will be respected (Polit & Beck 2008: 173; Burns & Grove 2009: 198; Jooste 2011: 278)	
Application in this study	
<ul style="list-style-type: none"> • Right to fair treatment 	<ul style="list-style-type: none"> • 20 participants were invited that complies with the study population criteria • All participants were given the assurance that there will be no discrimination against them if the participant chooses not to participant • The data collection process was facilitated by an experienced independent facilitator who handled the participants with the required respect and tact
<ul style="list-style-type: none"> • Right to privacy 	<ul style="list-style-type: none"> • The participants were given the assurance by the researcher that all data and information supplied will be handled in strict confidence

3.6 CONCLUSION

Chapter 3 outlines the research design and methods implementation used during this study. The chapter covered the objectives, methods and techniques used during the data collection and analysis as well as actions implemented to improve and enhance quality in research in depth. The specific ethical issues considered during the study were also discussed.

Chapter 4 reflects the views of the research participants during the Focus Group Inquiry held pertaining to the current CPD programme in the private hospital.

4

RESEARCH FINDINGS AND LITERATURE CONTROL

"Don't be afraid of the space between your dreams and reality. If you can dream it, you can make it so"

Belva Davis

4.1 INTRODUCTION

Chapter 3 discussed the research design and methods utilised in this research study in depth. The chapter furthermore stated the objectives of the research as well as the process followed to conduct the research.

In Chapter 4, the focus is on the research findings and literature control of the data obtained during the Focus Group Inquiry with participating nurse practitioners from the critical care (CCU) and high care (HCU) units in the private hospital in Gauteng.

4.2 OVERVIEW OF RESEARCH FINDINGS

The findings are presented according to the questions asked on the AI Interview Schedule. The AI Interview Schedule was guided by the 4-D cycle of Appreciative Inquiry. The data from the Focus Group Inquiry was coded into the themes, categories and subcategories (see Table 4-1). Each theme, category and subcategory is discussed with supportive literature.

The first three Ds of the 4-D cycle of AI were used during the Focus Group discussion during **Phase 1** of the data collection process to achieve Objective 1: **Explore and describe views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng** as stated in Section 1.4 while **Phase 2** of the Focus Group Inquiry utilised the 4th D of the 4-D cycle of AI to achieve Objective 2: **Make recommendations to refine the current CPD programme in the private hospital to the hospital management** as stated in Section 1.4.

4.3 PHASE 1: EXPLORE CURRENT CPD PROGRAMME

Phase 1 of the Focus Group Inquiry was utilised to achieve Objective 1 set for this research study.

Explore and describe views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng.

During Phase 1, the first three Ds of the 4-D cycle of AI namely Discovery, Dream and Design utilising a specific question with each step guiding the Focus Group Inquiry (see Annexure C). The data from the Focus Group Inquiry was coded into the themes, categories and subcategories (see Table 4-1). Each theme, category and subcategory is discussed with supportive literature Sections 4.3.1 to 4.3.3.

Table 4-1: Summary of Research Findings from Phase 1

	Themes	Categories	Sub-categories
Step 1: View of current CPD programme	In-service training	Expert training	Product specialist
			Clinical Facilitator
			Medical Practitioners
			Unit Manager
		Educational Methods	On-the-Spot training
			Demonstration
			Workshops
			Clinical rounds
			Simulation

	Themes	Categories	Sub-categories
Step 2: Desired CPD programme	Workplace learning environment	Learning opportunities	Time
			Needs
			Availability of experts
		Facilitate and promote learning	Co-operative Learning Climate
			Encourage learning culture
			Recognition/Rewards
Step 3: Aspects that needs to be addressed	Management	Funding	
		Project Manager	

Each question and related themes, categories and sub-categories are discussed in-depth below.

4.3.1 Question 1: Discovery – View of Current CPD Programme

The following question was asked to the participants during Phase 1 Step 1 of the Focus Group Inquiry (see Annexure E):

Reflecting back on the continuous professional development programme in the private hospital what was most satisfying/peak experience?

A summary of the findings from the *Discovery* question related to the CPD programme is summarised in Table 4-2.

One theme emerged from the data namely *In-service Training*, two categories namely *Expert Training* and *Educational Methods* and nine subcategories emerge

from the findings. Each of the themes, categories and subcategories are discussed as well as supportive literature provided (see Sections 4.3.1.1 to 4.3.1.3).

The detail outcomes from Question 1 of the Focus Group Inquiry are summarised in Annexure F.

Table 4-2: Summary from the Discover question

Themes	Categories	Sub-categories
In-service training (Section 4.3.1.1)	Expert training (Section 4.3.1.2)	Product Specialist (Section a)
		Clinical Facilitator (Section b)
		Medical Practitioners (Section c)
		Unit Manager (Section d)
	Educational Methods (Section 4.3.1.3)	On-the-Spot training (Section a)
		Demonstration (Section b)
		Workshops (Section c)
		Clinical rounds (Section d)
		Simulation (Section e)

4.3.1.1 In-Service Training

In-service training was identified by the participating nurse practitioners as the important element in the current CPD programme that they perceived as being positive and should be built into in the design and improvement of the CPD programme.

Supportive quotations:

- "In-service training teaches you about different things in relation to the patient and makes it more practical."
- "In-service training gives you a feeling of belonging and lets you have knowledge of the hospital."
- "In-service programmes used to have value when they were still presented."

Literature control: In-service training in the healthcare environment refers to the training experience that nurse practitioners have during their service to improve professional skills, knowledge, attitudes and values based on the healthcare institutions and unit's demands but also incorporated the nurse practitioner's own needs (Muller 2009: 350; Munro 2008:955).

An in-service training programme should be assessed, planned and implemented according to the principles of an education programme (Davids 2006: 5; Muller 2009:351). In addition Muller (2009: 351) defines the purpose of in-service training as a mechanism to communicate, train and prepare the nurse practitioner for changes and new developments implemented by the health care institution. In-service training further ensures effective and efficient functioning of the nursing unit and the nurse practitioners within the team context of the unit. Shortcomings of skills, knowledge, attitudes and values based on the healthcare institutions and unit's demands are addressed during in-service training (Bahn 2006: 723). In the opinion of Davids (2006:5) institutions providing in-service training also contribute to the nurse practitioners' continuous personal and professional development.

Because nursing care is a practice-based profession, it is important to establish the opportunity for continuous professional development and learning through work as an accredited and valid programme as part of life-long learning of the nurse practitioner (Munro 2008: 955). According to Ghaye and Lillyman (2010: 109) learning from practice not only satisfies statutory and company requirements but gives personal satisfaction in the patient care that the nurse practitioner provides. It is the view of the researcher that the nurse

practitioners, as adult learners, are problem and tasks orientated and will value the immediate application of the learning content presented to them through in-service training (Bahn 2006: 724; Gravett 2008: 10; Muller 2009: 331).

Two categories namely *Expert Training* and *Educational Methods* emerge from the first theme *In-Service Training* supported by nine sub-categories that will be discussed in Sections 4.3.1.2 and 4.3.1.3

4.3.1.2 **Experts training**

The first category that the participants identified under the theme of *In-Service training* was the training provided by experts. They identify various experts that have a positive impact on their professional development as tabulated in Table 4-2 as sub-categories that are discussed in Section 4.3.1.2.

Supportive quotations:

- "Training must be given by experts."
- "We have doctors that are experts in their field and want to share their knowledge with us."

Literature control: An expert is a practitioner who functions from a knowledge and intuitive base. Experts have developed through years of experience combined with continuous professional learning and development activities, a comprehensive and expanded knowledge base (Jasper 2007: 30). Experts, as complex and critical thinkers, are reflective on what they do and operate from an understanding of the holistic situation to solve complex issues. Experts, although capable, tend to work collaboratively with multi-disciplinary professional teams when needed to ensure safe patient care. They are acknowledged for their leadership role in their area of speciality, research and practice (Jasper 2007: 30; Muller 2009: 346).

Experts adopt various roles depending on the situation. These include that of leadership, mentorship, being a change agent, role model, and expert witness as and when required. They are also seen as sources of authority and used in the process to influence policy, practice development and governance (Laurer 2006:

6; Jasper 2007: 30). Expert participation has the potential to motivate nurse practitioners to perform at their best and inspire them to become experts themselves (Launer 2006: 6). They organise their work and those of other members in the team while supervising them effectively (Hansten 2009: 141).

According to Wahab and Selamat (2011: 61) expert status is earned. Workers therefore decide when they consider someone to be an expert. Trainers and mentors have no guarantee that they are seen by the staff as being experts. The absence of or inaccessibility of experts reduces guidance and support that leads to frustration that negatively impacts on the speed of learning and decision-making (Wahab & Selamat 2011: 61). Experts, however, should be careful not to overpower the nurse practitioner because this can make the nurse practitioner to behave defensively. This might cause the nurse practitioner to withdraw and accept everything the expert says without questioning it. On the other hand this might frustrate and challenge the expert (McKimm & Swanwick 2010: 55).

Experts can be identified by their ability to intuitively grasp the situation and then focus directly on the problem without wasting scarce resources. Experts are able to effectively and efficiently lead a team (Hansten 2009: 141). According to Hansten (2009: 141) an expert is someone who can manage others skilfully while attending to items that go unnoticed by most less experienced nurse practitioners. However, experts sometimes find it difficult to be good educators because they battle to break down their intuitive, rapid way of thinking into steps required to clearly describe it to others (Hansten 2009: 141).

The objective of a CPD programme is to enhance the ability of nurse practitioners to provide competent and safe patient care. According to Parks and Jones (2010: 142) Benner's "From Novice to Expert" framework a process is proposed where the nurse practitioner progresses through three levels of skills performance: (a) a change from confidence about abstract principles to the application of concrete experience; (b) a change in the learner's awareness of the demand situation as a whole; and (c) a change from observer to active performer. In conclusion, Quinn and Hughes (2007: 372), however, point out that Benner does accept the fact that "*all nurses are not capable of becoming experts*".

According to Gravett (2008: 49) educators must express a sense of enthusiasm and describes an enthusiastic educator as someone who “*cares about and values their subject matter. They teach it in a manner that expresses those feelings with the intent to encourage similar feelings in the learner. Emotions, energy and expressiveness are outwardly visible in their instruction*”.

The four sub-categories identified in support of the category “Experts’ Training” are discussed in Sections a) to d).

a) Product Specialist

Training supplied by subject matter experts namely *Product Specialists*, was rated highest by the participants with seven of the 13 participants identifying these expert training sessions as peak experiences in the current CPD programme.

Supportive quotations:

- “For me training by product specialists was one of the peak experiences, even HC staff understood it.”
- “Persons who present it were up to date and I learnt a lot.”
- “The product specialist teaches me how to trouble shoot, it make me feel safer and I felt empowered.”

Literature control: In the opinion of St-Pierre, Alderson and Saint-Jean (2011: 2) nurse practitioners new to intensive care units experience a high level of stress and fear before the nurse practitioner reaches technological competence. The authors are also of the opinion that poorly prepared nurse practitioners then rather focus on the equipment instead of safe patient care. This again in the long run leads to a feeling of overload and stress by the nurse practitioner.

As confirmed by Munro (2008: 959) the use of product specialists to train nurse practitioners in the use of equipment or to develop new skills and competence is of great use. Literature, however, stressed that it is important to also address the underpinning fundamental knowledge to the process supported by the equipment (Munro 2008: 959). The fast changes in technological advances

require nurse practitioners to be constantly adapted to new processes and equipment to maintain effective and practice safe nursing care. Nurse practitioners should be aware of how equipment operates inclusive of any special features. The quest for economic demands and quality led to applying the latest techniques and equipment that requires training by product specialists as the experts on the equipment (Bahn 2006: 723; Jooste 2011: 99). The information in manufacturers' publications, training and demonstrations supplied by product specialists and experts are valuable sources of expert knowledge on technology and device education (McKinley 2007: 118).

b) Clinical Facilitators

The participants identified the training provide by the clinical facilitators as one of the most satisfying experiences on the part of five of the 13 participants reference the in-service training provided by clinical facilitators.

Supportive quotations:

- "Clinical facilitators teach me to understand why I do things – make me feel safer."
- "Clinical facilitators' evaluations help me to realise what I know and what I do not – could improve my knowledge."
- Clinical facilitator training about cardiac output give me insight – can apply it daily."

Literature control: According to McKinley (2007: 25) an expert "*is an individual who has achieved a level of role maturity*". These individuals, either a clinical facilitator or a clinical nursing specialist are viewed to be team players and "doers" who help others through mentorship and empowerment to grow in their jobs and careers. Literature uses the term clinical facilitator, clinical nursing expert, clinical educator and supervisor interchangeably in some instances (McKinley 2007: 25). A clinical facilitator is also defined by Quinn and Hughes (2007: 488) as the primary nurse practitioner with mentor and educational co-ordination status responsible to be actively involved in supporting the learning of nurse practitioners in a practical environment. The role of the clinical facilitator

in the learning environment is described by Quinn and Hughes (2007: 488) as that of teacher/practitioner, clinical teacher, education facilitator, practice educator, practice development nurse/facilitator, and educator/practitioner.

The use of these various terms for the clinical facilitator clearly indicates the role and responsibilities expected from the facilitator. The responsibilities of the clinical facilitator include among others the support of the nurse practitioner during developmental and learning opportunities and the mentoring of the nurse practitioners in continuous professional development planning and execution (Quinn & Hughes 2007: 486). To facilitate by definition means "to make easier". Learning on the other hand, is the ability to gain understanding or knowledge through a process of study, instruction or experience. The purpose of development is not only the acquisition of knowledge but also the ability to apply that knowledge to practice in a competent fashion (McKinley 2007: 92). A clinical facilitator's ability to facilitate learning develops with personal education and development, experimentation, experience and mentoring (McKinley 2007: 92).

The clinical facilitator has to act as a positive role model, be motivated and conveying knowledge and skills enthusiastically while maintaining collegial or person-to-person relationships with the nurse practitioners during the process of continuous professional development (Muller 2009: 347). The clinical facilitator, as expert, is responsible to stimulate critical thinking through interactive debate while also being prepared to learn in the process. The clinical facilitator should ensure that appropriate learning opportunities exist utilising the most appropriate educational methods for the transfer of knowledge and skills. The clinical facilitator should, however, ensure that the educational process is planned and purposeful creating a secure environment for the nurse practitioners to learn (Muller 2009: 347).

Literature supports the impact that clinical facilitators have in the continuous professional development of nursing practitioners (Nell 2007: 1). Because clinical facilitators dealt with adult learners it is important to note that there is a co-responsibility between the two role players i.e. the nurse practitioner and the clinical facilitator to ensure effective learning (Muller 2009: 347). The goal of a clinical facilitator is "The development of a nursing practitioner to be accountable

for the continuous improvement of quality nursing care". The benefits of clinical facilitation are that it increases staff morale, improves the quality of nursing care, increases the effectiveness of change, and has an input on the recruitment and retention of staff (AMNCH [n.d.]).

An important observation from McKinley (2007: 102) is that it must be remembered that not all learning needs to be facilitated by the clinical facilitator or the clinical nursing specialist. Other experts like physicians, dieticians, respiratory therapists, and pharmacist might be used when appropriate (McKinley 2007: 102).

c) Medical Practitioners

The participants identified the *Expert training* that they received from medical practitioners to be of equal importance to the training provided by clinical facilitators with five of the 13 participants identifying it as a peak experience in the current CPD programme in the hospital.

Supportive quotations:

- "If the doctors are involved in training it creates a team spirit and we appreciate their inputs."
- "I learn more from the doctor in ten minutes than I learn during a six hour workshop."
- "Prefer to learn from the doctor that is an expert in his field."

Literature control: Traditionally the different professions in healthcare follow different approaches to professional development. As the environment and work of health care professionals change for a readiness to cross traditional boundaries the requirement for inter- and multi-professional training increases. It is argued by Quinn and Hughes (2007: 452) that inter-professional training and education breaks down the traditional silos between the different professions in the healthcare environment facilitating cultural changes and enhancing teamwork. Literature suggests that due to the increasing complexity of the healthcare function and demands on the nursing practitioner, increased collaboration through multi-professional and shared learning programmes

improve professional development, teamwork and practice (Quinn & Hughes 2007: 452; Collin et al. 2010: 1).

In the opinion of Quinn and Hughes (2007: 452), the tendency for the future is the willingness to share knowledge and skills within a multi-professional team giving up exclusive claims to specialisation in order to meet patient needs effectively. The medical practitioner, as member of the multi-professional team, is considered to be an expert because the practitioner is trained to function effectively as a consultant who can integrate the roles required to present optimal patient-centred medical care. Medical practitioners are able to establish and maintain clinical knowledge and skills while performing complete patient assessments. While able to seek appropriate consultation from other health professionals' medical practitioners recognise the limitations of their expertise (Boyle 2007: 9; Ramani & Leinster 2008: 358).

Inter professional training has a number of benefits for the various role players. For the nurse practitioners inter-professional training and learning provides the nurse practitioner with a better understanding of the various role players' responsibilities in the team creating an environment where the nurse practitioners know what is expected from them in the ward. The medical practitioner on the other hand learned to have a better understanding of his colleagues in the team while using the opportunity to provide expert knowledge and training (Boyle 2007: 9). The responsibility to identify learning opportunities for the nurse practitioner is, however, not the responsibility of the medical practitioner. Learning and education should be part of the daily functioning of the unit. The responsibility to identify and utilise development opportunities, that can be presented by medical practitioners remains with the individual nurse practitioner (Muller 2009: 334). Medical practitioners involvement in on-the-spot training become more apparent because of their interaction with other professionals such as nurse practitioners who have established on-the-spot training opportunities as part of their recognised training methodologies (Launer 2006: 2).

d) Unit Manager

The participants identified the Unit Managers as the fourth most satisfying experience to receive training from as part of the current CPD programme in the hospital with one of the 13 participants listing it as a peak experience. They specifically associate orientation and procedural development with the Unit Manager.

Supportive quotations:

- "Sr R is an expert in her field and her informal training was of great value."

Literature control: The role of the unit manager is to create an environment conducive for learning and development while actively participating in the development of nurse practitioners in the unit. The unit manager should establish an environment that encourages open-mindedness for critical questions and debate in the unit (Quinn & Hughes 2007: 345; Meyer et al. 2009: 168; Muller 2009: 334). The unit manager as part of the CPD programme is therefore responsible to effectively communicate, have a professional attitude towards nursing and a good knowledge of the unit. The unit manager, because of knowledge of the illnesses of the patients can speak on behalf of a patient and provide valuable inputs regarding the patient's treatment (Meyer et al. 2009: 165). The unit manager being responsible for safe quality patient care is co-responsible with the nurse practitioner to be a role model to the nurse practitioners in the ward (Meyer et al. 2009: 167).

According to Hawes (2009: 13) the knowledge and clinical experience that the unit manager has is of vital importance to the development of a safe patient care environment. The unit manager is overall responsible for the unit's quality and safety of patient care (Hawes 2009: 14; Meyer et al. 2009: 165). Included in the requirement for quality is the responsibility to monitor and maintain the professional standards of the nurse practitioners in the unit through empowerment, problem-solving and mentoring of staff (Hawes 2009: 15; Meyer et al. 2009: 161). The ideal unit manager is defined by Hawes (2009: 17) as a

manager who develops her staff through leadership, mentoring and modelling (Australian Nursing Federation 2003: 2).

In the opinion of Meyer et al. (2009: 166) CPD is a unique challenge for a unit manager due to the fact that the unit manager should merge a diverse group of nurse practitioners with various levels of expertise and experience. The unit manager should create opportunities relevant to the unit for the nurse practitioners to develop professionally. The unit manager as expert has to demonstrate sound knowledge in the clinical field while being knowledgeable in management processes (Meyer et al. 2009: 166).

According to Munro (2008: 254) quality patient care should be a collaborative effort amongst the stakeholders in the healthcare environment. The unit manager, the clinical facilitator, and the nurse practitioners are collaboratively responsible for professional development of nurse practitioners in the unit (Australian Nursing Federation 2003: 2). If collaboration is not realised it become difficult to implement a CPD programme successfully or to improve the quality of patient care (Muller 2009: 256). The unit manager as an expert clinician is responsible to establish the standard of nursing care while ensuring a work environment that encourages nurse practitioners to strive towards and achieve excellence in patient care (Australian Nursing Federation 2003: 2).

4.3.1.3 Educational Methods

During Phase 1 of the Focus Group Inquiry the participants also identified the different educational methods as a second category of the current CPD programme that should be maintained and built on for the improved CPD programme in the hospital.

Literature control: In the opinion of Muller (2009: 347) "*Knowledge makes sense only if the learner understands its application value*". This conclusion requires that the most appropriate educational method and models should be utilised for the effective transmission of knowledge (Launer 2006: 6). There is a wide range of educational methods and strategies available to the nurse educator. In the selection of the most appropriate educational method consideration should be given to the objective of the learning opportunity. The

choice of the appropriate educational method largely depends on the situation and the individual's abilities (Quinn & Hughes 2007: 188; Bruce et al. 2011: 193).

As stressed by Bruce et al. (2011: 193) educational strategies and methods should match the educational approach at all times as well as the developmental requirements of the nurse practitioner.

The five sub-categories identified in support of the category *Educational Methods* are discussed in Sections a) to e).

a) On-the-Spot training

The participants identified the *On-the-Spot* training method as one of the most satisfying experiences with eight of the 13 participants referencing it in their feedback.

Supportive quotations:

- "On-the-Spot training is the best. Need the knowledge now. Doctor explains it and I can apply it."
- "Learning from Dr T on the spot was excellent – will always remember it."
- Dr W helps me to apply the theory better because he teaches me on the spot."

Literature control: On-the-Spot training or teaching moments are described in the literature as a situation where a nursing interaction is also utilised as learning and training opportunities. This is normally an unplanned event that enables the nurse practitioner to learn on the spot (Launer 2006: 12; Muller 2009: 341). The method of training is specifically uses by the unit manager or the clinical facilitator of the unit (Muller 2009: 341). On-the-Spot training's primary function is the enhancement of patient quality care while maintaining respect for the dignity or without harming the patient (Meyer et al.2009: 161). According to Muller (2009: 334) learning and education should be part of the daily routine and functioning of any nursing unit.

On-the-spot training and support occurs throughout the career development of nurse practitioners. On-the-spot training often forms the most important element of a nurse practitioner's professional development and supports the process to retain nurse practitioners because it prevents stress and burnout (Launer 2006: 2). All on-the-spot situations contain an element of professional development as well as standard-setting and monitoring (Launer 2006: 1). On some occasions the focus will, however, be entirely on personal and professional development (Launer 2006: 3).

Learning and instructions like giving information, demonstrating, questioning, problem-solving, directing learner's work, observing and assessing learner's performance, and providing feedback through direct personal interaction between the educator and nurse practitioner are all examples of on-the-spot training activities. In medical education, case presentation and bedside rounds by the doctor are also often a part of on-the-spot training activities (Teaching Strategies/methodologies, 2003: 2). On-the-spot moments are also defined by Launer (2006: 2) as "*an exchange between professionals to enable the development of professional skills*". An alternative view offered by Launer (2006: 2) for on-the-spot learning is to "*facilitate learning in relation to live practical issues*". On-the-spot teaching tends to occur spontaneously as part of everyday practice. This includes spontaneous one-on-one teaching that arises during the performance of nursing procedures or simply by asking appropriate questions (Quinn & Hughes 2007: 204).

b) Demonstrations

Demonstrations by various experts were identified by three of the 13 participants as peak experiences in the current CPD programme.

Supportive quotations:

- "Can stay up to date with equipment after step-by-step demonstration."
- "Practical demonstration of equipment helps me to be safe at bedside."
- "After demonstrations I have knowledge how to trouble shoot and feel more empowered to do my job well."

Literature control: A demonstration is a process where the educator shows the recipient how a specific interaction or procedure is performed. The expert uses the demonstration to show step-by-step how the task should be executed while encouraging questions to stimulate the learning process. Various methods can be used to present the demonstrations like a direct demonstration or through the use of a video. In situations where a patient is used as part of the demonstration it is essential to fulfil the requirements for ethical and legal principles (Muller 2009: 340-341).

Demonstrations are good for the transfer of theory to practical applications. Participants are given the opportunity during the demonstration to practice what has been covered during the demonstration (Teaching Strategies/methodologies 2003: 2). Demonstration as a learning method can be utilised with small and larger groups. As stated by Adekoya and Olatoya (2011: 321) the effectiveness of learning is, however, greater in smaller groups. Demonstration strategy is considered to be a strategy that challenge participants to “learn how to learn” while working collaboratively in groups seeking solutions to problems. Participants that encounter new concepts for the first time need strategies to acquire the new knowledge (Adekoya & Olatoya 2011: 322).

c) Workshops

The participants identified the *Workshops* that they attend as being of equal importance to the training they received through *Demonstrations* with four of the 13 participants identifying them as peak experiences of the current CPD programme in the hospital.

Supportive quotations:

- “Prefer training sessions once per month. It gives an opportunity for feedback on hospital issues and keeps staff up to date.”
- “Formal training sessions are best for the HC staff because we cannot learn in the busy unit where it is all about admissions and discharges.”
- In a busy unit like HC staff working with patients does not have the time to learn anything. Six-hour sessions are much better.”

Literature control: Workshops are a useful teaching methodology where the participants are removed from their busy daily activities. If well planned with a clear purpose, workshops are an effective teaching methodology for applying theoretical principles (Muller 2009: 343; Myers 2011: 1). Workshops normally take on the form of didactic presentations of the information involving a large group of nurse practitioners (Teaching Strategies/Methodologies 2003: 3).

Workshops are an effective and popular teaching method for the dissemination of new information. They create a social interaction between nurse practitioners that enhance professional development (Myers 2011: 1; Steinert 2011: 1). Many types of professional development are called workshops including lectures and seminars. Care should, however, be given to ensure that workshops are active with an emphasis on problem-solving (Steinert 2011: 1).

d) Clinical rounds

The participants in the study identified multi-disciplinary rounds, doctor's patient rounds or clinical nurse unit rounds as the fourth important educational method with six of the 13 participant referencing it as a peak experience of the current CPD programme.

Supportive quotations:

- "Learning during doctor's rounds is of great value because you remember it."
- "Did learn from the multi-disciplinary team during rounds – help me to stay up to date."
- Know what to do after doctor's rounds because he likes to share his knowledge with us."

Literature control: Clinical rounds are a structured setting where the key clinicians involved in the patient's care gathered to consult and co-ordinate the patient care plan. The needs of the patient drive dialogue and discussions correlating theory with practice. It also provides the opportunity for the multi-disciplinary team to plan and evaluate the patient's treatment (Quinn & Hughes 2007: 365; Meyer and Van Niekerk 2008: 174-175; NSW Department of Health

2011: 4). Clinical rounds are patient-focused and may be utilised with great success during training through the process of information sharing, problem-solving and treatment planning (Muller, 2009: 341; NSW Department of Health 2011: 5).

Clinical rounds can be applied with the same success within the clinical nursing unit because nurse practitioners have the opportunity to access the skills that everybody in the team have to offer (Muller 2009: 341; NSW Department of Health 2011: 6). The educational method is very effective in settings where there are clinical facilitators or mentors responsible for clinical and educational accompaniment for the unit (Muller 2009: 341).

From a study performed by Boyle (2007: 9) it is concluded that doctors indicate that they have a better opportunity to provide training during clinical rounds to the multi-disciplinary team. Clinical rounds as a training method are less like to interrupt the doctor's time and therefore waste less time. Because the team know each other well, training is focused on areas not previously covered or on areas indicated where there is a lack of knowledge or competence (Boyle 2007: 9). Clinical rounds create an environment of acknowledgement that leads to increased job satisfaction and increased accountability within the team while it positively affects patient outcomes and stay (NSW Department of Health 2011: 6, 9). Clinical rounds promote and reflect a professional and personal life-long learning culture (NSW Department of Health 2011: 8).

Clinical rounds offer rich learning opportunities for the integration of clinical theory and practice. The inclusion of other members of the medical team makes the clinical round unique in terms of interdisciplinary learning opportunities (Bruce et al. 2011: 270).

e) Simulations

The unexpected feedback from the participants is the identification of the value of *Simulation* in the current CPD programme with the lowest identification rate of only one of the 13 participants identifying it as an important educational method. The Focus Group Inquiry uses the term *Mocks* which is in its nature simulation of a real situation for the purpose of training. The researcher

therefore uses the term *Simulation* because this is also the terminology used in the literature.

Supportive quotations:

- "For me basic life support and mock recuses are very interesting and helpful. When I need to apply it to a patient I could do it and save a life."

Literature control: Simulation is defined by Meyer and Van Niekerk (2008: 175) as "*the imitation of a real-life situation, usually in simplified form*". Simulation includes a variety of techniques and approaches applicable to the various training requirements. Simulation can be used at all levels of practice, from novice to experts (Ker and Bradley 2007: 2). It creates a training environment where the trainee can make as many mistakes as possible until he or she is competent while no harm is done to any patient (Teaching Strategies/Methodologies 2003: 1; Quinn & Hughes 2007: 254; McKimm & Swanwick 2010: 133).

The objective of simulation is to prepare the nurse practitioner for real-life situations but without a real patient involved and the related anxiety. This allows the nurse practitioners opportunities to develop their skills in a low-risk setting (Ker & Bradley 2007: 3; Quinn & Hughes 2007: 254; Meyer & Van Niekerk 2008: 175). The advantage of such a training setting is that there is no risk to the patient as part of the development process and relatively low-cost if a mistake occurs (Ker & Bradley 2007: 5; Meyer & Van Niekerk 2008: 175; McKimm & Swanwick 2010: 135). Simulation creates an opportunity for the nurse practitioner to grow in professional development from novice to expert (Carlson 2009: 15; McKimm & Swanwick 2010: 137; Bruce et al. 2011: 345).

f) Summary of Educational Methods

In Table 4-3 the researcher summarised the preferred educational methods identified by the participating nurse practitioners for the refinement of the CPD programme in the CCU and HCU of the private hospital in Gauteng.

Table 4-3: Summary of Educational Methods

Advantages	Disadvantages/Cautions	Keys to success
a) On-the-Spot		
<ul style="list-style-type: none"> • Active involvement of learners in natural practise environment • Individualise approach • Learner specific needs • Opportunities for role modelling, demonstration, and observation of professional habits and attitudes • Practice to build skills and problem solving in real situations • Learn under supervision and guidance of experts • Continuous feedback opportunities • Foster teamwork • Develop verbal communication skills^{1,8} 	<ul style="list-style-type: none"> • Relies on a good preceptor with effective learning, questioning and feedback skills • Personality conflicts can hamper it • Is time consuming¹ 	<ul style="list-style-type: none"> • Provide constructive feedback • Make learning expectations and objectives clear • Role model and demonstrate learning • Identify learner needs and adapt level to need • Take advantage of teachable moments • Elicit learners thoughts and understanding through open-ended questions • Continuous constructive feedback • Ensure new ideas and skills are applied • Encourage independent inquiry and learning¹
b) Demonstration		
<ul style="list-style-type: none"> • Promote learning through modelling • Promotes self-confidence • Creates question and answer opportunities • Focuses attention on specific details • Can reinforce learning • Can be used as peer assessment • If model is used, can stop and repeat • More students at a time • Held demonstration is same place – familiar environment • Atmosphere more relaxed – more questions^{1,6,7} 	<ul style="list-style-type: none"> • Limited value for candidates who do not learn best by observation • Theory away from situation • More time, less time for patient care • Patient privacy may be compromised • Cannot stop procedure to revisit issues • Tiring for patient • Procedure not always available • Theory/practice correlation – away from situation • Limited number of students at a time • Demonstrator must have specialised expertise • At patient’s bedside^{1,7} 	<ul style="list-style-type: none"> • Demonstrator must be able to do the procedure well • Demonstration must be planned carefully • Keep simple and explanations thorough enough • Support demonstration with visual aids where possible • Learners must be given the opportunity to practice^{1,7}

Advantages	Disadvantages/Cautions	Keys to success
c) Workshop		
<ul style="list-style-type: none"> • Effective for new information and to clarify existing information • Large group • Cover underlying concepts and principles • Groundwork for subsequent activities • Stimulate learner interest • Can be recorded for future use • Can use different teaching strategies for example demonstrations, simulations and so forth ^{1, 8} 	<ul style="list-style-type: none"> • Passive learning – burden for promoting learning on facilitator • Establish a “tell me” attitude with learners • Level of learning • Limited opportunities for assessment and feedback • Can overload learners with information • Very little learner independent thinking allowed • Can lead to boredom • Limit to knowledge teaching ¹ 	<ul style="list-style-type: none"> • Know purpose • Know audience • Must be an expert • Learning objective best achieved by this method must be identified • Careful not to overload • Ensure a solid introduction, body and closure • Good examples to explain major principles • Use sign post • Periodically summarise and give conclusion • Active speaking with quotes, stories, and so forth • Audio-visual aids • Effective presentation skills • Interactive lecturing techniques • Time management • Allows questions and conclusion ^{1, 8}
d) Simulation		
<ul style="list-style-type: none"> • Portrays real situation • Eliminates irrelevant aspects • Use when patient can be endangered • Use where “real” experience is not available • Immediate feedback • Held demonstration is same place – familiar environment • Atmosphere more relaxed – more questions • Form of assessment • Shorten time to master practice • Reinforces confidence ^{1, 2, 5, 7} 	<ul style="list-style-type: none"> • Simulators can be costly to buy and maintain • Limited number of learners at the same time • Scheduling and logistic challenges • Transfer of learning to real-life setting • Lack of realism • Can never substitute real patient in real clinical setting • Poor validity if associated with lack of realism ^{1, 3, 10} 	<ul style="list-style-type: none"> • Hands-on learning experience required • Best first learn in other way than direct patient contact • Full briefing beforehand and full debriefing • Trainer must know and understand the simulation facilities • Near as possible to real-life situation ^{1, 4, 5}
<p>References:</p> <ol style="list-style-type: none"> 1. Teaching Strategies/Methodology 2003: 1 2. Bruce et al. 2011: 244 3. Quinn & Hughes 2007: 254 4. Quinn & Hughes 2007: 255 5. Bruce et al. 2011: 227 6. Jooste 2011: 251 7. Bruce et al. 2011: 266-268 8. Bruce et al. 2011: 248 9. Bruce et al. 2011: 258 10. McKimm & Swanwick 2010: 140 		

4.3.2 Question 2: Dream - Desired CPD Programme

The Dream phase was used to develop new focus points uncovered during the Discovery question. The following question was asked of the participants during Phase 1 Step 2 of the Focus Group Inquiry (see Annexure E):

What are your wishes for an ideal continuous professional development programme in a private hospital? – What are the possibilities of such a programme?

The summary of the findings from the *Dream* question related to the CPD programme is summarised in Table 4-4.

One theme emerges from the data namely *Workplace Learning Environment*, two categories namely *Learning Opportunities* and *Facilitate and Promote Learning* and six subcategories emerged from the findings. Each of the themes, categories and subcategories are discussed as well as supportive literature provided (see Sections 4.3.2.1 to 4.3.2.3).

Table 4-4: Summary of the Dream Phase outcomes

Themes	Categories	Sub-categories
Workplace learning environment (Section 4.3.2.1)	Learning opportunities (Section 4.3.2.2)	Time (Section a)
		Needs (Section b)
		Availability of Experts (Section c)
	Facilitate and promote learning (Section 4.3.2.3)	Co-operative Learning Climate (Section a)
		Encourage learning culture (Section b)
		Recognition/Rewards (Section c)

In the Dream phase the participants were given the opportunity to develop great thoughts, wishes and possibilities to improve the CPD programme in the hospital

(Watkins & Mohr 2001: 44). The following phrase from Belva Davis “*Don’t be afraid of the space between your dreams and reality. If you can dream it, you can make it so*” stated that there are no limits to dreams and wishes. The detail outcomes from Question 2 of the Focus Group Inquiry are summarised in Annexure G.

4.3.2.1 Workplace Learning Environment

The *workplace learning environment* was identified during Phase 2 by the participants as the important element in the current CPD programme that is perceived to be incorporate in the design and improvement of the CPD programme.

Supportive quotations:

- “We want an environment where our needs can be reached so that we can practice with confidence.”
- “Management must negotiate with experts to be available for training.”
- “Staff wants to meet their teaching needs.”
- “Experienced staff must be dedicated and willing to learn and support inexperienced staff.”

Literature control: A workplace learning environment is described by Quinn and Hughes (2007: 202) as “*one in which the educational needs of the learner are met*”. It is important for the andragogical process for adult learners that the environment is not threatening but is supportive and encourages them in all of the aspects required for effective learning whereby they can value and reflect their experience (Quinn & Hughes 2007: 202; Jooste 2011: 60).

All managers in an organisation are involved in the process to create a learning environment. Their role is to support, encourage and facilitate an environment where work and learning merges. To ensure that an effective learning environment exists, management is required to exercise discretion and judgement (Commonwealth of Australia 2010: 251). According to (Meyer et al. 2009: 112) the clinical learning settings is an important element in the

development of nurse practitioners' knowledge, skills and interpersonal abilities because these settings create the opportunities for nurse practitioners to practise their clinical and interpersonal skills required to become skilled professionals. It is important to notice that the clinical learning environment is a collaboration of various health professionals and must provide for such interactions and involvement. The success of these interactions affects the effectiveness of the environment as a learning environment and opportunity. Nurse practitioners should be aware of the importance that multi-disciplinary teams play in the clinical learning setting (Meyer et al. 2009: 114).

Lack of time, limited contact with colleagues, absence of experts, lack of meaningful acknowledgement and rewards, funds for learning opportunities, easy access to learning material and computer infrastructure, reluctance of co-workers to support learners, and policies that discourage learning are propositions identified by Wahab and Selemat (2011: 67) as work environment aspects that are inhibitors to learning.

Two categories namely *Learning opportunities* and *Facilitate and promote learning* emerge from the second theme *Workplace learning environment* supported by six sub-categories which are discussed in Sections 4.3.2.2 to 4.3.2.3 below.

4.3.2.2 Leaning Opportunities

The requirement for appropriate learning opportunities was identified during Phase 1 Question 2 by the participants as an important element of the workplace learning environment in the current CPD programme that needs to be incorporated in the design and improvement of the CPD programme.

Supportive quotations:

- "More opportunities must be created to learn."
- "In the moment training must be used, even if the unit is busy."

Literature control: Learning opportunities are defined by Uys and Gwele (2005: 23) as "*a learning situation created by a nurse educator for a student to use to achieve a learning outcome*" (Bruce et al. 2011: 119).

To develop a workplace learning environment it is important for an organisation to identify learning opportunities for its staff. These learning opportunities can be either formal or informal as both are crucial in the creation of a positive learning environment. The process to identify these learning opportunities normally includes training needs analysis. This analysis should incorporate the needs of the team and the organisation. Individual and team performance plans are integral elements of the process to identify staff deficits and the training needs to overcome these gaps. Plans to breach the needs must reflect the diversity of the individual and the organisation's needs (Commonwealth of Australia 2010: 251).

Organisations should ensure that individuals have maximum access to learning opportunities. Effective communication and liaison within the organisation enhances individual team and organisation performance (Commonwealth of Australia 2010: 251). Every situation within a nursing setup has a different requirement for development and learning. It is therefore important to match the need and opportunities such as coaching and mentoring, formal or informal training or even buddying. Of importance is to continuously assess the situation including using annual performance reviews and recognition (Commonwealth of Australia 2010: 252).

The three sub-categories identified in support of the category *Learning opportunities* are now discussed in Sections a) to c).

a) Time

The participants in the study identified the requirement for sufficient time for learning as one of the important elements to create learning opportunities.

Supportive quotations:

- "If the staff get the hours for training it will keep them motivated."
- "We need more time on duty for training."
- "There must be time for in-service training even if the unit is busy."

Literature control: According to Jooste (2011: 136) the time of nurse practitioners and other healthcare professionals is, if not the most valuable resource, one of the most important resources in a healthcare set-up. Time and the effective management of time are therefore important in the nursing environment and the responsibility of nursing management. The planning and prioritisation of activities primarily determine the utilisation of time. Each unit or nurse practitioner has the same amount of time in a day and must utilise this time for the optimal use for the unit and the individual nurse practitioners (Meyer et al. 2009: 236; Muller 2009: 352).

Continuous professional development as the responsibility of the individual nurse practitioner is restricted by the requirement that CPD activities should never compromise the nursing unit. Nursing units must ensure that there is a written policy in place regulating the fairness and consistency of continuous professional development activities. Proactive planning for CPD activities by the unit manager in conjunction with the nurse practitioners in the unit will prevent crisis management cause by nurse practitioners that attend unplanned learning opportunities (Muller 2009: 353). Unit managers should manage the time allocated to nurse practitioners in the unit in such a way to maintain equality and fairness in the attendance of workshops and conferences or other developmental opportunities because nursing managers have an obligation to facilitate professional and skills development in the unit (Muller 2009: 353).

b) Needs

Participants identified and recognised staff training needs as being an important element to create effective learning opportunities.

Supportive quotations:

- "There are different needs for training and that must be evaluated so that teaching can be done according to the level of knowledge."
- "Training must meet teaching needs."
- "Teaching needs should be provided according to evaluated outcome of knowledge."
- "In every unit there are specific needs."

Literature control: Training needs analysis is defined by Quinn and Hughes (2007: 489) as “*a training and educational strategy that meets the continuing professional needs of healthcare staff, both qualified and unqualified*”. Satisfying the training needs of nurse care practitioners is also seen as a mechanism to improve nursing care services. The process of training needs analysis is also defined as the systematic consultation and identification of training needs by those who are in a position to create a positive learning environment to satisfy the needs.

The needs analysis of individuals is completed during performance appraisals and reviews and planned as part of personal development plans (Quinn & Hughes 2007: 489-490). According to Quinn and Hughes (2007: 461) it is vitally important to carefully define the concept of staff appraisals to ensure that it is not confused with other related concepts such as performance reviews and assessments.

In its literal sense, appraisal “*is the estimation of value or quality, and it is this emphasis on value that makes it more global than assessment*” (Quinn & Hughes 2007: 461). Performance appraisal is defined by Muller (2009: 354) as “*the systematic assessment of the nursing/midwifery practitioner’s knowledge, skills, values, and conduct that are related to the role expectations and responsibilities of the job requirements and job description*”. According to Muller (2009: 354), appraisals form an integral part of the development, growth and management of personnel and can therefore be seen as a tool for personnel development.

The purpose of appraisals in the educational and professional development setting can be identified as being those aimed at the individual and those aimed at management. From the individual’s point of view appraisals are aimed to encourage self-development, evaluation and review while from management’s view they are used to clarify objectives, improve communication, identify staff development requirements and needs and to evaluate organisational performance (Quinn & Hughes 2007: 462; Muller 2009: 354). In conclusion, Quinn and Hughes (2007: 462) state that the process of staff appraisals focuses on two questions:

- “Are you contributing to the growth and development of the organisation?”
- “Is the organisation contributing to your own growth and development?” (Muller 2009: 354).

The identification of training needs is not limited to the individual nurse practitioner but is the responsibility of everybody that has an educational interest in the individual such as unit managers, clinical facilitators, and so forth (Quinn & Hughes 2007: 489-490). In the opinion of Quinn and Hughes (2007: 486) the facilitation of training needs to better meet the needs of nursing care requirements through investing in the development of staff is very important.

The process to identify the needs of staff include an on-going cycle of assessment and feedback, planning, development and evaluation of staff and units' requirements to ensure that the needs of the organisation and the individuals are linked and align with each other (Quinn & Hughes 2007: 486). Assessment is an integral part of any CPD programme. It is, however, important that assessment tools, procedures and mechanisms are clear, flexible and fair. Any assessment should at all times strive to assess the outcome of the learning opportunity to ensure that development programmes adds value for all the stakeholders (Coetzee et al. 2007: 214).

Assessment is defined by Coetzee et al. (2007: 214) as a “*structured process in which evidence of performance is gathered and evaluated against agreed criteria*” (Meyer et al. 2009: 49). Assessment can therefore be seen as a data collection activity for the measurement of knowledge, behaviour, skills, performance, attitudes and values. The results from the assessment are used to make informed decisions about the nurse practitioner's competence (Coetzee et al. 2007: 214; Meyer et al. 2009: 300).

The process of assessment in CPD actively involves the nurse practitioner to develop and guide training needs analysis to give nurse practitioners access to learning and development opportunities. Assessment provides to the nurse practitioner information regards the nurse practitioner's current skills and knowledge in a process to identify gaps and needs for further education and training (Coetzee et al. 2007: 215).

When used correctly assessment tools may be utilised to supply valuable information about the nurse practitioner during the recruitment and orientation process. The assessment process could become costly and time consuming if not managed (Coetzee et al. 2007: 215). Although the main objective of assessment is to assess learning outcomes, it may also be used to improve nurse practitioners' facilitation, learning programme development and educational environment improvement.

The literature differentiates between various types of assessment. Three types of assessment are useful to evaluate a training programme. Diagnostic assessment is used to provide the clinical facilitator with the nurse practitioner's prior learning, skills, values and attitudes needed in the planning of CPD activities. During diagnostic assessments formal and informal assessment tools are used. A pre-test is such a formal assessment to measure the nurse practitioner's knowledge, skills, values, attitudes and level of competence. Diagnostic assessment is also very useful during a development process specifically when the clinical facilitator battles to determine the cause of an identified problem (Coetzee et al. 2007: 219; Jooste 2010: 59).

Formative assessment is done throughout the process of learning and development. It is used by the nurse practitioner to determine the current state of competence with the objective to develop and improve performance and practice before the next assessment. Formative assessment is therefore conducted during the instruction process providing information not only to the clinical facilitator but also to the nurse practitioner who may be used to adapt learning methods and strategies (Coetzee et al. 2007: 219).

In conclusion Coetzee et al. (2007: 219) pointed out that formative assessment therefore has learning, coaching and development functions. Evaluative assessment on the other hand is a post-assessment activity to provide content relevance feedback and ensure quality of the overall process (Coetzee et al. 2007: 221).

The process to assess the combined impact of foundational, practical and reflexive competence is done through a process of integrated assessment. During integrated assessment the context of the assessment should be as close

as possible to the real-life application. It is very important to prevent fragmentation of the assessment during integrated assessment not only to reduce costs but also to ensure that nurse practitioners are able to apply the skills and knowledge in a holistic patient care application (Coetzee et al. 2007: 222).

Results of appraisals, assessment and feedback can be used effectively to prepare a portfolio of evidence that includes samples of the nurse practitioner's work relevant to the development programme. The portfolio serves as evidence of the nurse practitioner's ability to demonstrate competence and provide evidence of knowledge, skills and attitudes. Because the nurse practitioner is forced to decide what to include into the portfolio it also acts as a review by the nurse practitioner of own progress which can be used for continuous professional development planning (Coetzee et al. 2007: 225; Jooste 2010: 59). In conclusion Coetzee et al. (2007: 225) state that "*Portfolios emphasise strengths, the development of skills, improvement and personal reflection*" and therefore provide a broad picture of the nurse practitioner's learning and development.

Assessment is a learning and development tool providing the nurse practitioners with continuous feedback on performance. Assessors must ensure that feedback provided is positive and in the form of constructive criticism to maximise the impact. The feedback during the assessment process must be clear, accurate and detailed with reference to the nurse practitioner's performance and achievements. Feedback must provide information on each of the assessment criteria and learning outcomes (Coetzee et al. 2007: 240; Meyer et al. 2009: 300).

Feedback is utilised by the assessor as part of the learning and development process by ensuring that nurse practitioners are advised on further development opportunities. The process of feedback also provides the opportunity to discuss ways to improve performance in situations where a nurse practitioner is still found not to be competent in a specific competence. An assessor, however, should at all times handle assessment results with confidentiality (Coetzee et al. 2007: 215, 240; Meyer et al. 2009: 301).

c) Availability of Experts

The availability of experts to learn from was identified by the participants in the study to be of high important to ensure that sufficient learning opportunities exist for an effective CPD programme in the hospital.

Supportive quotations:

- "Want experts to be more available."
- "Availability of experts to train us is a problem."
- "Management must negotiate with experts to be more available."

Literature control: In Section 4.3.1.2 it is stated that the absence of or inaccessibility of experts reduces guidance and support that leads to frustration on the part of the nurse practitioners which negatively impacts on the speed of learning and decision making (Wahab & Selamat 2011: 61). In the South African context the availability of experts is not always possible because most of the experts are in private practice where time is limited. Ward rounds and on-the-spot training opportunities are where experts normally transfer their knowledge. In the experience of the researcher, experts are not available during normal working hours to participate in workshops and lectures.

Professional networks connecting various people within the same profession can be very rewarding. The various perspectives on a situation tend to create an environment of open discussion and sharing of knowledge and information creating new understanding (Meyer et al. 2009: 164). The unit manager plays an important role to promote a professional network to ensure that expert training is available to the nurse practitioners as part of a CPD programme (Meyer et al. 2009: 163).

4.3.2.3 *Facilitate and Promote Learning*

Organisations should develop strategies that ensure the utilisation of workplace learning opportunities. These strategies should focus to encourage members of a team to share knowledge and skills. This encourages a culture of learning within the team. However, organisations should ensure that procedures implemented to

utilise workplace learning opportunities target the development of appropriate skills, attitudes and knowledge while assessing individuals' competencies and identifying development and learning needs (Commonwealth of Australia 2010: 252).

Organisational structures and processes should support team members to develop a culture to share the benefits of learning with others through the recognition, feedback and rewards of workplace achievement and learning (Commonwealth of Australia 2010: 252).

The three sub-categories identified from the data in support of the category *Facilitate and promote learning* are discussed in Sections a) to c) below.

a) Co-operative Learning Climate

The participants identified the need for a co-operative learning *climate as a requirement* to facilitate and promote learning in a CPD programme in the private hospital and to be successful. The participants identified agency staff as part of the nursing team within the unit. This is confirmed by the literature.

Supportive quotations:

- "Feedback from people that attend training must be given so that everybody can keep up to date."
- "Permanent staff must improve their attitude towards training agency staff because they are part of the team."
- "There must be teamwork to join training – if I look after the patient during training today; I want to go to the next training session."

Literature control: According to Gravett (2005: 43) a co-operative learning climate can be defined through the various elements of the term. Climate in educational terms "*refers to the prevailing condition, atmosphere or ambience whereas learning climate encompasses aspects such as the physical, affective-social and intellectual*". Co-operative is derived from co-operate which can be broken down into its two elements: "co" meaning together and "operate" meaning to work which indicates that it means to work together, being helpful and sociable, sharing, collaborating, and joint effort (Gravett 2005: 43).

One of the best ways to facilitate and promote learning is the use of the combined knowledge and abilities of the nursing team. Literature suggested the utilisation of team members who have achieved their personal best in learning creating learning opportunities. To create learning opportunities within an organisation it is important to create and facilitate an environment that is conducive to learning and that promotes learning.

One of the important aspects of such a true learning environment is to encourage open and constructive communication and dialogue. Such an environment not only creates and promotes positive learning but also creates an opportunity for creative thinking and problem solving (Gardiner 2012: 1). Non-nursing team members such as doctors, dieticians, and so forth can be valuable contributors to the nursing learning environment. However, it is important that these team members are induced to the ethos of the unit and encouraged to see themselves as a resource for learning (Quinn & Hughes 2007: 346).

Nursing teams have an expanded body of knowledge that creates the ideal opportunity to share knowledge resulting in an increase of efficiency in the unit (www.motivation-tools.com; Quinn & Hughes 2007: 452). Efficiency is the responsibility of the team as a whole. The sharing of tasks creates the opportunity of team members to understand the whole process increasing motivation and knowledge (www.motivation-tools.com). Literature on multi- and inter-professional teamwork confirms that collaboration between multi-professional teams and shared learning programmes increases the learning opportunities available within a nursing unit, facilitates cultural changes and promotes effective learning and teamwork (Quinn & Hughes 2007: 452).

According to Earley and Bubb (2004: 141) organisations should devote a portion of their limited CPD funds also to temporary staff. It is a known fact that hospitals made use of substantial numbers of temporary or agency staff as part of their staffing strategy. The following reasons as to why organisations should spend some of their CPD funds on agency staff are presented. Temporary staff forms a substantial part of hospital's workforce and costs the organisation a lot. They receive very little support for professional development from their agencies at present. The service they provide is not always effective but many temporary

staff end up staying with the organisation. For this reason CPD is a good way to recruit and retain temporary staff (Earley & Bubb 2004: 141).

b) Encourage Learning Culture

The participants also identified that there has to be a learning culture present in the CPD programme in the private hospital that encourages learning.

Supportive quotations:

- "We want to practise with confidence and be able to practise safely."
- "In-service training creates a sense of belonging. We all learn together."

Literature control: Humanistic learning theory point out that adult learning is different from that of children's learning. Nurse practitioners within a workplace focussing on CPD bring a lot of prior knowledge, experience and personalities to the learning environment. In Hutchinson's (2005: 5) view nurse practitioners will learn if nursing management creates and provides a secure, motivational learning environment that satisfies the basic, social and emotional needs as identified by Maslow who argues that all individuals have a drive to self-actualisation once these needs are satisfied (Hutchinson 2005: 5; Quinn & Hughes 2007: 23-24).

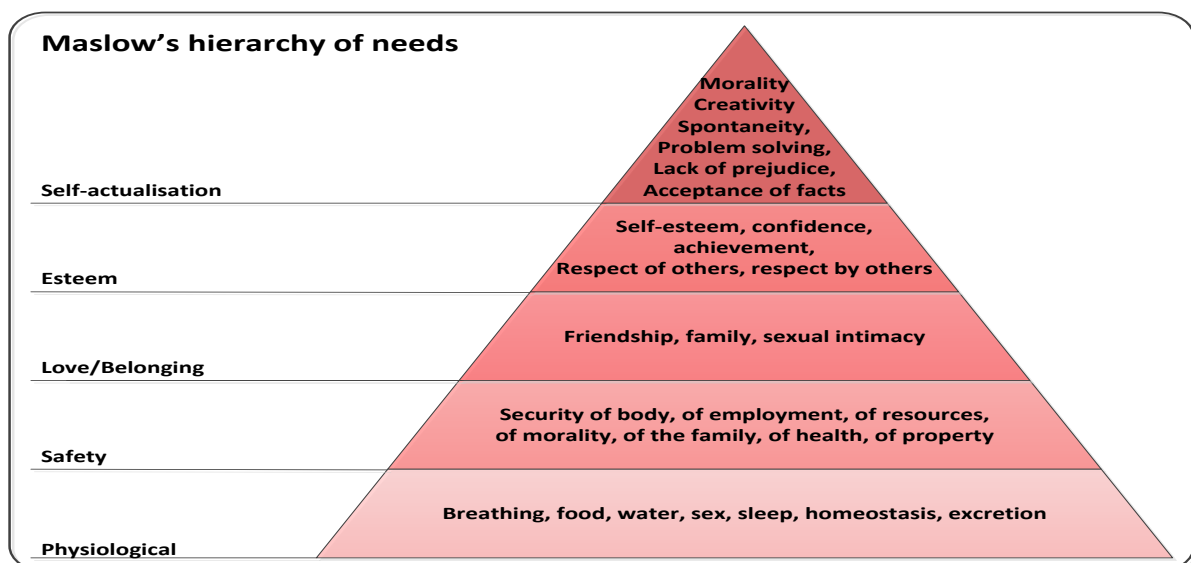


Figure 4-1: Maslow's hierarchy of needs

Literature confirms that the need to create a safe learning environment is as important as any other element in the learning process. Maslow, however, through his argument of self-actualisation, argues that the individual must first satisfy his basic needs before he or she can reach a state of self-actualisation (London Deanery 2012: Online; Hutchinson 2005: 5). This confirms that nurse practitioners who face difficulties that have an impact on their physiological well-being, safety and belonging may very well struggle to optimally utilise learning opportunities. For effective workplace learning nurse practitioners must feel that they are safe and part of a team. It is noted by Turnbull (2000: 3) that: *“As organisational members, we learn to collaborate, influence, negotiate, motivate, and achieve results through our interaction with others, all of which can be highly charged with emotion.”* The implication of this is that all members of the healthcare team must be involved to create a positive learning environment (London Deanery 2012: Online).

The needs hierarchy of Maslow is just as relevant to nursing practitioners participating in a CPD programme because it has implications on learning and development. Deficiency needs like self-esteem and love negatively impact on nurse practitioners ability to learn and should first be addressed before effective learning can commence (Bruce et al. 2011: 88-89). In the opinion of Bruce et al. (2011: 90) a lack of self-esteem tends to suppress originality and creative ideas or might lead to disruptive behaviour that nurse practitioners display in an effort to gain approval and acceptance from peers. A CPD programme should establish a learning environment that takes the needs of all participants into consideration where nurse practitioners feel at ease, acceptable and respected (Bruce et al. 2011: 90).

c) Recognition/Rewards

For management to create an environment that fosters and promotes learning the participants identified that there should be an effective mechanism in place to recognise and reward learning as part of the CPD programme in the private hospital.

Supportive quotations:

- "Rewards for learning motivate us."
- "Some people never attend training and nothing happens to them – we want to be rewarded for training."

Literature control: Organisations and unit managers should create an environment that foster and promote learning. The identification and recognition of above average and extraordinary activities on the part of nurse practitioners add to the promotion and facilitation of learning within a unit. Organisations should ensure that such rewarding is structured, fair and transparent (Muller 2009: 354; Meyer et al. 2009: 255). Rewards may be described as the *"identification of above average work ability (knowledge, skills, attitudes and value, including the personal valued added by the employee) and the achievements that demand special mention and even promotion"* (Muller 2009: 354).

For unit managers to manage improvement and performance it is essential to provide honest feedback and recognition for good performance to ensure that an effective learning environment is created and maintained (Jooste 2011: 87).

4.3.3 Question 3: Design - Aspects that need to be addressed

The following question was asked to the participants during Phase 1 Step 3 of the Focus Group Inquiry Annexure E:

What do you see as challenges for a continuous professional development programme?

A summary of the findings from the *Design* question related to the CPD programme is summarised in Table 4-5.

One theme emerged from the data namely *Management* and two categories namely *Funding* and *Project Manager* emerge from the findings. Each of the

themes and categories are discussed as well as supportive literature provided (see Sections 4.3.3.1 to 4.3.3.3).

The detail outcomes from Question 3 of the Focus Group Inquiry are summarised in Annexure H.

Table 4-5: Summary of the Design Phase outcomes

Themes	Categories
Management (Section 4.3.3.1)	Funding (Section 4.3.3.2)
	Project Manager (Section 4.3.3.3)

4.3.3.1 Management

The involvement of management was identified the participants as an important challenge that needs to be addressed in the current CPD programme to ensure success in the design, improvement and implementation of the CPD programme in the private hospital.

Supportive quotations:

- "Training must be a drive from management to improve quality of patient care."
- "Management must be involved in the whole process of training planning to ensure that our needs are addressed."
- "Training is not noticed by management because we do not get any rewards for training."

Literature control: Management in a health care environment takes place at various levels depending on the size, functional and physical distribution of

health care services provided by the organisation (Muller 2009: 100). Management in the health care setting has been defined as the responsibility to ensure safe effective efficient quality care.

Nursing management must occur within the professional-ethical and legal context in accordance with good business principles. Management is therefore responsible to provide the necessary resources, equipment, trained staff, and environment to ensure an environment where safe quality care can be practised (Muller 2009: 100; Meyer et al. 2009: 227). Traditionally career development was seen as the sole responsibility of the individual but due to the positive impact that trained staff has on the success of an organisation the responsibility of management to assist in the professional development of nurse practitioners is recognised (Jooste 2010: 260).

Management is normally divided into top, middle and first level of management. Top management, which includes the nursing management and deputy nursing manager, operates at a collegial level responsible for the nursing services rendered in the institution. They do not perform nursing care activities themselves anymore but delegate and supervise to the next levels of management the execution of these nursing care activities (Muller 2009: 100; Meyer et al. 2009: 227).

The assistant nursing manager within the nursing set up is considered to be middle management. The role of middle management is the development and implementation of nursing policy. The funding of continuous professional development should be regulated by policy to ensure effective implementation (Muller 2009: 353). First level management consists of the nursing unit manager while registered nurse practitioners support the unit manager with supervisory tasks. The unit manager is directly responsible for the supervision and co-ordination of nursing care to the patient. The role of the unit manager includes activities like planning, organisation, co-ordination, supervision, motivation, guidance, training and controlling of staff in the unit (Muller 2009: 100; Jooste 2010: 261; Meyer et al. 2009: 227).

The development of nursing staff is one of the important functions of management to ensure the optimal utilisation of the unit's professional

resources. These development activities include the coaching and development of nurse practitioners in the unit through guidance and assistance to the nurse practitioner to carry out tasks effectively and to develop the nurse practitioner's careers (Jooste 2010: 249). This includes the planning for continuous professional development and career planning to ensure motivated and effective nursing staff. An important principle that must be maintained in this process is fairness and equality in the attendance of conferences, workshops and other developmental opportunities (Muller 2009: 353).

4.3.3.2 Funding

During the Focus Group Inquiry the participants identified the requirement and provision of funding not only in terms of financial support to staff to attend training opportunities but also the time that is required as an important element of the current CPD programme that should be addressed during the improvement and implementation of the CPD programme in the private hospital.

Supportive quotations:

- "There must be a specific budget for training that is visible to the staff."
- "Our hours that we spend during off duty time on training must be paid out to us."
- "We want more funding for training."

Literature control: The unit manager is responsible to involve nurse practitioners in stimulating and developmental projects. In support of this, the unit manager must plan and budget to support staff with the time as well as the registration fee for conferences and courses to ensure that nurse practitioners are given the opportunities to attend conferences and courses on a continuous and rotating basis (Jooste 2011: 265).

Unit managers have to create a culture and environment that it conducive to learning (Meyer et al. 2009: 125). For unit managers to ensure an environment that is conducive to learning they should be committed and enthusiastic ensuring

that nurse practitioners are committed and enthusiastic and motivated to develop (Meyer et al. 2009: 125).

4.3.3.3 *Project manager*

The participants identified during Focus Group discussion the requirement for a dedicated project manager to address and manage the challenge that they experience with the implementation of the current CPD programme in the private hospital.

Supportive quotations:

- "Training must be organised by a dedicated person that has a passion for training."
- "Get one person that is motivated and can give consistency to training."

Literature control: Contrary to what most people believe, the responsibility of a project manager is not to create a complex project plan but to understand a business's goals, the technology involved, be able to direct and motivate people, communicate at various levels, be able to deal with problems and stress while ensuring that everything is done that needs to be done (White Papers 2001: 2; Steyn et al. 2012: 2-3; NBC Universal Media 2012: Online).

Common characteristics of projects are that they have clear and agreed upon objectives, defined start and completion dates with specific performance requirements with regard to time, cost and milestones (White Papers 2001: 2; Steyn et al. 2012: 2-3).

A project manager's tasks are to assemble the project team and manage the execution of the project. It is the responsibility of the project manager to analyse the requirements to identify the real need and gap between the current and future system. This forms the basis of the project scope and plan (White Papers 2001: 3; Portny 2012: 2).

The project plan on the other hand must include elements like a project sponsor, the schedule and time, resources, and so forth (White Papers 2001: 2). Any

successful project should have a clearly defined scope that sets out the objectives and parameters of the project. Without a project scope projects tend to have goal posts that change and time and cost that overrun their boundaries (NBC Universal Media 2012: Online). When the project manager resources the project the project manager should know the strength of each member of the team to be able to utilise and manage them to the best advantage of the project. The project manager as team leader should be enthusiastic and inspiring to motivate the team while instilling a team spirit (NBC Universal Media 2012: online; Portny 2012: 1). For a project to be successful the project manager and project team must always keep the big picture in mind while keeping a finger on the pulse through monitoring of progress against tasks planned and accomplished (NBC Universal Media 2012: Online; Portny 2012: 1).

4.4 PHASE 2: REFINE THE CURRENT CPD PROGRAMME

Phase 2 of the Focus Group Inquiry was utilised to achieve Objective 2 set for this research study.

Make recommendations to refine the current CPD programme in the private hospital to the hospital management.

The themes identified during Phase 1 of the Focus Group Inquiry from the first three questions related to 4-D AI cycle namely Discovery, Dream and Design led to a vision of what the content and elements of the future CPD programme in the private hospital should be. The data from Phase 1 was used as input to follow a process to make recommendation for the refinement of the current CPD programme during Phase 2, the Delivery "*What must be*", by the participants in the Focus Group Inquiry.

The following question was asked to the participants during Phase 2 of the Focus Group Inquiry (see Annexure C):

What is your vision with regard to the ideal continuous professional development programme?

From the data the researcher identified a number of elements that need to be included in the future CPD programme in the private hospital.

Six elements of refinement of the current CPD programme were identified and are discussed in Sections 4.4.1 to 4.4.6.

The detail outcomes from Question 4 of the Focus Group Inquiry can be found in Annexure I.

4.4.1 Steering Committee

The participants identified the requirements of a steering committee to plan, manage and drive the CPD programme in the hospital. The participants also recommend that there should be a pilot programme implementing the functionalities and elements identified in the study followed by another AI cycle.

The following aspects related to the steering committee were identified by the participants that need to be addressed:

- Constitution
- Membership requirements
- Purpose of the steering committee
- Communication requirements

Each of these aspects has now been discussed in Sections 4.4.1.1 to 4.4.1.4.

4.4.1.1 *Constitution of the Steering Committee*

The Focus Group Inquiry participants felt strongly that their input to the constitution should be incorporated in the constitution of the steering committee. They indicated that the programme would not be successful if it is only driven by an individual. The participants recommend that the programme should be driven by a team consisting of at least the following members to ensure drive and knowledge as well as continuity:

- Clinical Facilitator
- Unit manager
- Elective group of nurse practitioners from the CCU and HCU
- Elective doctors working in the CCU and HCU

4.4.1.2 Membership Requirements for the Steering Committee

The participants in the Focus Group Inquiry identified the need to define the requirements that the members of the steering committee should comply with. The requirement is that the members should firstly be willing to be part of the steering committee of their own free will but must also be selected by the staff from the participating units. This specifically applies to the elected nursing practitioners that are part of the steering committee.

The participants further identified the following personal requirements for a member of the steering committee. They believe that if a person does not express these attributes that the member will not be able to contribute effectively to the success of the steering committee and the CPD programme. These attributes are:

- **Passion:** The requirement is that the member should be passionate and enthusiastic for nursing, continuous professional development and their role as a member of the CPD project steering committee.
- **Interpersonal skills:** The person elected for the steering committee should present with the required interpersonal skills to deal with management, the doctors and the staff from the units involve in the CPD programme.
- **Expert:** It is believed by the participants that the members should be experts in their specific field for which they are selected to be a member of the steering committee.

4.4.1.3 Purpose of the steering committee

During the Focus Group discussion the view was expressed that the purpose of the steering committee is to actively and passionately drive a pilot project that implements the improved continuous professional development programme in the private hospital based on the elements of strength that were identified in this study through the evaluation of the current CPD programme using the AI approach.

4.4.1.4 Steering Committee Communication requirements

One of the important tasks identified for the steering committee is that of communication. This relates to communication with all stakeholders in other words nursing practitioners, management, experts and clinical facilitators to ensure not only understanding of the programme but also support and knowledge of opportunities. One of the most important communication activities for the steering committee is to act as liaison with the quality manager of the hospital to ensure that activities are aligned with the hospital's objectives of safe nursing care and service delivery as well as with the personal growth and development objectives of the nurse practitioners.

4.4.2 Assessment of needs

The Focus Group identified the need to accurately identify the need for training on the part of all stakeholders as one of the most important elements of the CPD programme. The participants envisaged a mechanism that may identify the training needs derived from the patient and the nursing practitioners while considering the risk of the specific unit.

The objective of clinical assessment is to obtain information regarding the nurse practitioner's clinical performance in order to make formative and summative judgement (Meyer and Van Niekerk, 2008: 189). In conclusion Meyer and Van Niekerk (2008: 189) state that clinical assessment has the two interrelated functions of being educative and that of gate-keeping.

The gate-keeping function specifically focuses on the maintenance of professional standards with the objective to protect the patient and the community. It is concluded that the most effective manner to assess clinical competence is through observation in the clinical setting. Clinical competence may, however, also be assessed through the auditing of the records of nursing care and through the performance of a physical check of the patient that is being cared for by the nursing practitioner (Meyer and Van Niekerk, 2008: 189).

4.4.2.1 Patient needs

The participants felt that because patient safety and quality nursing care is of the utmost importance the need for training must firstly be derived from the patients' profile and needs. The participants envisage a mechanism to be developed where the patients' diagnoses are used to determine the training needs for the CCU and HCU.

4.4.2.2 Nurse practitioners needs

The participants stated that it is as important that the nurse practitioner's training needs be based on the patients' profile and needs. The suggestion is that this be done through a process of unplanned evaluations of the nurse practitioners as well as a series of formal assessments to determine the knowledge and skills levels of the nurse practitioners. These assessments should be relevant to the patient's population in the CCU and HCU. A timeframe of six months is foreseen to perform this as part of the pilot project.

4.4.2.3 Incident Assessment in Critical Care and High Care Units

The requirement was identified that the training needs identified must be correlated with that of the CCU and HCU incidents. This needs to be done for each CCU and HCU specifically because the risks of the different units are not the same due to the differences in equipment, patients and staff mixture.

4.4.3 Planning

Phase 2, the Delivery question was also used by the independent facilitator to identify the elements that should be included in the planning of the detailed CPD programme in the CCU and HCU of the hospital. The planning process should include the traditional elements of planning a programme of this nature in other words the **what**, the **who**, the **when**, and the **where**.

4.4.3.1 What

The importance of what the training topics as derive from the training needs consist of and how they are being planned was stressed by the participants of the Focus Group Inquiry. It was identified that this is very important to ensure the scarce resources are used effectively to maximise the impact.

4.4.3.2 Who

The requirement to ensure that the training presenters are actually specialists and experts in their field was identified by the participants to be part of a CPD programme and the requirements of the programme steering committee. This will ensure that the nurse practitioners remain focused and motivated with regards to the CPD programme and on continuous personal development.

4.4.3.3 When

One of the most important elements of the CPD programme planning process to ensure its success and identified by the participants of the Focus Group Inquiry is the planning of where the training takes place. The participants felt that if this is not addressed properly the effectiveness of the training suffers. The elements identified that need to be considered are:

- **Frequency:** It is important for the steering committee to determine the optimum rate of frequency for the different units because it varies between the CCU and HCU. The participants from the HCU indicated that they would prefer a monthly frequency with longer sessions;
- **Length of sessions:** The length of the sessions needs to be considered to ensure maximum utilisation of time and impact but also to ensure that sufficient time is allowed for the subject at hand. There should also be a good mix between short and long sessions. The participants from the CCU and HCU with experience indicate that they would prefer more short session.

4.4.3.4 Where

During the Focus Group Inquiry the participants expressed a strong requirement that the most effective environment for the training should be created. Training done in units is considered not to be effective due to the following factors:

- The environment is too noisy.
- Nurse practitioners' attention is diverted due to the fact that they focus on the patient care.
- Longer sessions cannot be handled in the CCU and HCU because of the activity level.

It is strongly envisaged that there should be a separate training room that is removed from the work environment but conducive for learning and training of practical and equipment skills and competencies. It is recommended by the participants that such a training facility must be equipped with the required training aids and equipment used in the different CCU and HCU of the hospital.

4.4.4 Budget

During the Focus Group Inquiry it was identified that the participants have very limited knowledge and experience with the planning and budgeting process of the hospital while this is such an important element of any CPD programme to be successful.

The participants recommend that one member of the steering committee should be tasked to investigate and find out the details of the budget and planning process within the hospital. As part of this process the current budget should also be interrogated to determine what the committee would be able to achieve budget wise during this budget cycle and how this can be influenced positively to achieve the objectives set by this study for the CPD programme in the hospital. The steering committee, once understanding the budget process, should then ensure that the future requirements for the CPD programme are budgeted for in the next financial year.

Despite the fact that it is important for the steering committee to understand the process and to manage it for future CPD programme requirements it is as

important for the planning process to be open and transparent to all the nurse practitioners in the units. The nurse practitioners require visibility and feedback as part of the future process to build and ensure trust in the system.

4.4.5 Visibility

During Phase 2, the Delivery question, the participants in the Focus Group Inquiry envisage a CPD programme where everybody involved has effectively been informed of the elements and training sessions in such a way that nurse practitioners have sufficient time to nominate themselves and to plan for the training presented.

The participants suggested that the CPD programme include a PR campaign through the use of the following mechanisms:

- Posters that announce the training session and the subjects that will be covered well in advance.
- The topics should be publicised in the CCU and HCU.
- Mechanisms should be found to inform all nurse practitioners of the CCU and HCU well in advance of the planned training session.

Sufficient time should be allowed for everyone that has the requirement and need to plan for the training session.

4.4.6 Reward system

One very important element in the delivery of the future CPD programme is a mechanism to acknowledge relevant training and development by nurse practitioners of the CCU and HCU of the hospital. The participants identified that one of the steering committee's pilot objectives should be to address the need for a recognition and rewards system.

4.5 CONCLUSION

Chapter 4 discussed the results and findings from the Focus Group Inquiry held with the nurse practitioners from the CCU and HCU of the private hospital to evaluate the current CPD programme with the objective to identify elements of strength that can be used to refine the programme. The outcomes from the

Focus Group Inquiry first phase was utilised during the second phase to developed refinements to the current CPD programme in the CCU and HCU of the private hospital in Gauteng.

Chapter 5 summarise the conclusions drawn from the data and results from the research data. The chapter also make recommendations as to the steps needed to implement the recommended improvements for the CPD programme in the private hospital.

5

CONCLUSIONS AND RECOMMENDATIONS

"We must become the change we want to see"

Mahatma Gandhi

5.1 INTRODUCTION

Chapter 4 was used to discuss in depth the data collected and analysed and utilised to refine the current Continuous Professional Development (CPD) programme in the Critical Care (CCU) and High Care (HCU) units of the private hospital in Gauteng.

This chapter, Chapter 5, is used to draw conclusions from and make recommendations as to the next steps required to refine, utilise and implement the recommendations made by the nurse practitioners to the current CPD programme in the hospital to become a programme of excellence.

5.2 RESEARCH AIMS AND OBJECTIVES

The overall aim of this research was to evaluate the CPD programme for nurse practitioners working in the CCU and HCU of a private hospital in Gauteng. In order to achieve this aim, the objectives were guided by the 4-D cycle of Appreciative Inquiry:

Objective 1: Explore and describe views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng;

Objective 2: Make recommendations to refine the current CPD programme in the private hospital to the hospital management.

5.3 CONCLUSIONS AND RECOMMENDATIONS

The research findings are concluded and related recommendations are made using the Phases and objectives (guided by the AI Interview Schedule) to guide the discussion.

Phase 1

5.3.1 Conclusions: Objective 1 - Explore Current CPD Programme

During Phase 1 of the research the first objective was to utilise the first three steps (see Table 1-3) of the 4-D AI cycle to explore and describe the views of the nurse practitioners working in the CCU and HCU of the private hospital in Gauteng in an effort to identify the aspects of the current CPD programme that is worth maintaining and needs to be address to refine the CPD programme. From the data it can be concluded that **In-service Training** that needs to be maintained within an effective **Workplace Learning Environment** supported by **Management** were identified by the research participants as the most important elements that need to be strengthening during the refinement of the current CPD programme.

5.3.1.1 Question 1: View of the Current CPD Programme

From the first question *“Explores the views of the critical care nurse practitioners, pertaining to the current CPD programme in the CCUs and HC units in the private hospital in Gauteng?”* using the Discovery step of the 4-D AI cycle during the Focus Group Inquiry to explore the participants understanding of their positive experiences of the current CPD programme in the CCU and HCU of the private hospital in Gauteng one theme **In-service Training** supported by two categories emerged. The research participants identified the importance that **In-service Training**, with special reference to the two categories of **Expert Training** and **Educational Methods**, have on the positive experiences of nurse practitioners from the CCU and HCU of the current CPD programme in the private hospital.

5.3.1.2 Question 2: Desired CPD Programme

With question two, the researcher's aim was, utilising the Dream step of the 4-D AI cycle, to identify the desired CPD programme for the CCU and HCU in the private hospital in Gauteng to improve quality patient care. From the data the **Workplace Learning Environment** emerged to be the most important aspect that needs to be addressed in the CPD programme of the future. The **Workplace Learning Environment** was divided into **Learning Opportunities** and **Facilitate and Promote Learning** to have the most positive affect for the participants that needs to form part of the future CPD programme to improve quality patient care.

5.3.1.3 Question 3: Aspects that need to be addressed

The third question utilised for this study during the Design step of the 4-D AI cycle was to identify aspects that need to be addressed within the current CPD programme in the CCU and HCU in the private hospital in Gauteng. From the data emerged the requirements for **Funding** and **Project Management** of the CPD programme that need to be addressed but also required **Management** support to ensure the success of the CPD programme in the CCU and HCU of the private hospital in Gauteng.

5.3.2 Phase 1: Recommendations

In Table 5-1 the recommendations based on the research findings from the Focus Group Inquiry related to the responsibilities and actions of the various stakeholders in the CPD programme are summarised.

Table 5-1 tabulate the activities, responsibilities and actions of management, the clinical facilitator and the nurse practitioners that were identified by the research study during Phase 1 as important aspects of the current CPD programme that is worth maintaining and needs to be address to refine the CPD programme. The table identify the activity together with who is responsible for what to ensure that the future CPD programme in the CCU and HCU of the private hospital in Gauteng are improved.

Table 5-1: Phase 1: Recommended activities, responsibilities and actions

Activity	Responsibility and Actions		
	Management	Clinical Facilitator/Expert	Nurse Practitioner
Identify and prioritise learning and development needs.	<ul style="list-style-type: none"> • Identify CCU and HCU training needs. • Prioritise training and development requirements. • Align training needs and organisation's objectives. 	<ul style="list-style-type: none"> • Support nurse practitioner and management in needs analysis process. 	<ul style="list-style-type: none"> • Identifying own training and development needs. • Agreed personal development plan with management.
Provide enabling factors – time , funding, facilities, etc.	<ul style="list-style-type: none"> • Plan staff release for training effectively. • Create in-service training opportunities. • Provide funding for training. • Reward training activities. • Arrange for availability of experts. 	<ul style="list-style-type: none"> • Provide training opportunities. • Mentor nurse practitioners. • Plan training activities. 	<ul style="list-style-type: none"> • Offer to act as mentors to colleagues. • Willingness to provide feedback to colleagues after training opportunity.

Activity	Responsibility and Actions		
	Management	Clinical Facilitator/Expert	Nurse Practitioner
Enable training and development programmes	<ul style="list-style-type: none"> • Support nurse practitioners to attend training opportunities. • Fund training opportunities. • Make time available for training. • Create and foster positive learning environment and culture. • Recognise and reward development. 	<ul style="list-style-type: none"> • Manage CPD programme. • Provide training. • Mentor nurse practitioners. • Provide expert training. 	<ul style="list-style-type: none"> • Engage in training activities. • Attend lectures, workshops, and so forth. • Mentor and support colleagues. • Provide feedback to colleagues after training attendance.
Monitor, assess and evaluate training programmes	<ul style="list-style-type: none"> • Feedback to staff on effect on practice. • Provide feedback to expert on impact of training on practice. • Monitor success of training programmes and interventions. • Review priorities. 	<ul style="list-style-type: none"> • Evaluate impact of training opportunities on practice. • Assess nurse practitioners competence and increased efficiency. • Monitor learning intervention on practice. 	<ul style="list-style-type: none"> • Reflect on training opportunities. • Reflect on learning and the effect that it has on practice.

During the Focus Group Inquiry it was evident that involving all stakeholders, including the manager, clinical facilitator and nurse practitioners to design a CPD programme are required. Each stakeholder has a vital and unique role to enhance the success of a CPD programme.

Phase 2

5.3.3 Conclusions: Objective 2 - Refine current CPD programme

The objective of Phase 2 was to develop recommendations for the refinement of the current CPD programme in the CCU and HCU of the private hospital in Gauteng. Utilised the fourth question from the 4-D AI cycle (see Table 1-3) and the data from Phase 1 of the Focus Group Inquiry the participants identified recommendations, namely to create an **Steering Committee** to drive the CPD programme as well as the requirements for the **Assessments of Needs, Planning, Budget, Visibility** and a **Reward System** as the elements that requires attention and refinement within the current CPD programme in the CCU and HCU of the private hospital in Gauteng. The recommendations are summarised in Table 5-2.

Table 5-2: Phase 2: Recommended actions to implement the recommendations

Action	Description	Responsible
Appoint CPD Steering group for the CCU and HCU of the private hospital in Gauteng	Develop processes to identify potential steering group members. Develop processes to select members. Appoint the first CPD steering committee. Steering committee to select Committee Leader.	Unit manager
Create pilot CPD programme for the CCU and HCU of the private hospital in Gauteng	Register pilot project with hospital management. Agree on a project name. Develop project scope and agree with management.	Steering Committee
Determine training needs of CCU and HCU of the private hospital in Gauteng	Use the collaborative inputs from the unit manager, shift leaders, experts, Clinical department and staff to determine the training needs. Perform a literature study on training needs for the applicable units. Develop assessment tools to evaluate the current competency levels.	Steering committee

Action	Description	Responsible
Determine the training frequency and schedule of the CCU and HCU of the private hospital in Gauteng	<p>Determine the less busy times of each unit.</p> <p>Determine the best overlapping time because of the cost to duplicate training sessions.</p> <p>Do training in less busy times.</p> <p>Develop a training schedule and roster.</p>	Steering committee
Develop a rewards mechanism and system for CPD activities in the CCU and HCU of the private hospital in Gauteng	<p>Develop a point system for training received.</p> <p>Build into rewards process.</p> <p>Review/maximise performance process because currently not conducive to give recognition.</p>	Steering committee
Budget for the execution of the project CPD programme in the CCU and HCU of the private hospital in Gauteng	<p>Elicit the budget process for current budget allocation.</p> <p>Gain staff input to the budget.</p> <p>Agree on budget with management.</p> <p>Communicate the budget to the unit staff.</p>	Steering committee
Develop and appoint an expert panel to support CPD activities of the private hospital in Gauteng	<p>Identify staff members that are experts in their area.</p> <p>Agree with the identified staff to become part of the expert panel.</p>	Steering committee
Develop a project implementation plan for the CCU and HCU of the private hospital in Gauteng for 2013 and 2014	<p>Develop project plan.</p> <p>Through participation agree on project plan with staff and unit management.</p> <p>Agree project plan with management.</p>	Steering committee
Implement pilot CPD project in the CCU and HCU of the private hospital in Gauteng	<p>Execute project plan elements and schedule.</p>	Steering committee

Action	Description	Responsible
Re-evaluate the pilot CPD programme in the CCU and HCU of the private hospital in Gauteng	Design and implement an evaluation plan for the pilot CPD programme after two year from implementation.	Unit Manager

The recommendations derived from Phase 2 are delineated in Section 5.3.4.

5.3.4 Phase 2: Recommendations

Four recommendations were derived from Phase 2:

- Recommendation 1:** Appoint a steering group to drive the CPD programme. The participants identified individuals as possible key drivers of the first steering group. Nurse practitioners should nominate members for the steering group which have a passion for CPD and have relevant subject knowledge. Once nominated, nominated person should volunteer to become a member of the steering group. One of the unit managers should take up the responsibility to appoint the first steering committee.
- Recommendation 2:** Pilot refined CPD programme: Based on the feedback from the nurse practitioner during Phase 1 and 2 (see Table 5-1 and Table 5-2) the current CPD programme should be refined and implemented as a pilot CPD programme. Names for the programme was suggested: Journey to excellence, Avengers, Dreams come alive and Colour your mind. It was suggested to have a competition within the CCU and HCU to select the most appropriate name for the “*new CPD programme*” to enhance buy-in on the part of all nurse practitioners.
- Recommendation 3:** Implement the pilot CPD programme: An action plan and timeline was envisaged by the nurse practitioners and researcher for implementing the pilot CPD as it was regarded as important to define the scope and timeframe in which the project is to be executed and managed (see Figure 5-1).
- Recommendation 4:** Re-evaluate the pilot CPD programme: Once the pilot CPD programme has been implemented, the programme should be re-evaluated using the AI-cycle. Evaluating, refining, implementing and

re-evaluating are a methodology of continuous improvement. Additional monitoring and evaluation systems could include monitoring the number of nurse practitioners attending the CPD programme as well as exploring changes in patient care at the bedside.

	2013												2014						
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Appoint Steering Committee																			
Create Pilot Project																			
Register Pilot Project with Hospital Management																			
Select a Project Name																			
Develop project scope																			
Agree project scope with Hospital Management																			
Determine training needs																			
Determine training frequency and schedule																			
Develop and agree project budget																			
Develop detail project implementation plan																			
Develop budget																			
Get management approval for budget																			
Communicate budget with staff																			
Appoint expert panel																			
Develop and implement new rewards system																			
Develop rewards system																			
Agree implementation of new rewards system																			
Implement project plan																			
Re-evaluate the CPD programme for improvements																			

Figure 5-1: Recommended Pilot Project Implementation Timeline

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher identified a number of research topics that could be addressed in future research based on the findings from the Focus Group Inquiry.

- Implement and re-evaluate the pilot CPD programme.
- Evaluate the understanding by nursing shift leaders of their position and role as experts to be actively involved in a CPD programme.
- Explore the perception of the experts in the critical care environment concerning their role and responsibilities regarding mentoring/on-the-spot teaching.
- Explore the learning environment in critical care units.

5.5 CONCLUSION

During this study the researcher has aimed to understand the challenges regarding the attendance of the current CPD programme and evaluate the programme in collaboration with the nurse practitioners in the CCU and HCU of the private hospital in Gauteng. Effective CPD programmes are vital as it has

been shown that it influences the quality of patient care. From the study and literature review it has become clear that the best practice would be if the researcher can follow a research methodology that focuses on the positive rather than the negative and instead of trying to correct what is not working rather to build on the strength of what works and is being experienced as being positive by the nurse practitioners affected by the CPD programme.

The research has identified a number of positive elements that were used in the current CPD programme that should be continued, such as expert training at bedside. Additional recommendations have been made to move the current CPD programme to excellence, with a specific focus of creating a steering committee to manage the CPD programme. Due to the continuous improvement nature of the AI methodology it is recommended that the process of evaluating the CPD programme has to be repeated after the implementation of the pilot CPD programme to determine the effectiveness thereof and refine it further.

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7 ANNEXURES

Annexure A: Ethical Considerations

Annexure A1: Ethical Committee Approval



Number	:	S173/2011
Title	:	Valuating a continuous professional development programme for Critical Care nurse practitioners in a private hospital in Gauteng
Investigator	:	Mrs Karen Lategan, Department of Nursing Science, University of Pretoria (SUPERVISORS: Dr IM Coetzee / Dr T Heyns)
Sponsor	:	None
Study Degree:		M Cur: Nursing Education

This Student Protocol was reviewed by the Faculty of Health Sciences, Student Research Ethics Committee, University of Pretoria on 14/11/2011 and found to be acceptable. The approval is valid for a period of 3 years.

Prof M J Bester	BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc (Biochemistry); PhD (Medical Biochemistry)
Prof R Delport	(female)BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed Computer Assisted Education
Prof J A Ker	MBChB; MMed(Int); MD – Vice-Dean (ex officio)
Dr NK Likibi	MBB HM – (Representing Gauteng Department of Health) MPH
Dr MP Mathebula	Deputy CEO: Steve Biko Academic Hospital
Prof A Nienaber	(Female) BA (Hons) (Wits); LLB (Pretoria); LLM (Pretoria); LLD (Pretoria); PhD; Diploma in Datometrics (UNISA)
Prof L M Ntthe	MBChB(Natal); FCS(SA)
Mrs M C Nzeku	(Female) BSc(NUL); MSc Biochem(UCL,UK)
Snr Sr J. Phatoli	(Female) BCur (EtAl); BTech Oncology
Dr R Reynders	MBChB (Pret), FCPaed (CMSA) MRCPC (Lon) Cert Med. Onc (CMSA)
Dr T Rossouw	(Female) MBChB.(cum laude); M.Phil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), D.Phil
Mr Y Sikweyiya	MPH (Umea University Umea, Sweden); Master Level Fellowship (Research Ethics) (Pretoria and UKZN); Post Grad. Diploma in Health Promotion (Unitra); BSc in Health Promotion (Unitra)
Dr L Schoeman	(Female) BPharm (NWU); BAHons (Psychology)(UP); PhD (UKZN); International Diploma in Research Ethics (UCT)
Dr R Sommers	Vice-Chair (Female) - MBChB; MMed (Int); MPharMed.
Prof T J P Swart	BChD, MSc (Odont), MChD (Oral Path), PGCHE
Prof C W van Staden	Chairperson - MBChB; MMed (Psych); MD; FCPsych; FTCL; UPLM; Dept of Psychiatry

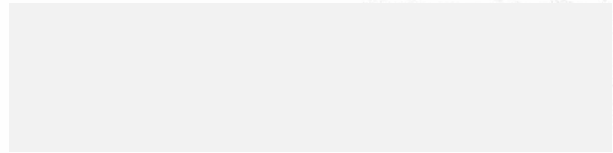
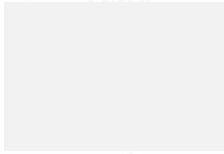
Student Ethics Sub-Committee

Prof R S K Apatu	MBChB (Legon,UG); PhD (Cantab); PGDip International Research Ethics (UCT)
Mrs N Briers	(female) BSc (Stell); BSc Hons (Pretoria); MSc (Pretoria); DHETP (Pretoria)
Prof M M Ehlers	(female) BSc (Agric) Microbiology (Pret); BSc (Agric) Hons Microbiology (Pret); MSc (Agric) Microbiology (Pret); PhD Microbiology (Pret); Post Doctoral Fellow (Pret)
Dr R Leech	(female) B.Art et Scien; BA Cur; BA (Hons); M (ECI); PhD Nursing Science
Dr S A S Olorunju	BSc (Hons), Stats (Ahmadu Bello University –Nigeria); MSc (Applied Statistics (UKC United Kingdom); PhD (Ahmadu Bello University – Nigeria)
Dr L Schoeman	CHAIRPERSON: (female) BPharm (North West); BAHons (Psychology)(Pretoria); PhD (KwaZulu-Natal); International Diploma in Research Ethics (UCT)
Dr R Sommers	Vice-Chair (Female) MBChB; M.Med (Int); MPhar.Med
Prof L Sykes	(female) BSc, BDS, MDent (Pros)

DR L SCHOEMAN; BPharm, BA Hons (Psy), PhD;
Dip. International Research Ethics
CHAIRPERSON of the Faculty of Health Sciences
Student Research Ethics Committee, University of Pretoria

DR R SOMMERS; MBChB; M.Med (Int); MPhar.Med.
VICE-CHAIR of the Faculty of Health Sciences Research
Ethics Committee, University of Pretoria

Annexure A2: Private Hospital in Gauteng: Research Committee



RESEARCH COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2012-0011

Ms Karin Lategan

E mail: karinlategan@mweb.co.za

Dear Ms Lategan

RE: VALUATING A CONTINUOUS PROFESSIONAL DEVELOPMENT PROGRAMME FOR CRITICAL CARE NURSE PRACTITIONERS IN A PRIVATE HOSPITAL IN GAUTENG

The above-mentioned research was reviewed by the Research Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at [REDACTED], has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Academic Board of [REDACTED] (Research Committee).
- ii) All information with regards to [REDACTED] will be treated as confidential.
- iii) Netcare's name will not be mentioned without written consent from the Academic Board of [REDACTED] (Research Committee).
- iv) All legal requirements with regards to patient rights and confidentiality will be complied with.
- v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability
- vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist
- vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)
- viii) [REDACTED] must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from Academic Board of [REDACTED] (Research Committee) as well as a FINAL REPORT with reference



to intention to publish and probable journals for publication, on completion of the study.

- ix) A copy of the research report will be provided to [redacted] once it is finally approved by the tertiary institution, or once complete.
- x) [redacted] has the right to implement any Best Practice recommendations from the research.
- xi) [redacted] reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.

xii) Please note that this approval is granted for a maximum of 36 (thirty-six) months from the date approved.

We wish you success in your research.

Shannon Nell
23/5/2012

Yours faithfully



Prof Dion du Plessis

Full member: Research Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Nell
Chairperson: Research Committee



Date: 23/5/2012

Annexure A3: Private Hospital Approval

4 May 2012


**LETTER CONFIRMING KNOWLEDGE OF CLINICAL MEDICATION RELATED TRIAL OR CLINICAL
NON-MEDICATION RELATED TRIAL RESEARCH TO BE CONDUCTED IN THIS
FACILITY**

Dear Karin Lategan,

**Re: Valuating a continuous professional development programme for Critical Care nurse
practitioners in a private hospital in Gauteng**

We hereby confirm knowledge of the above named research application to be made to the
Research Committee and in principle agree to the research application for
, subject to the following:

- i) That the research may not commence prior to receipt of FINAL APPROVAL from the Academic Board of (Research Committee).
- ii) That the researcher will notify the Academic Board of (Research Committee) of the proposed date of commencement of the project, in writing.
- iii) That insurance stating the necessary indemnity cover (where applicable) will be provided by the researcher and maintained for the duration of the research, protecting both the staff and the hospital facility from potential liability
- iv) That, in accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist
- v) That will be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from Academic Board of (Research Committee) as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

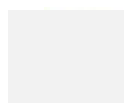
- vi) That the Hospital Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects /  or should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully,



P.B Rood
General Manager



Annexure B: Participation leaflet and informed consent

Participation leaflet and informed consent

Dear Colleague

You are invited to participate in the Appreciative Inquiry (AI) research project that will take place at your private hospital. This information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher at any time.

TITLE OF STUDY

Evaluating a continuous professional development programme for critical care nurse practitioners in a private hospital in Gauteng: An Appreciative Inquiry approach

The purpose and objectives of the study

You are invited to take part in a research study. Your participation will be as a nurse practitioner working in the High care or critical care unit.

The overall aim of this research was to evaluate the CPD programme for nurse practitioners working in the CCU and HCU of a private hospital in Gauteng. In order to achieve this aim, the objectives were guided by the 4-D cycle of Appreciative Inquiry:

Objective 1: Explore and describe views of nurse practitioners working in the critical care and high care units pertaining to the current CPD programme in the private hospital in Gauteng;

Objective 2: Make recommendations to refine the current CPD programme in the private hospital to the hospital management.

Explanation of procedures to be followed

You as nurse practitioner are requested to participate in a collaborative effort to evaluate the current CPD programme.

Risk and discomfort involved

As a participating nurse practitioner, you will experience no discomfort. There is also no risk involved in this study. However, your input into this project will require some of your time and effort.

Benefits of the study

Appreciative Inquiry looks at organisational issues, challenges, and concerns in a significantly different way. Thus, instead of focusing on problems, organisational members first discover what is working particular well in their organisation. Then, instead of analysing possible causes and solutions, they envision what might be like if *"the best of what is"* occurred more frequently.

The power of AI is the way in which participants become engaged and inspired by focusing on their own positive experiences. AI does address issues and problems, but from a different and often more constructive perspective: it reframes problem statements into a focus on strengths and successes (Coghlan, Preskill, & Catsambas 2003:5).

This has a positive influence on members of an organisation, once the members feel motivated, valued and appreciated, their internal motivation, attitude's and co-operation with colleagues improve and together they can move the organisation forward towards co-constructed goals/outcomes.

Voluntary participation in and withdrawal from the study

Participation occurs on a voluntary basis, and you can withdraw from the project without stating any reason should you no longer wish to take part.

Ethical approval

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

Additional information

If you have any questions about your participation in this Appreciative Inquiry process, you should contact the researcher, Ms Karin Lategan

Work telephone: (012) 422 2300

Cellphone: 083 276 0088

Email address: karinlategan@mweb.co.za

Confidentiality

Your input into this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

Consent to participate in this study

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

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

Participant's signature

Date

Karin Lategan

Researcher

Annexure C: Appreciative narrative interview schedule

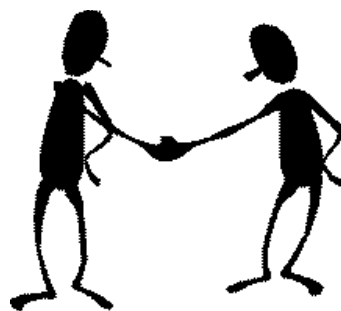
**Appreciative Inquiry interview schedule
Nurse educators**

Question 1:

Reflecting back on the continuous professional development programme in the private hospital that was most satisfying/peak experience? (Please write me the story)

Question 4:

What is your vision with regard to the ideal continuous professional development programme?



Thank you for your participation. Your inputs are appreciated.

Annexure D: CV of the Experienced Independent Facilitator

CURRICULUM VITAE

DR SONJA GROBLER

PERSONAL

DATE OF BIRTH	6 September 1968
NATIONALITY	South African citizen
MARITAL STATUS	Married
IDENTITY NUMBER	6809060066089
HEALTH	Excellent
HOME ADDRESS	1227 Woodlandsdrive Queenswood Pretoria 0186 Gauteng
TELEPHONE	083 310 5431
E-MAIL	sonja@heartware.co.za

OCCUPATIONAL HISTORY

- 2010-CURRENTLY -Director of Heartware Junxion(LTD) – Teen- and adolescent facilitative programs, coaching, life skills, value programs, sexuality programs
- Psychotherapy
 - Clinical Accompaniment – University of Pretoria(B.Cur)
 - Clinical Accompaniment – University of Johannesburg(B.Cur)
 - Clinical Accompaniment – University of Johannesburg(M.Cur)
 - External examiner – University of Johannesburg(M.Cur)

2005-CURRENTLY	-CONSULTANT: Qualitative Research, Data Collection, - Analysis, Individual Psychotherapy, Process driven therapy through Scrapbooking, Individual coaching, Adolescent group coaching, Clinical accompaniment UP, UJ, Supervisor MCur students UJ, Supervisor UP(2 Doctoral students Nursing Science)
2006-2009(June)	Owner: Restaurant & Tea garden
2002-2005	Consultant for GITOC(Government owned IT company) – Change Management and Business processes manager
2002-2005	Director: Facilitation Excellence(privately owned business coaching company)
2001-2002	Manager Organisational Development – Orion Group Company consists of Real Estate(industrial real estate, shopping centres, hotels & resorts, garages and other enterprises) <ul style="list-style-type: none"> • Individual executive coaching • Change management(workers council fascilitation) • Team coaching(mergers & acquisitions) • Skills development: Identifying training needs, CV development(Hotel trainees, Security staff, Cleaning personnel), Facilitate internal and external trainers, Evaluate outcomes, Productivity Measures, Screening course material, Qualification audits. • Organisational development: Nature and structure of teams defined and developed. • In duty training: Life skills training – Time management, conflict management etc • Screening – Job applications
2000 - 2001	(Part time)Orion Holdings, Orion Hotels & Resorts: - Corporate Team Coaching, Executive Coaching

1999-2001	Human Dynamics: Corporate stress assessments and counselling
July 1998-currently	Consultant: Qualitative research; Corporate stress counselling; Corporate Team Coaching; Executive Coaching
2000	University of Pretoria: Research Assistant(part time) Rand Afrikaans University: Mentor MCur students – Clinical Psychiatric Psychotherapy University of Potchefstroom: External Examiner
1995-2001	Private practitioner: Counselling, psycho therapy, psychiatric assessments, individual psychotherapy, family psychotherapy, group psychotherapy, relaxation therapy.
1996-1999	University of Pretoria: Psychiatric Nursing Science Lecturer RESPONSIBILITIES: Lectures: Psychiatric nursing science theory and practice(BCUR I, II, III, IV, BCUR Honours), Clinical psychiatric nursing modalities: group work, individual therapy, crisis intervention, social skills training, interpersonal skills training, family therapy etc, MA SOCIAL WORK(Psychiatry), Moderator: SG Lourens Nursing College, Moderator: Lebone College of Nursing, External examiner RAU, Clinical supervision. Mentor – Nursing Residence
1995	University of Pretoria: Part time Psychiatric Nursing Science Lecturer RESPONSIBILITIES(as above)
1994-1996	Vista Private Clinic: Clinical Psychiatric Nursing Specialist RESPONSIBILITIES: Implementation and coordinator of day programme brought from USA, in duty training of

nursing staff as well as administrative staff, individual therapy, group therapy, family therapy, crisis intervention(24 hour crisis line), community lectures, marital therapy consultant, research, job descriptions, supervision of nursing staff end students, clinical facilitation and education of students(diploma and degree), lectures, quality assurance, Psychiatric assessments.

1991-1994	Vista Private clinic: Registered nurse(General, Psychiatric, Community- & Midwifery)
1987-1990	University of Pretoria/Pretoria Academical Hospital: BCur student

ACADEMIC QUALIFICATIONS

BCUR	University of Pretoria, SA, 1990
NGD(non degree purposes)	Rand Afrikaans University, SA, 1991
MCur	Rand Afrikaans University, SA, 1994
DCur	Rand Afrikaans University, SA, 1998
Certificate	Deloitte & Touche, 2004 -
Fascilitation	

PROFESSIONAL QUALIFICATIONS

- Registered General, Community, Psychiatric Nurse, Midwife
- Private practicing counsellor
- Lecturer
- Psychiatric Nurse Specialist

- Consultant – Qualitative research
- Consultant Team Coaching facilitator
- Consultant Executive Coaching facilitator
- Student Mentor/Councillor

PUBLICATIONS

- Grobler, S & Poggenpoel, M 1996: The adolescent's experience of admission to a psychiatric hospital. *Geneeskunde*, Jan/Feb: 40-44
- Grobler, S; Myburgh, CPH & Poggenpoel, M 1999: Adolescent interpersonal communication skills. *Curationis*, Des
- Grobler, S 2001: An approach towards adolescent interpersonal communication skills. *Southern African Journal of Child and Adolescent Mental Health*
- Gmeiner, A; Grobler, S & Van Wyk, S 2000: An interpersonal communications approach for adolescents: A case study. *SA Journal of Child and Adolescent Mental Health*
- Treadwell, I; Grobler, S De Witt, TW 2000: The impact of a new educational strategy for acquiring neonatology skills. *Medical Teacher*, Vol 23, No 5, p478
- Grobler, S; Treadwell, I 2000: Perceptions of medical students on skills training in simulation – a qualitative study. *SAMJ*

PAPERS DELIVERED

- "Adolescent communication patterns "4th International Qualitative Health Research Conference. Vancouver, Canada 1998(20 Feb)
- Poster "Perceptions of medical students on skills training in simulation-a qualitative study"
- Poster"An interpersonal communications approach for adolescents: A case study", Unisa, 2000

Annexure E: Completed Appreciative Narrative Interview Schedules

2

Appreciative narrative interview schedule
Nurse educators

1) Reflecting back on the continuous professional development programme in the private hospital that was most satisfying/peak experience?
(Please write me the story)

- Clinical facilitators teach me to understand why I do things - make me feel safer *Expert*
- Learning from Dr Thomson on the spot was excellent - will always remember it *Expert*
- I learn more from the doctor in 10 min than I learn during a six hour workshop *Expert*
- Know what to do after doctor's rounds because he likes to share his knowledge with us
- Practical demonstration of equipment helps me to be safe at bedside *Product specialist*

2

2) What are your wishes for an ideal continuous professional development programme in a private hospital?

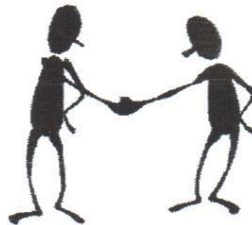
- If I know how, the stress will be less
- There must be teamwork to join training, IF I look after the patient during training today, I want to go to the next training session.
- Training must meet teaching needs
- We need more time on duty for training
- Management must negotiate with experts to be available for training.

3) What do you see as challenges for a continuous professional development programme?

- Management must be involved in the whole process of training planning to ensure that our needs are addressed
- Training must be on the same time every month
- Management can paid experts

2

4) **What is your vision with** regard to the ideal continuous professional development programme?



Thank you for your participation. Your inputs are appreciated.

3

Appreciative narrative interview schedule
Nurse educators

- 1) Reflecting back on the continuous professional development programme in the private hospital that was most satisfying/peak experience?
(Please write me the story)

1) After demonstration I have knowledge how to troubleshoot and feel more empowered to do my job well
2) Formal training sessions are best for the HC staff because we cannot learn in the busy unit where it is all about admissions and discharges
3) Prefer to learn from the doctor that is an expert in his field
4) Clinical facilitators evaluations help me to realise what I know and what I do not - could improve my knowledge

3

2) What are your wishes for an ideal continuous professional development programme in a private hospital?

- 1) If the staff get the hours ^{Time} for training it will keep them motivated.
- 2) Availability of experts to train us is a problem.
- 3) More opportunities must be created to learn.
- 4) Some people never attend training and nothing happens to them - we want to be rewarded for training.
- 5) We must work together.

3) What do you see as challenges for a continuous professional development programme?

- 1) Training is not noticed by management because we do not get any rewards for training.
- 2) Management don't reward us for training.
- 3) Get one person that is motivated and can give consistency to training.

(f)

Appreciative narrative interview schedule
Nurse educators

1) Reflecting back on the continuous professional development programme in the private hospital that was most satisfying/peak experience?
(Please write me the story)

Orientation & In service - feeling of belonging. know the hospital
In service - Teach you about Product special
the different equipments, at home list
relation, policy & protocol. Demonstration
Spot teaching e.g. Abnormal
ABC → in relation - so the patient
meaning practically
On the spot

10

2) What are your wishes for an ideal continuous professional development programme in a private hospital?

- More time to attend in-service training
- Meet ^{teaching} needs - build → confidence and able to practice safely. create sense of belonging

Workplace learning environment

Encourage learning culture

3) What do you see as challenges for a continuous professional development programme?

- Staff must have a drive to learn
- Provide 15 minutes lectures ^{start} during diagnosis
- Involvement of management
- Advertisement to all staff and staff permanent and Agency.

Project manager

4

4) **What is your vision with** regard to the ideal continuous professional development programme?

- Evaluate the ^{level of} staff knowledge.
- Plan, implement and evaluate and evaluate
- motivate - continuous and the response thereof.



Thank you for your participation. Your inputs are appreciated.

8

**Appreciative narrative interview schedule
Nurse educators**

1) Reflecting back on the continuous professional development programme in the private hospital that was most satisfying/peak experience?
(Please write me the story)

1. Inservice training use to have value. In some units training not in progress at present. Due to staff shortage.

2. Training by Themba. Dialysis. Hicare staff understood: Peak experience → Product specialist

3. Poor communication between units for inservice training sessions.

4. Hicare no um for ± 2 years no formal training. Stayed behind on training + communication.

5. Now better: Formal training once p. month.

6. Formal training sessions once per month: also feedback on hospital issues: staff up to date.

8

2) What are your wishes for an ideal continuous professional development programme in a private hospital?

1. Time
2. Expert trainers - Availability of expert
3. Framework to join training → Co-operative learning
4. Staff enthusiasm → Co-operative learning
- * 5. Agency give 6 hours for training/incentives
6. Dedicated staff
7. More clinical facilitators → Facilitators - Experts
8. Place to basic training: Agency staff.
Wish: All staff to be well informed.
- * 9. Permanent staff attitude towards training agency staff → Co-operative learning

3) What do you see as challenges for a continuous professional development programme?

1. Campaign drive: Very. Focus on training.
2. Review results for patient review → Funding.
3. Rewards + recognition for ward most attending → Floating trophy
4. Ex. 1st Thursday of every month.
5. Shares with big companies: Commitment: Dialysis.
Diabetes: stationed in Unit.
6. Doctor x1 stationed in Unit.
7. CUS Job description: adhere to it.

SAN'S PRIVATE HOSPITAL.

4) **What is your vision with** regard to the ideal continuous professional development programme?

How to start the process:

- Invest in current staff in expert staff.
- Review Maximising:
 - Current skill reviews: strengths + weaknesses.
 - Uplifting strengths of staff.
 - Allocate staff according to strengths on different shifts.
 - Evaluate risk in unit: Focus on training.
 - Teambuilding: include permanent agency staff.

Socialise → Campaign

Feedback to staff to complete the staff

More sessions like this to evaluate nursing frustration.

- Create
- "THANK YOU"!! to staff.

"Dreams can come true" / "Dreams come alive"
The Avengers
"Journey to excellence"



Thank you for your participation. Your inputs are appreciated.

(12)

Appreciative narrative interview schedule
Nurse educators

1) Reflecting back on the continuous professional development programme in the private hospital that was most satisfying/peak experience?
(Please write me the story)

- Sr Rowan is an expert in her field and her informal training was of great value
- On-the-spot training is the best need the knowledge now Doctor explains it and I can apply it.
- Learning during doctor's rounds is of great value, because you remember it.
- Prefer to learn from the doctor that is an expert in his field.
- Can stay up to date with equipment after step by step demonstration. *product specialist*
- We have doctors that are experts in their field and want to share their knowledge with us.
- The product specialist teaches me how to trouble shoot. It make me feel safer and I felt empowered.

12

2) What are your wishes for an ideal continuous professional development programme in a private hospital?

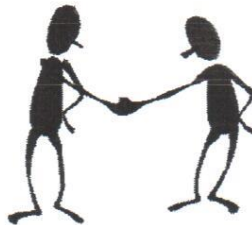
- Staff want to meet their teaching needs.
- There must be time for in-service training even if the unit is busy.
- Management must negotiate with experts to be more available.
- Rewards for learning motivate us
- I want to feel safe when I work

3) What do you see as challenges for a continuous professional development programme?

- Training must be a drive from management to improve quality of patient care.
- Funding is not available for courses.
- Dedicated persone that has a passion for training must organised it.

(12)

4) **What is your vision with** regard to the ideal continuous professional development programme?



Thank you for your participation. Your inputs are appreciated.

Annexure F: Summary of Discovery (Phase 1)

Table F-1: Detail outcomes from the Discovery Phase

Topics	Participant													Tot	
	1	2	3	4	5	6	7	8	9	10	11	12	13		
In-service Training	x	x	x		x	x	x					x		Not handed in	7
Expert training															
• Product specialists				x		x	x	x		x	x	x			7
• Clinical facilitators		x	x		x	x	x								5
• Medical practitioners		x			x	x			x			x			5
• Unit mangers						x									1
Educational methods															
• On-the-spot training		x	x	x	x	x	x		x			x			8
• Demonstrations		x	x	x		x	x	x	x			x			8
• Workshops			x		x			x							3
• Clinical rounds		x			x	x			x		x	x			6
• Simulation	x														1

Note: The feedback from participant 12 was all consider being negative and parked in the "Parking Lot".

Annexure G: Summary of Dream (Phase 2)

Table G-1: Detail outcomes from the Dream Phase

Topics	Participant													Tot			
	1	2	3	4	5	6	7	8	9	10	11	12	13				
Workplace learning environment	x		x	x	x	Participant only complete question 1		x							Not handed in	5	
Learning opportunities																	
• Time	x	x	x	x	x		x	x	x	x	x	x	x	x			11
• Needs		x		x	x		x		x				x				6
• Availability of Clinical Facilitator		x	x		x		x	x		x	x	x					8
Facilitate and promote learning																	
• Co-operative learning climate		x	x	x				x	x	x	x						7
• Encourage learning culture	x	x		x				x					x				5
• Recognition/Rewards			x										x				2

Annexure H: Summary of Design (Phase 3)

Table H-1: Detail outcomes from the Designing Phase

Topics	Participant													Tot
	1	2	3	4	5	6	7	8	9	10	11	12	13	
Management		x	x	x	x	Participant only complete question 1	x	x				x	Not handed in	7
• Funding	x	x	x		x		x	x				x		7
• Project manager		x	x	x	x		x		x	x	x	x		9

Annexure I: Delivery (Phase 4)

Inservice training ①

① Peak experiences

ICU
On the spot teaching

did not expect
not formal
expert teaching

High care:

UM - formal training = dates known
ward carries on
Tamba - dialysis &
level of presentation

ICU
General
Medical
Surgical

Pd round with (multi disciplinary team)

- dietician
- ~~physio~~ physio
- doctor
- clinical facilitator
- nurse taking care of pt
- nurse student
- infection control

looks
different
in each ward

- expert teaching
- need for training
- " " safety-confidence builds
- time
- different needs for different units

ICU / HCU
slow pace / fast pace
Sat once
Semi

② Dream about CPD program? What are the possibilities? Ideal program. ②

(Everybody to be knowledgeable
Same level of training of people working together.)

- Different levels of training - accommodated
- Funding & hours (↓ motivational)
- Expert trainer - ↑ time
- Mngement to be involved

↓
Hosp wage
Zonal matrons
CEO
Unit mngers
Drs - training } Buy in

- Agency involvement - agencies pay own staff - hours. 6. to get train)
- (+) attitude towards staff (expert trainees - not CNS nurses)
- More clinical facilitators (expert trainees - not CNS nurses)
1 Students
1 High care
1 ICU
1 General wards

ICU - novice / beginner (3)
- competent / advanced beginner
formal training →
less formal → for more competent nurses.
Staff need } assessment ..
pt need }
Team approach - management
- pt.
- nurses
- drs.
- families
- attitude ▽
- Eagerness to attend in service training
exciting
- Reward & recognition system
portfolio of evidence
- Congress attendance
- Central venue for training

Advertise training! (PK) ④
 Short lectures. (15 min).
 Dr involvement. (15 min) training

③ Innovation on how it can happen? (actions?)

Short lectures (15 min) → be flexible, repeat sessions, reschedule

Expat

minutes + display → PR

ingment buy in

funding for training

all agency + permanent staff

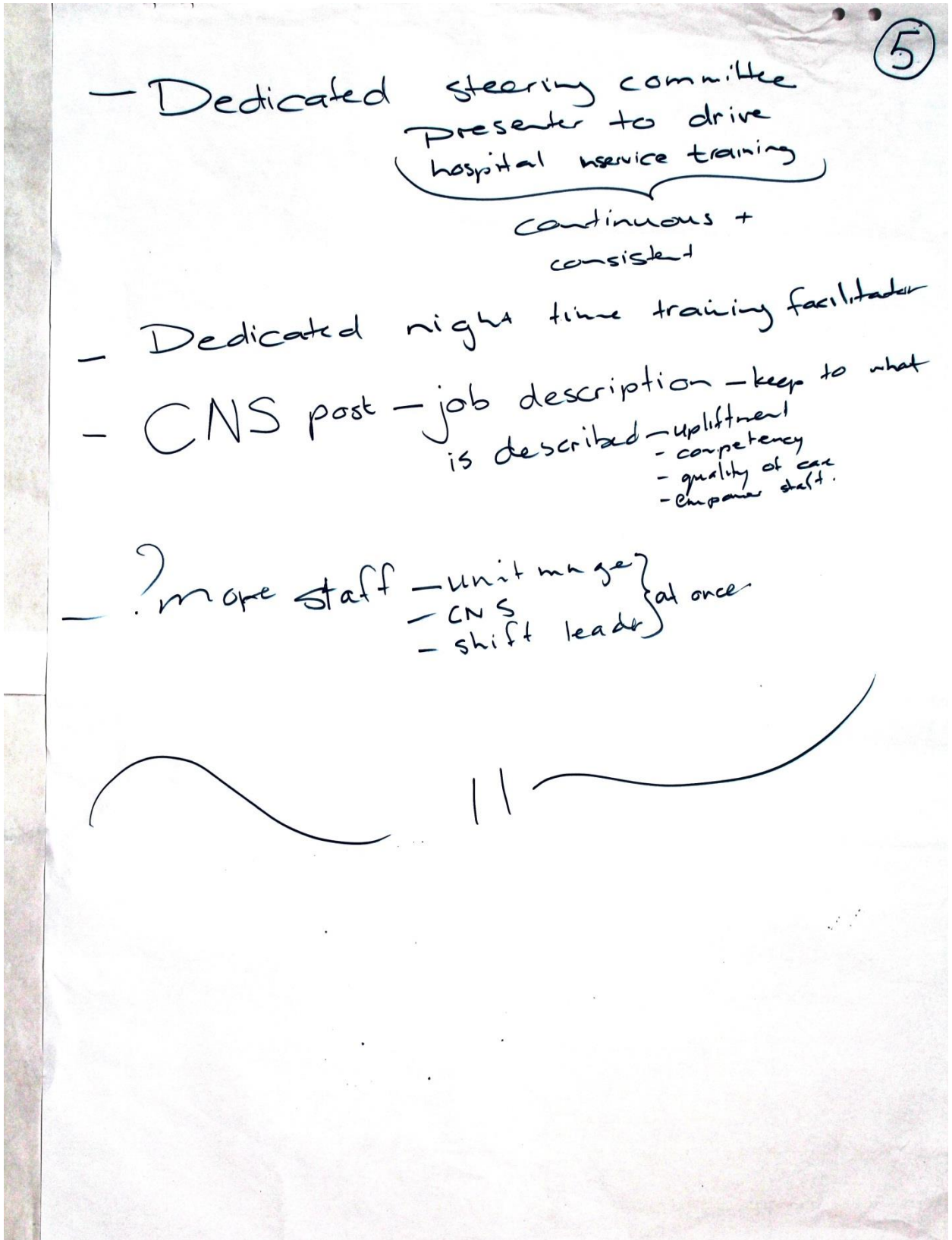
⊗ use professionals already working in the hospital for

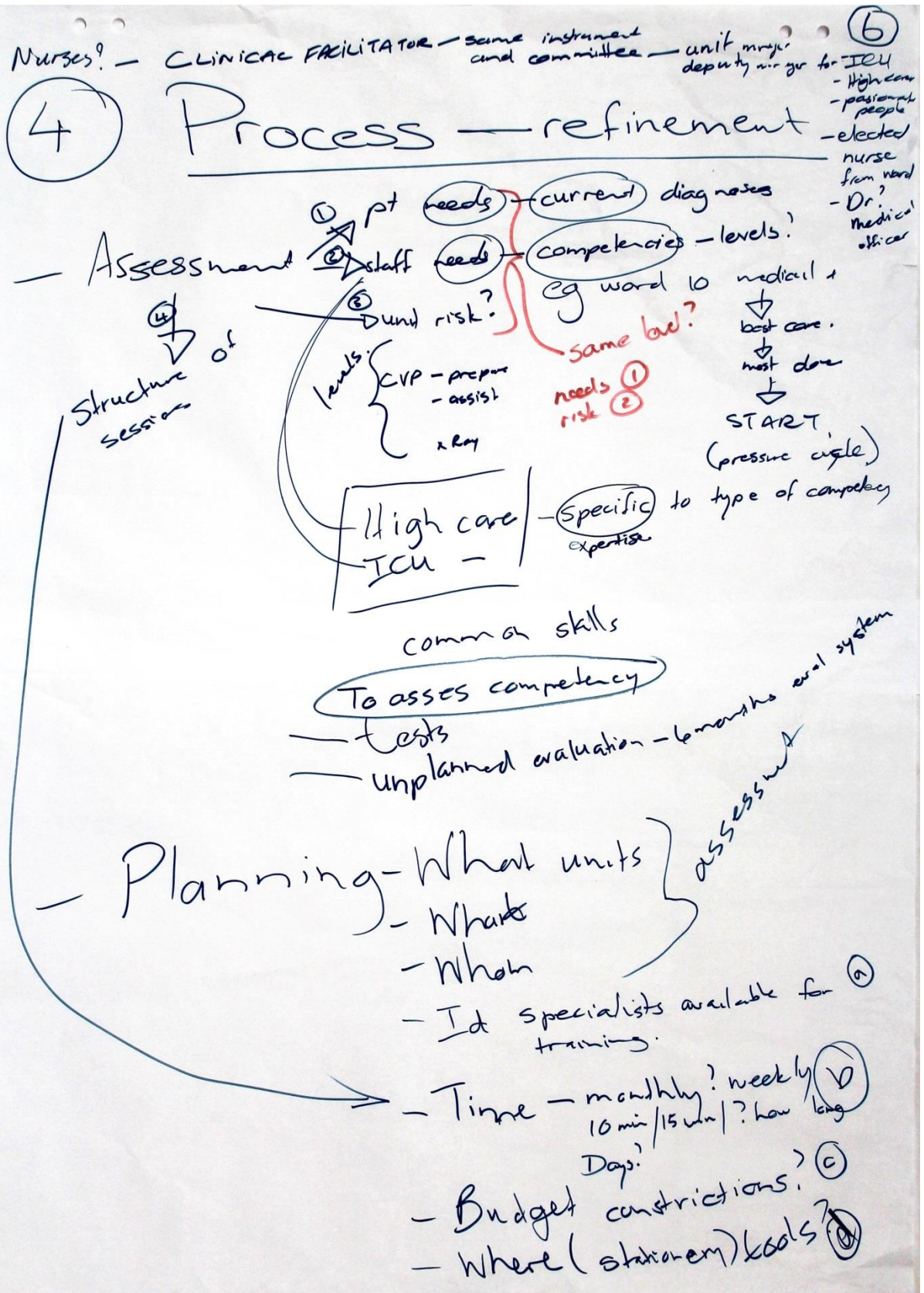
Review activities → staff/pt ratio → money
 → do training

Recognition - ↑ training - trophy
 Structured programme (PR) - everybody knows - dedicated place/room

Dr in the unit (on call) available for special unit.

Commitment from companies toward equipment mgmt training





(7)

e) Visibility - PR?

f) ? What form of reward maximizing performance?
- Who takes responsibility - I identify the team

ACTION

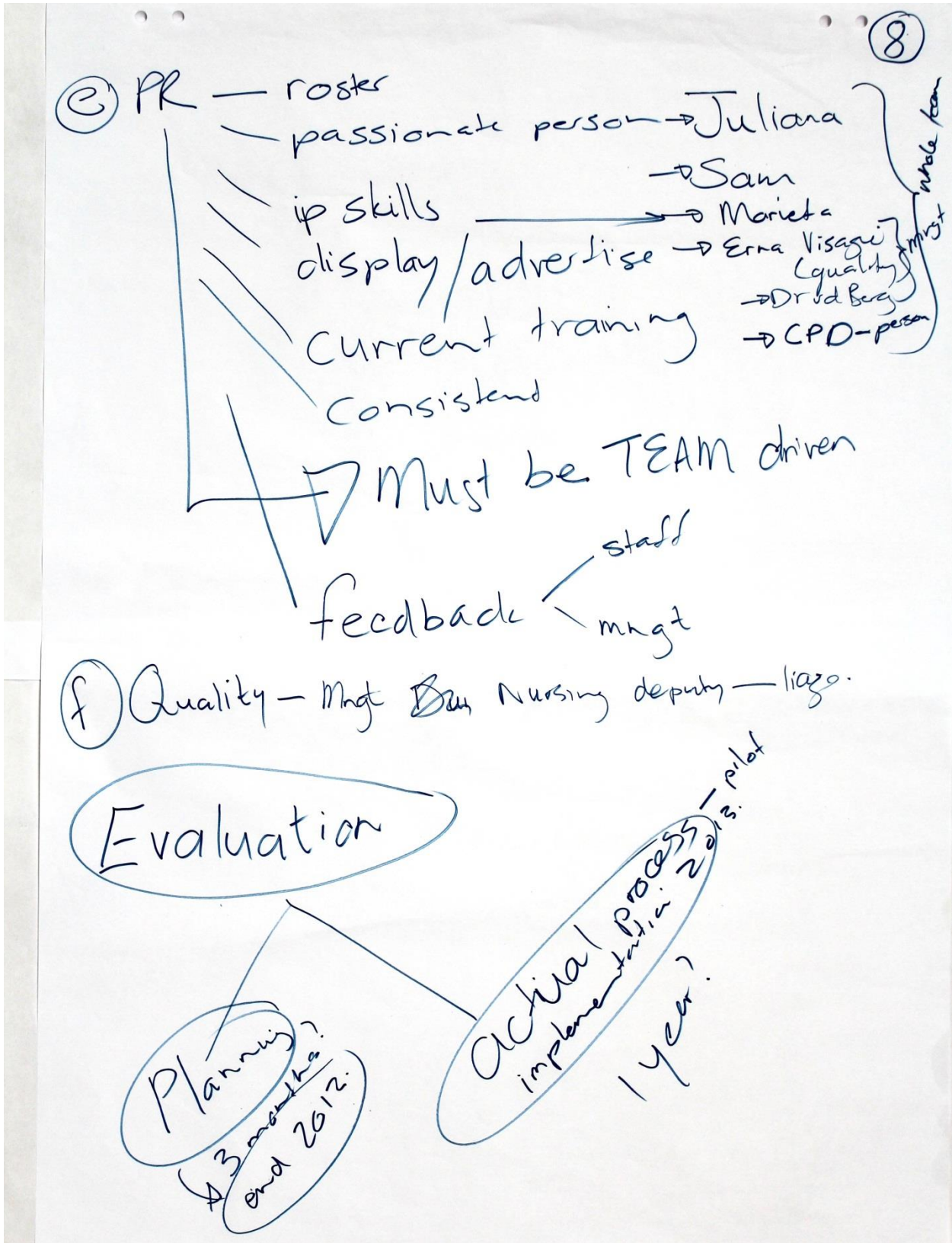
a) Go to unit mangers + ask abt skills
Ask sisters in charge of units - working on the floor
Google

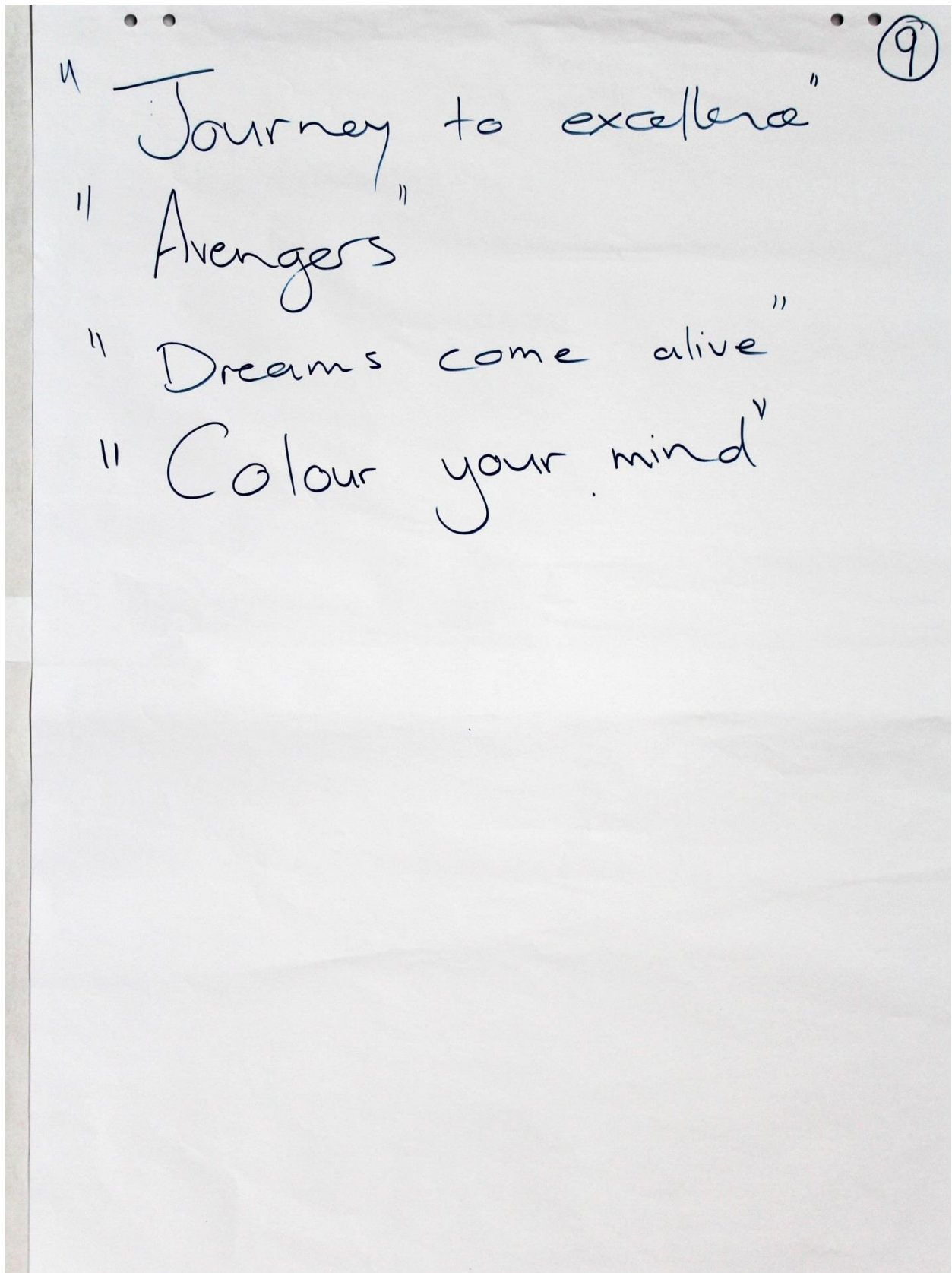
* Clinical dept - decide level of person/expert
(expert training?)
Ask staff for interests - then do allocation.

b) Units less busy times - will differ
Do training in less busy times

c) Review maximizing process - ?
Open discussion abt budget
↓
transparent for training eg "equipment"
"point system" for training done

d) Preferences for training
"There are locks available"

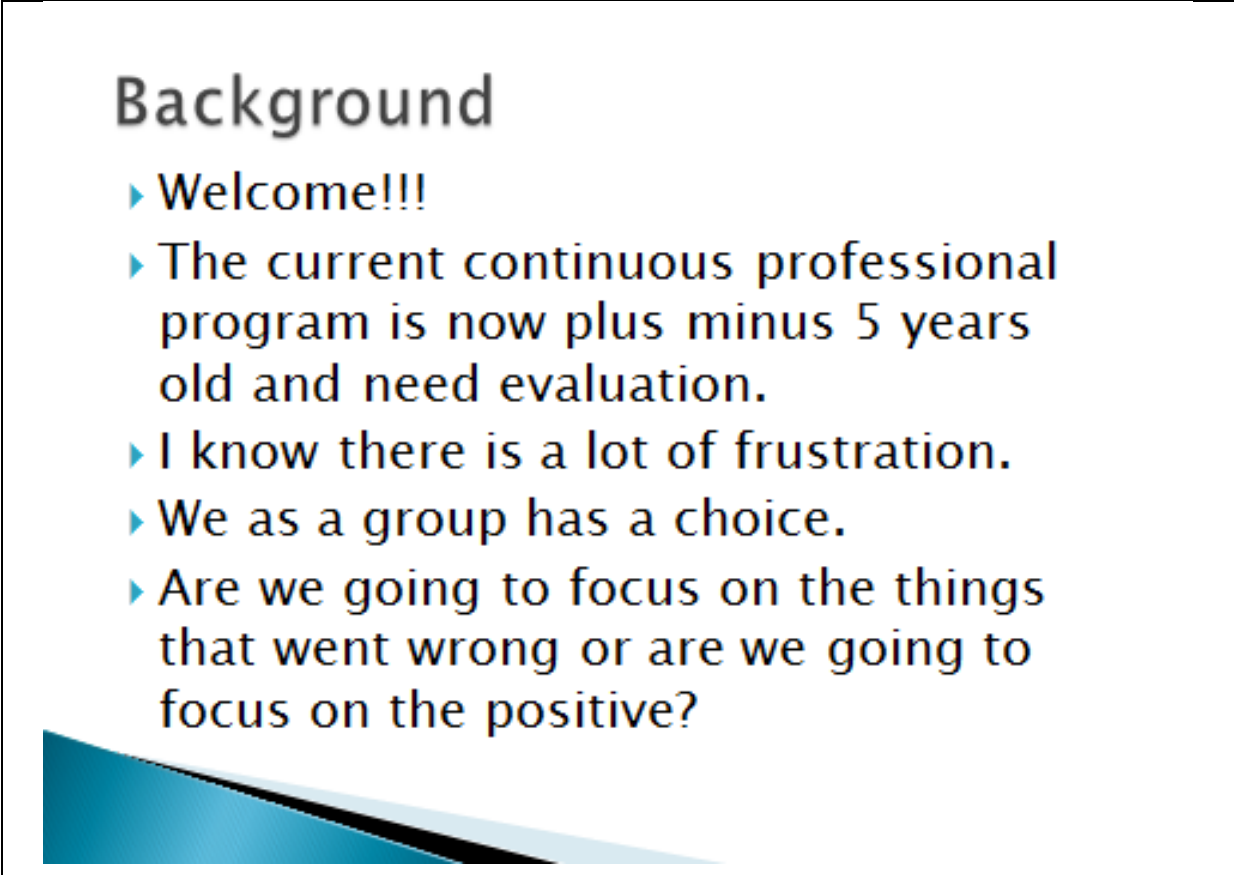




Annexure J: Background to the study

The researcher also used this opportunity to describe the research methodology and expectations of the Dream of the AI process. The researcher use the following phrase from Belva Davis *"Don't be afraid of the space between your dreams and reality. If you can dream it, you can make it so"*. The following quote from an unknown source summarise the dream that is the objective of the research *"The positive thinker sees the invisible, feels the intangible, and achieves the impossible"*.

Power Point Presentation used during Focus Group Inquiry by the researcher.

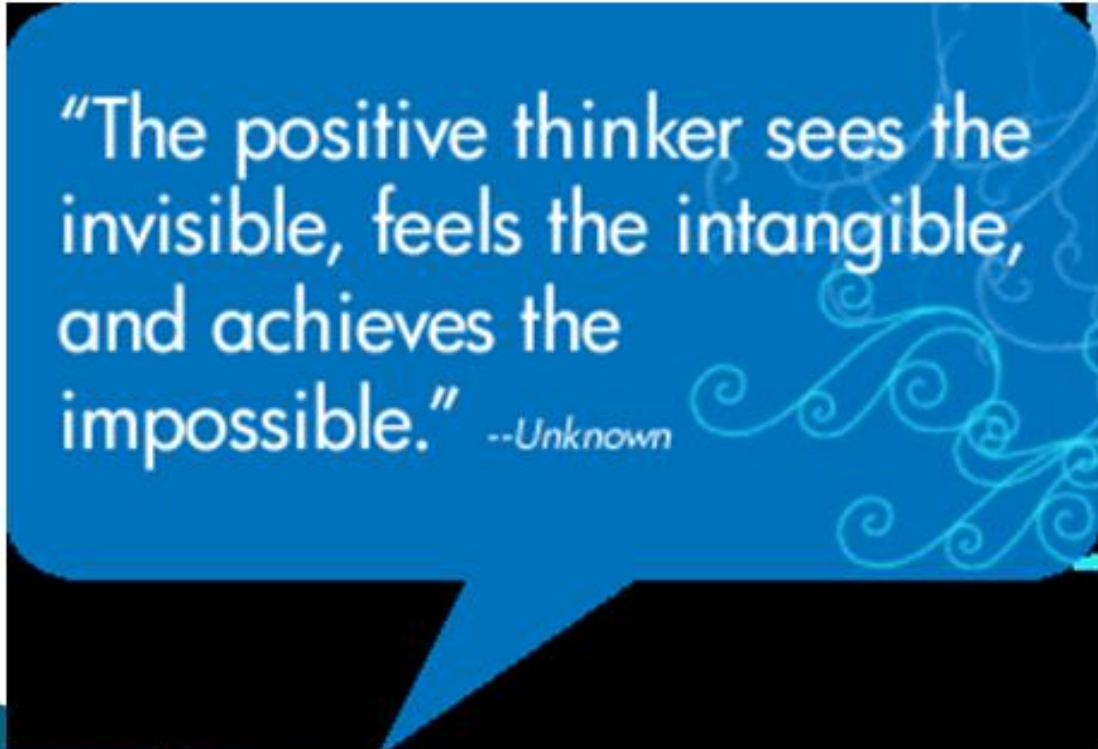


Background

- ▶ Welcome!!!
- ▶ The current continuous professional program is now plus minus 5 years old and need evaluation.
- ▶ I know there is a lot of frustration.
- ▶ We as a group has a choice.
- ▶ Are we going to focus on the things that went wrong or are we going to focus on the positive?

The Appreciative Philosophy

- ▶ In every society, organization, or group, something works.
- ▶ What we focus on become our reality.
- ▶ People have more confidence and comfort for the future if they carry forward parts of the past.
- ▶ It is important to value differences.
- ▶ So you as a group have a say and a choice.



“The positive thinker sees the invisible, feels the intangible, and achieves the impossible.” --Unknown



Annexure K: Ground rules to the Focus Group Inquiry

As part of the discussion of the expectations, the following ground rules of engagement during the Focus Group Inquiry were agreed with all participating in the focus group:

- Commitment from all
 - Participant actively
- Honesty
- General language for communication will be English but individuals will be allowed to complete written comments in Afrikaans
- Monitor time in a polite way
 - Keep inputs concise and relevant
 - The facilitator will monitor the relevance of the communication and use this as an indication to stop the session
- Participation
 - Encourage everybody to talk freely
 - Show respect to everybody's opinion
 - Keep it positive
 - We speak as equals

The Focus Group Inquiry was managed within these ground rules with all participating to make it successful.

Annexure L: Letter and Curriculum Vitae from editor

Annexure L1: Letter from editor

To whom it may concern

I have duly edited Karin Lategan's Master's thesis. My CV is attached for your information. In addition, I am at present editing and translating for the UP Languages Services headed by Joanne Lombard.

Sincerely,

Joan Hettema
250 Troye St
Muckleneuk
0002
(012) 440-4753/ 072-126-5174

Annexure L2: Curriculum Vitae of editor

CURRICULUM VITAE

Joan Hetteema

Tel/Fax: (012) 440-4753

Cell: 072-126-5174

e-mail: jhetteema@absamail.co.za

Date of Birth:	9 February 1937
Type of Drivers Licence Held:	Yes Code 08
Nationality	South African
Health:	Excellent
Languages:	English, Afrikaans, Latin, French
Computer Literacy:	Office 2000: MS Word

EDUCATION

1943-1949: BROOKLYN PRIMARY SCHOOL, PRETORIA

1950 -1954: PRETORIA GIRLS HIGH SCHOOL – FULL MATRIC EXEMPTION

1955-1957: UNIVERSITY OF PRETORIA – (ENGLISH & LATIN MAJORS)

OTHER SUBJECTS: ANTHROPOLOGY, ZULU, HISTORY OF ART, AFRIKAANS

1987 – UNISA – HONOURS ENGLISH LANGUAGE AND LITERATURE –

(Shakespeare and his Age, Poetics, The Augustans, Moderns, Comparative Literature (Bacon/ Principia Mathematica – Newton)

1971-1974: ALLIANCE FRANCAISE – TROISIÈME DEGRÉ

EXPERIENCE

1958 – 1960 – CSIR – NATIONAL BUILDING RESEARCH INSTITUTE

Proof reader, language assistant for technical publications, translator, open days, function, visitors.

1961 – 1962 – S A INFORMATION SERVICES

S A PANORAMA – internationally distributed glossy journal

Editorial staff – journalist/writer, news gatherer, researcher, proofs, final copy (Dec. 1962 –birth of daughter)

**1963 – 1966 – S A INFORMATION SERVICES
S A DIGEST – internationally distributed weekly news journal**

Editorial staff – journalist/writer, researcher, proofreader, final copy, translation, annual report copy/translation..

1966 - 1967 – PERFORMING ARTS COUNCIL OF THE TRANSVAAL (PACT)

*Media liaison for local and overseas actors, singers & dancers, preparation of theatre programmes, public relations
(birth of son July 1968)*

1969 - 1972 – PRETORIA NEWS

General News and Educational Reporter – campus reporter for all tertiary institutions

**1972 – 1974 – DEPARTMENT OF INFORMATION
S A DIGEST**

Journalist/writer, proofs, final copy, translation, annual report translation into English

1974 –1980 – CSIR

NATIONAL BUILDING RESEARCH INSTITUTE (1974 – 1980)

*Language editor for technical publications
Scripts/ photographs and final production (both sound and visual) –
Audiovisual productions (tape/slide)*

1980 –1989 – CSIR

*Co-editor: **SCIENTIAE** – quarterly glossy mouthpiece of CSIR distributed worldwide to scientific. (News gathering, rewriting of scientific copy, photographs, proofreading and final production as well as liaison with scientific community).*

(Marked assignments for Unisa Basic English Course 1988-1989)

1990 – 1995 – UNIVERSITY OF PRETORIA

Journalist/writer for university publications: features and news as well as interviews with special responsibility for Faculty of Veterinary Science

Head Media Liaison (print and electronic media) for all faculties at the University

**(voluntary early retirement from University of Pretoria September 1995 and move to Cape Town)
1995-1998**

FREELANCE WORK IN CAPE TOWN – features and photographs for Health Supplement of Cape Times, feature articles for various PR companies.

1999 –2012

LECTURING: JOURNALISM – BOSTON CITY CAMPUS – *MEDIA HOUSE* – Pretoria **LECTURING:** (first, second and third year students – 1999 &2000 – writing four study guides.)

LECTURING – DAMELIN HATFIELD – **COMMUNICATIONS AND MEDIA 111 (2000 & 2001)**

LECTURING – ROSEBANK COLLEGE – PRETORIA – **JOURNALISM, MEDIA/BUSINESS COMMUNICATIONS** and **BUSINESS ENGLISH** (2002)

FREELANCE WRITING/EDITING - COFFEE TABLE BOOK – FOR CITY OF TSHWANE METROPOLITAN MUNICIPALITY

PREPARING COPY FOR CALENDARS ON “OU RAADSAAL/UNION BUILDINGS FOR CITY OF TSHWANE METROPOLITAN MUNICIPALITY

EDITING: CONFERENCE PAPERS, PRESS RELEASES; ANNUAL REPORTS; THESES – MASTERS AND DOCTORATES; PUBLICATIONS

LECTURING – TSHWANE UNIVERSITY OF TECHNOLOGY – **ENGLISH BUSINESS COMMUNICATIONS (2004)**

LECTURING TSHWANE UNIVERSITY OF TECHNOLOGY – **ENGLISH BUSINESS COMMUNICATIONS AND MEDIA STUDIES (2005)**

LECTURING TSHWANE UNIVERSITY OF TECHNOLOGY – **ENGLISH BUSINESS COMMUNICATIONS, MEDIA STUDIES 1 & 2, ENGLISH FOR JOURNALISM 1& 2, (2006/2007)**

Judge: Publications Forum (annual competition countrywide) 2008, 2009, 2010, 2011,2012

LECTURING COLLEGE CAMPUS – **ENGLISH (UNISA) PUBLIC RELATIONS, EVENTS PLANNING - 2008**

LECTURING COLLEGE CAMPUS – PUBLIC RELATIONS, MEDIA STUDIES AND JOURNALISM, BUSINESS COMMUNICATIONS – 2009

LECTURING COLLEGE CAMPUS, PUBLIC RELATIONS, MEDIA STUDIES AND JOURNALISM, ADVERTISING COPYWRITING – 2010

EDITOR/TRANSLATOR -UP Language Services – part time - 2012

Doctoral, Masters and Baccalaureus theses/dissertations – UP and TUT – 2009 - present