National Council for the Professional Development of Nursing and Midwifery

Report on the Continuing Professional Development of Staff Nurses and Staff Midwives

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National Council for the **Professional Development** *of* **Nursing** *and* **Midwifery**

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

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Glossary

ABA	An Bord Altranais
ANA	American Nurses Association
ANCC	American Nurses Credentialing Centre
CE	Continuing Education
CPD	Continuing Professional Development
CPE	Continuing Professional Education
DATHs	Dublin Academic Teaching Hospitals
DoHC	Department of Health and Children
ERHA	Eastern Regional Health Authority
HSEA	Health Service Employers Agency
ICN	International Council of Nurses
MHB	Midland Health Board
National Council	National Council for the Professional Development of Nursing and Midwifery
NMC	Nursing and Midwifery Council (United Kingdom)
NMPDU	Nursing and Midwifery Planning and Development Unit
NQAI	National Qualifications Authority of Ireland
OHM	Office for Health Management
PDP	Personal Development Plan
SEHB	South Eastern Health Board
SHB	Southern Health Board
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
USA	United States of America
WHO	World Health Organisation

Foreword

The National Council for the Professional Development of Nursing and Midwifery (National Council) is pleased to present this report which reviews the activities of staff nurses and staff midwives in relation to continuing professional development. Staff nurses and staff midwives provide the majority of direct care to patients/clients of the health services on a twenty-four hour basis. They comprise the largest group of health service workers and as such have great potential to further contribute to population health, achieve the goals of the national health strategy, *Quality and Fairness: A Health System for You* (DoHC 2001a), and to support the implementation of the health service reform programme.

As the structures of the health services develop, the manner in which healthcare is delivered will continue to evolve. Changes in legislation as well as policy developments will continue to have an effect on the way that nursing and midwifery are practised. This report makes recommendations regarding continuing professional development, career development and competencies for staff nurses and staff midwives.

The National Council wishes to acknowledge the enthusiastic help of all those involved in the focus groups, the link people who supported and distributed the questionnaires and, most importantly, the staff nurses and staff midwives who by participating have contributed to the overall development of nursing and midwifery in Ireland.

My thanks are due to my colleagues, Kathleen Mac Lellan (Head of Professional Development), Christine Hughes, Jenny Hogan, Mary Farrelly and Georgina Farren (Professional Development Officers), and Sarah Condell (Research Development Officer), all of whom contributed to the preparation of the report. Finally, particular thanks are extended to Valerie Small, who led the project and managed the research phase.

Yvonne O'Shea

Chief Executive Officer

Executive Summary

Nurses and midwives face the challenge of embracing new methods of care delivery which will provide a quality service that is truly people-centred. Important professional development issues were raised by nurses and midwives in the consultation process which formed the basis for *Agenda for the Future Professional Development of Nursing and Midwifery* (National Council 2003a). Many nurses and midwives expressed concern regarding continuing professional development (CPD) activities from a number of aspects, namely equity of access, relevance to practice, integration of new knowledge into practice, limited opportunities to access and engage in CPD due to staff shortages, and changes in skill mix. They also described engagement of staff in CPD activities from an organisational point of view as being 'ad hoc' with no pre-determined professional development plans for the individual nurse or midwife, nor with reference to service requirements at ward or unit level.

There is growing evidence of the need to link CPD with organisational goals. The construction of career pathways in a healthcare system which is subject to radical and far-reaching change is an issue of growing importance to nurses and midwives.

Geographical location and tenure of employment continue to significantly influence participation and support for CPD. Staff nurses and staff midwives wish to engage in CPD and personal development planning (PDP): however, the support and resources need to be more equably available. Maintaining and developing competencies is a necessary process in providing the skills required for implementing the health service reform programme.

Finally, a number of recommendations are made concerning the development of structures to support CPD for staff nurses and staff midwives. These include, enhancement of career development and job satisfaction among nurses and midwives, retention of valued staff, enhancement of nursing and midwifery practice, and hence enhancement of service provision. Objectives, deliverables and the responsibilities of the various stakeholders arising from these recommendations are outlined.

CHAPTER 1

Introduction and Methodology

Background to the project

The National Council for the Professional Development of Nursing and Midwifery (National Council) is a statutory body set up by ministerial order on foot of recommendations contained in the *Report of the Commission on Nursing* (Government of Ireland 1998). The function of the National Council is to promote the professional development of nursing and midwifery, taking into account changes in practice and service need. One of the key responsibilities of the National Council is to provide guidance to the profession in relation to post-registration professional development. In May 2003 a project was initiated by the National Council to examine issues which relate in particular to the continuing professional development (CPD) of staff nurses and staff midwives. This report provides information about the activities of these nurses and midwives in relation to CPD and makes recommendations regarding future strategic planning for the profession in relation to CPD requirements.

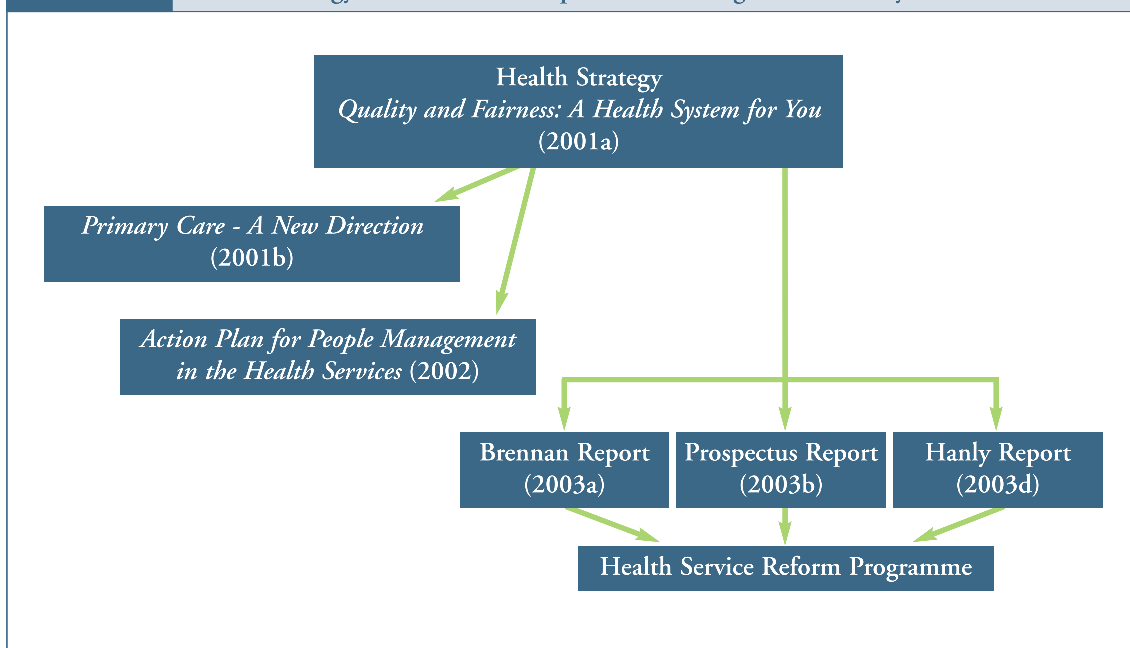
The *Report of the Commission on Nursing* provided the momentum for major development of and changes in nursing and midwifery (Government of Ireland 1998). Since the publication of the report the changes in career structures and strategic direction have all impacted on the professional development of nurses and midwives. Other influences on this development have emanated from government-led strategies such as *Quality and Fairness: A Health System for You* (DoHC 2001a), *Primary Care Strategy* (DoHC 2001b), the *Action Plan for People Management in the Health Services* (DoHC/HSEA 2002), *A Research Strategy for Nursing and Midwifery* (DoHC 2003a) and the Health Service Reform Programme (see Figure 1.1). Studies have highlighted some issues of concern in relation to the profession and CPD (DATHs 2000, DoHC 2002, McCarthy et al 2002).

The terms of reference for this project were developed from a number of sources mentioned above but were primarily derived from submissions, discussions, meetings and workshops held with the profession in order to inform the recently published report, *Agenda for the Future Professional Development of Nursing and Midwifery* (National Council 2003a).

This report examines CPD issues relevant to staff nurses and staff midwives by reviewing:

- CPD activities of staff nurses and midwives
- competency achievement and maintenance relevant to service need and personal professional development of staff nurses and staff midwives
- career choice relevant to CPD and competency of staff nurses and staff midwives.

FIGURE 1.1 Health Strategy: context for development in nursing and midwifery



Contextual framework

The contextual framework for this project encompasses the following elements:

- domains of competence
- career and personal development
- the health service.

Domains of competence

An Bord Altranais (2002) outlines the five domains of competence required for registration as a nurse or midwife[1]. The identified competencies underpin the theoretical, scientific and clinical knowledge of the registered nurse or midwife and form the foundations of CPD undertaken throughout the nurse or midwife's professional career.

Career and personal development

An individual's career and personal development does not occur in a vacuum: there are many influences, challenges and opportunities which affect the practitioner's decision-making in relation to career choice, personal development and professional growth. There is constant interaction between competence, maintaining competence and the delivery of high-quality care as an employee within a health service organisation. Ultimately the care the patient/client receives results from the continued growth and personal and professional development of the individual.

The health service

A desire for major change and reform in the Irish healthcare system has been evident since the launch of *Quality and Fairness: A Health Service for You* (DoHC 2001a). Subsequent reports have strengthened the rationale for improving the way healthcare is delivered given the continued fiscal policy and the growing demands to deliver value for money and high-quality service to the consumer. In the recently published *Prospectus: Audit of Structures and Functions in the Health System* (DoHC 2003b) four major reforms are proposed:

- the creation of a consolidated healthcare structure
- the development of supporting processes
- the strengthening of governance and accountability across the system – simpler governance and greater levels of accountability
- a re-organisation of existing agencies and their function.

Among the actions proposed to develop the supporting processes are the promotion of strong service planning and funding processes, the establishment of strong links between service delivery and evaluation, and the putting in place of enablers to support integration and enhance system capability and performance (DoHC 2003b). There is an obvious need to enhance system capability and performance because over 70% of the cost of the health service is payroll-related and services are delivered by and through people. The emphasis must therefore be on developing and managing the capabilities of those who work within the healthcare system, thus maximising the potential for development of the individual. *Sustaining Progress 2003-2005* (Government of Ireland 2003b) identifies the need for the health service to become more efficient, accessible and centred around public need. In making this a reality, enhanced skill mix, new ways of working and the redesigning of jobs will empower health personnel to reach their full potential, maintain skill levels and participate in the more rational utilisation of their services through a close matching of skills to functions and service needs.

There are discernible implications for the current and future development of nursing and midwifery and the profession as a whole in the published rationale for reforms and the demands for modernisation of the functions and structures of the health system.

Methodology

In preparation for this report a comprehensive literature review was conducted, encompassing relevant national and international literature and experience. Two focus groups were conducted and a questionnaire was developed from the literature. Staff nurses from four divisions of the register (general, psychiatry, mental handicap and sick children's) and staff midwives were invited to participate. Nurses and midwives from cities, towns and rural areas were represented, as were those working in community and in-patient settings.

Focus groups

Focus groups were conducted in order to explore issues such as competence for practice following registration and CPD. It was considered that issues relating to competency were difficult to capture in a questionnaire and that greater detail, professional insight and 'on the ground' information could be captured using a focus group methodology. The groups also provided an opportunity to pilot the questionnaire.

Directors of the nursing and midwifery planning and development units (NMPDUs) in the South Eastern Health Board (SEHB) and the Midland Health Board (MHB) were asked to convene the focus groups in their regions. The SEHB focus group had twenty attendees and the MHB fourteen attendees (all divisions of the register were represented).

The objective of the focus group sessions was to investigate CPD issues relevant to staff nurses and staff midwives by examining:

[1] An Bord Altranais outlines five Domains of Competence representing the level the student must meet on completion of the registration education programme for entry to the Register. They are:

- Domain 1. Professional/Ethical Practice
- Domain 2. Holistic Approaches to Care and the Integration of Knowledge
- Domain 3. Interpersonal Relationships
- Domain 4. Organisation and Management of Care
- Domain 5. Personal and Professional Development.

- staff nurses'/midwives' understanding of the term 'competency' and essential elements pertaining to competence
- competency achievement and maintenance with relevance to service need and personal professional development
- career choice with reference to CPD and competency.

Eight key questions formed the basis of the focus group discussions (see Appendix 1). Following a brief introduction to the project and an outline of the terms of reference, responses were captured on a flip chart. The participants were requested at the end of the session to confirm that the documented responses represented their views adequately and accurately. The venues selected for the two focus groups were central but neutral in that they were not associated with any healthcare organisation.

Questionnaire

The questionnaire was devised using key themes identified in the literature such as CPD, competency development following registration and organisational characteristics.

The questionnaire was piloted at the focus group sessions. Adjustments to and refinement of the questionnaire were carried out following the pilot phase. A mixture of open and closed statements was used in the questionnaire design in order to gather as wide a variety of quantitative and qualitative information from respondents as possible (see Appendix 2).

Access to staff nurses and staff midwives

Access to staff nurses and staff midwives was sought by writing to each director of nursing/midwifery or equivalent in all organisations within the Southern Health Board (SHB) and the Eastern Regional Health Authority (ERHA). In total seventy-one organisations were contacted: this included hospitals in bands 1-5, directors of public health nursing, directors of nursing (i.e., of psychiatry, mental handicap, general and sick children services) and directors of midwifery. Forty out of the seventy-one (56%) organisations responded positively to the correspondence and agreed to participate. The directors were asked for permission to access their staff and each was invited to nominate a link person for the purposes of distribution and collection of the questionnaires.

Distribution of questionnaires

Contact was made by telephone and email with the nominated link persons. Link persons were asked to provide details of the number of staff nurses and/or staff midwives employed in their respective organisations (this included part-time and temporary staff and job sharers). This was in order to calculate the potential total numbers of staff who might be invited to participate in the survey. The link person was asked to take account of staff who worked part-time, who were job sharing or on flexible working contracts and not simply whole-time equivalent numbers. In total 10,000 questionnaires were distributed, of which 2,005 were returned, giving a response rate of 20%. Of the 7,650 questionnaires that were sent to the ERHA 1,399 were returned, giving a response rate of 18%. Of the 2,405 sent to the SHB 606 were returned giving a response rate of 25%.

Each link person distributed and collected the questionnaires and thirty-seven of the forty link persons returned completed questionnaires.

Demographic profile of respondents to questionnaire

Location

Of the 2,005 nurses and midwives who responded, 70% were from the ERHA (n=1,399) and 30% were from the SHB (n=606). The majority (88%) of the respondents worked in hospital settings (Figure 1.2). Figure 1.3 shows the area of clinical practice where respondents were currently working.

FIGURE 1.2 Care settings

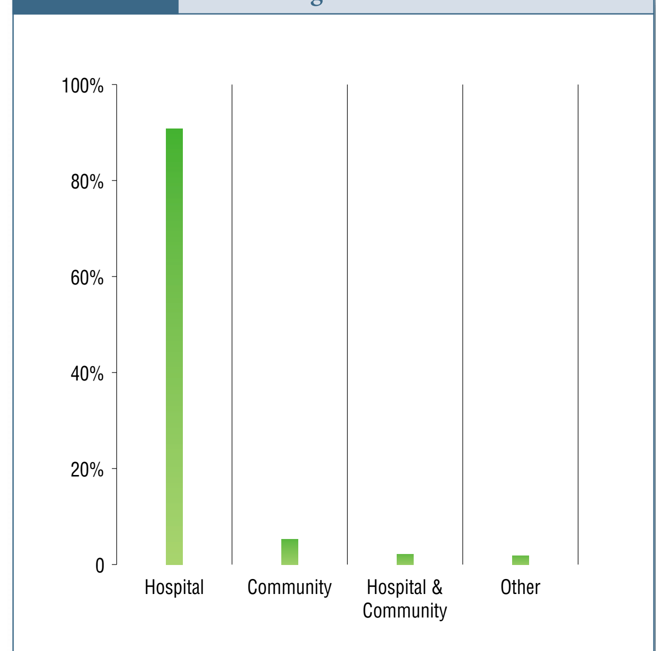
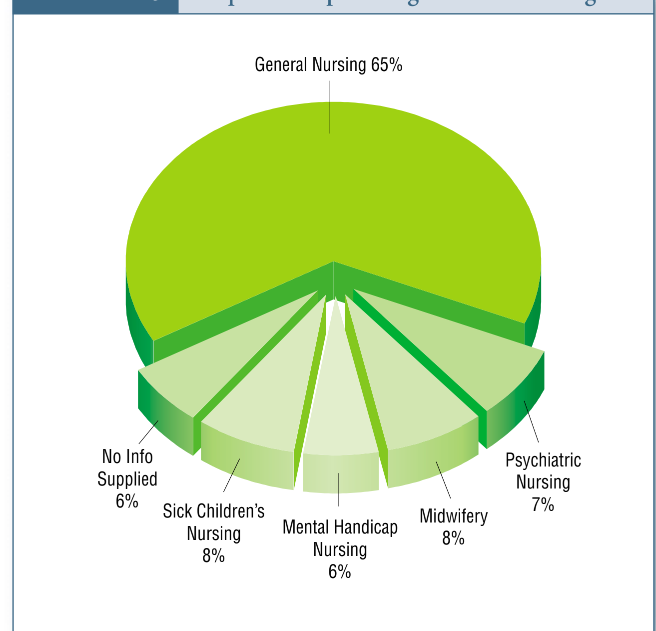


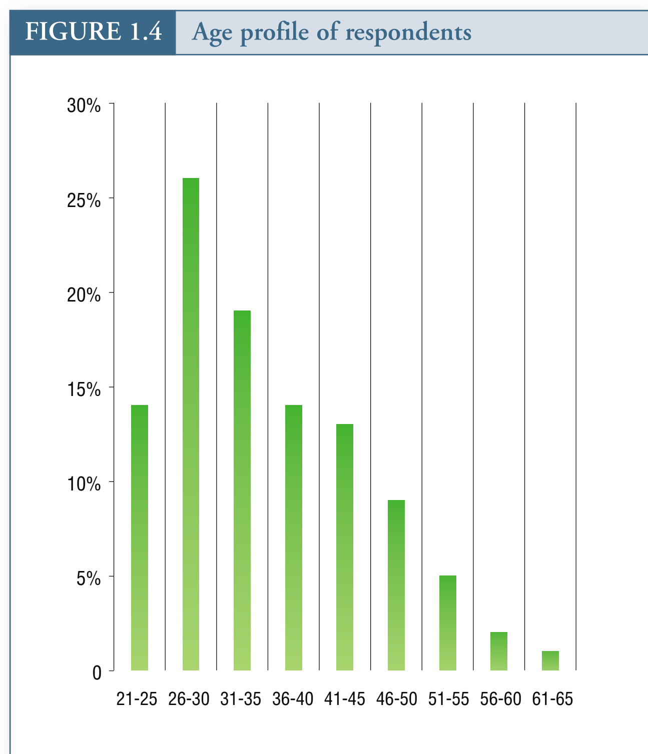
FIGURE 1.3 Respondents' practising division of the register



Gender and age profile

Ninety-one percent of respondents were female. Figure 1.4 shows the age profile of respondents.

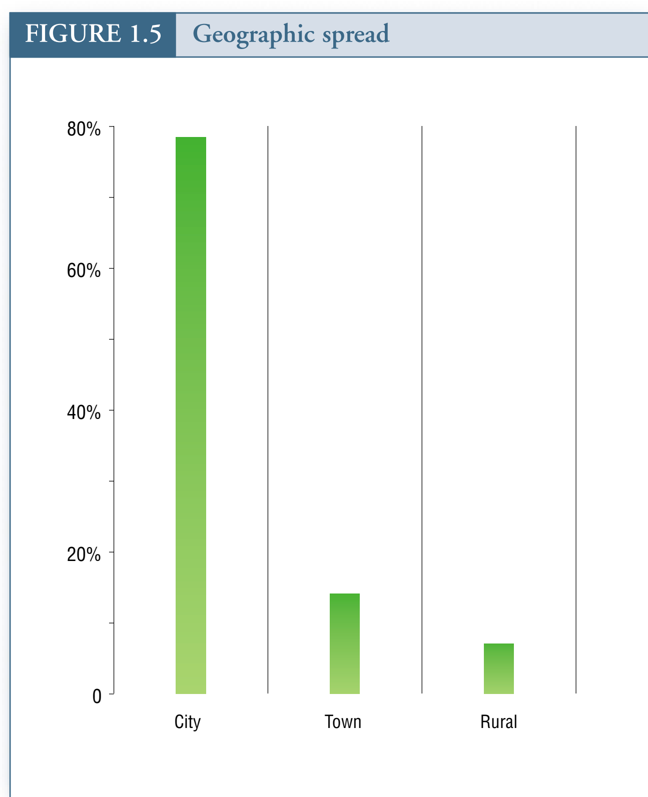
FIGURE 1.4 Age profile of respondents



Geographic spread

The geographic spread and location of respondents' places of work was captured under the headings city, town or rural location. The majority of respondents (78%) described their location as being in a city; 14% were located in towns with 7% describing their location as rural (see Figure 1.5).

FIGURE 1.5 Geographic spread



Years in current employment

When asked about years in current employment the majority indicated that they had worked in the same organisation for more than one year and approximately a quarter had worked in the same organisation for more than five years (see Table 1.1).

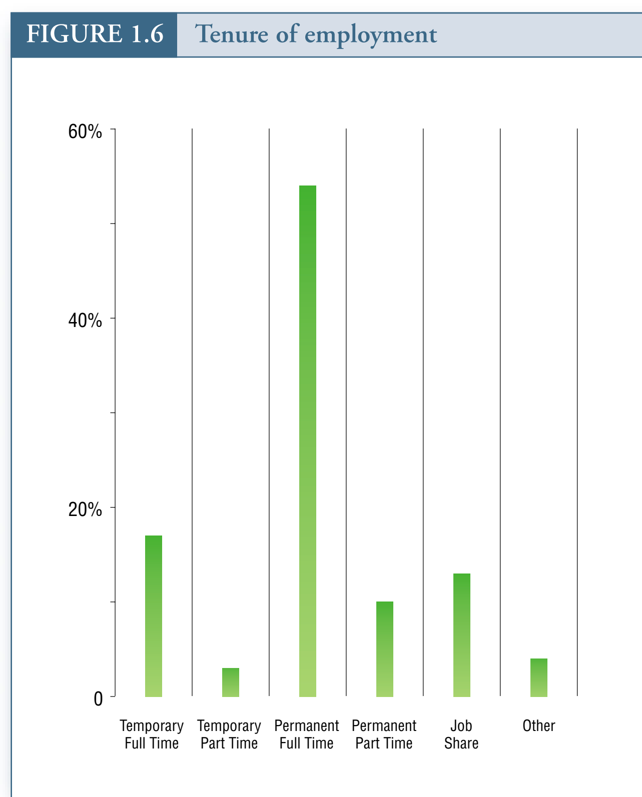
Table 1.1 Years in current employment

Number of years	%
Less than 6 months	4
6-12 months	7
1-2 years	22
3-5 years	23
More than 5 years	24
Other	13
Missing	6
Total	**99**

Tenure of employment

The nature of contracts held by respondents in their current employment was analysed: over half (54%) held permanent full-time contracts, with 17% holding temporary full-time posts (see Figure 1.6). Job-sharing accounted for 13% of those surveyed. When age and tenure were analysed, 63% of full-time employees were between twenty-six and forty years of age while 66% of job-sharers were aged between thirty-one and forty-five years. Almost 80% of temporary full-time staff were between twenty-one and thirty-five years of age.

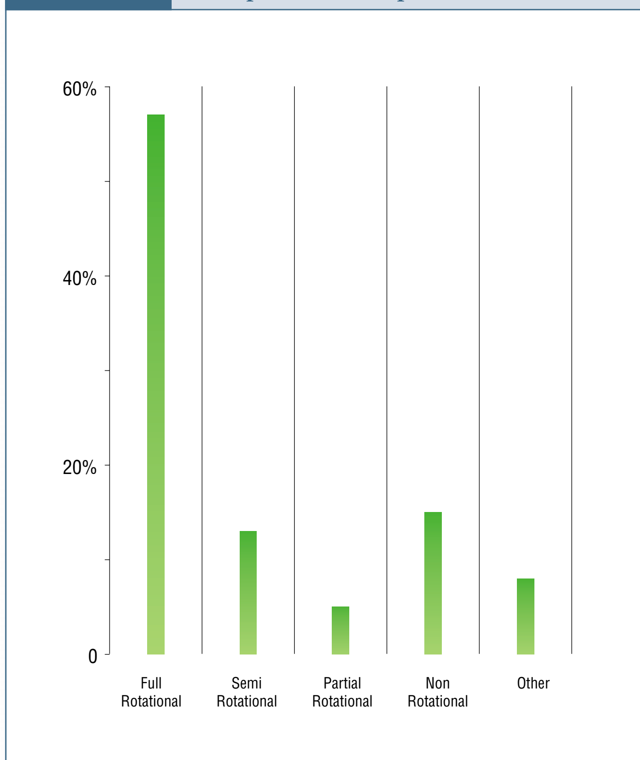
FIGURE 1.6 Tenure of employment



Shift patterns

The majority of staff nurses and staff midwives (57%) worked full rotational shifts, i.e. all shifts – day, night and weekends (see Figure 1.7). The second most common shift pattern was non-rotational and comprised regular day duty, excluding week-ends and night duty (15%). When tenure and shift pattern were analysed, 38% of job-sharers worked full rotational shifts, while a further 21% of job-sharers had non-rotational arrangements. Thirty-three percent of permanent part-time employees work on non-rotational regular day duty while 80% of temporary full-time staff worked a full rotational shift. Sixty-five percent of permanent full-time employees worked full rotational shifts

FIGURE 1.7 Shift patterns of respondents



Structure of the report

This chapter of the report has outlined the rationale for undertaking a study of the CPD needs of staff nurses and staff midwives and the context in which the study was undertaken. The methodological approach and a profile of the respondents have been described. Key themes in the international literature around CPD are discussed in Chapter 2. The findings presented in Chapters 3 and 4 are discussed in Chapter 5. This last chapter contains a number of recommendations concerned with structures to support CPD for staff nurses and midwives.

CHAPTER 2

Issues Relating to Continuing Professional Development

A number of key themes emerge from the literature in relation to the CPD of staff nurses and staff midwives. To contextualise the issues consideration is given to the concept of lifelong learning. CPD and its relevance to nurses and midwives is reviewed in order to demonstrate its influences on career development, career choice, and achieving and maintaining clinical competencies. Organisational factors which influence the CPD of staff are discussed within the context of 'magnet' hospitals; these hospitals are renowned primarily for empowering nurses and midwives, for creating attractive work environments and for having demonstrated better patient outcomes.

Lifelong learning

Lifelong learning is not a new concept (Duyff 1999). Growing attention is being given the world over to developing a positive attitude towards learning throughout life. Governments and leaders in every sector of society advocate a new learning culture for every citizen regardless of age (Medel-Anonuevo et al 2001).

Box 2.1 Definition of lifelong learning

Lifelong learning is a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills and understanding they will require throughout their lifetimes ... and to apply them with competence, creativity, and enjoyment in all roles, circumstances and environments.

(Commission for a Nation of Lifelong Learners, cited in Medel-Anonuevo et al 2001)

As information and communication technologies permeate society, the role of the individual learner is highlighted. Writing on lifelong learning for the twenty-first century Medel-Anonuevo et al (2001) assert that:

> 'Globalisation has produced outcomes and processes which make the learning of new skills and competencies of paramount importance … it is no longer enough to have the same living and working skills one had five years ago … learning to learn, problem solving, critical understanding and anticipatory learning – these are only a few of the core skills and competencies needed for all.'

The pace of change is an important impetus for lifelong learning. Today change is so rapid and constant that some futurists call it a blur (Clinton et al 2001). Change requires action on the part of nations, individuals, and professions. It is important that lifelong learning is conceived as a continuous process that the individual worker does not engage in alone, but engages in with support from significant others including the employer. To contribute maximum value to the quality of life of the individual, lifelong learning must be self-directed and active. It should focus on knowledge, values, skills and understanding, and go beyond acquiring these learning outcomes for their own sake (Clinton et al 2001).

Box 2.2 Characteristics of lifelong learning

- it is intentional – learners are aware they are learning
- it has specific goals, and it is not aimed at vague generalisations such as 'developing the mind'
- these goals are reasons why the learning is undertaken (it is not motivated simply by factors like boredom)
- the learner intends to retain and use what has been learnt for a considerable period of time.

(Knapper and Cropley 2000, cited in Gopee, 2001)

At a meeting of the European Council held in Lisbon in March 2000, government leaders set the European Union a ten-year mission to become the most competitive and dynamic knowledge-based economy in the world, capable of sustained economic growth with more and better jobs and greater social cohesion. Lifelong learning is a core element of this strategy, central not only to competitiveness and employability but also to social inclusion, active citizenship and personal development. Of specific interest to nurses and midwives is the call by the World Health Organisation (WHO) in its Munich Declaration (2000) to relevant authorities in its European region to step up their action to

strengthen links between lifelong learning and CPD to enable nurses and midwives to work efficiently and effectively to realise their full potential both as independent and interdependent professionals.

The Irish context

In the Irish context, lifelong learning has been the governing principle of educational policy since 2000 and is viewed as having a pivotal position in Irish economic and social strategy (Dept of Education and Science 2000). This principle is reflected in and supported by the *Qualifications (Education and Training) Act, 1999* (Government of Ireland 1999), which defines access, transfer and progression in education as follows:

- *access*: the process by which learners may commence a programme of education and training having received recognition for knowledge, skill or competence acquired
- *transfer:* the process by which learners may transfer from one programme of education and training to another having received recognition for knowledge, skill or competence acquired
- *progression:* the process by which learners may transfer from one programme of education and training to another where each programme is of a higher level than the preceding programme.

The National Qualifications Authority of Ireland (NQAI) has outlined the vision, principles and objectives that underpin its task of promoting and facilitating access, transfer and progression (NQAI 2003). The NQAI has adopted policies, actions and procedures which involve four policy strands, namely:

- credit
- transfer and progression routes
- entry arrangements
- information provision.

These policy strands will have direct relevance to those agencies concerned with the provision of CPD and education of nurses and midwives. An Bord Altranais is currently conducting a study in association with the NQAI to pilot the framework of potential descriptors for the national framework and a framework for nursing and midwifery education that respects the professional requirements of practice.

Continuing professional development

In the consultation process which informed the National Council report *Agenda for the Future Professional Development of Nursing and Midwifery* (National Council 2003a) nurses and midwives highlighted critical issues relating to their CPD. Concerns expressed about CPD activities included equity of access, relevance to practice, integration of new knowledge into practice, and the limited opportunities to access and engage in CPD because of staff shortages and changes in skill mix. They also described engagement of staff in CPD activities from an organisational point of view as being frequently *ad hoc* with no pre-determined professional development plans for the individual, ward or unit. The lack of local and organisational support for formal continuing education (CE) programmes was cited as a difficulty and while post-registration education was now more widely available, the general desire was for the provision of more flexible education programmes which would be modular in approach and would facilitate transferability and credit accumulation. Team working was highlighted in the report as the pillar that supports the delivery of high-quality service: continued investment in intradisciplinary and interdisciplinary CPD was described as the key to sustaining and improving service development.

Box 2.3 Definition of continuing professional development

CPD is 'the systematic maintenance, improvement and broadening of knowledge and skills, and the development of personal qualities necessary for execution of professional, technical duties throughout the individual's working life.'

(Friedman et al 2000, cited in Lawton and Wimpenny 2003)

Ryan (2003) contends that CPD[2] is a fundamental component that lies along the continuum of lifelong learning. The term CPD is defined and interpreted in various ways within the literature (NMC 2000, Lawton and Wimpenny 2003). Furze and Pearcey (1999) assert that trends in nursing have attempted to move the perception of CE or continuing professional education (CPE) to one that is more appropriate to the range of activities that CPD may encompass, which includes formal and informal learning (Ryan 2003).

The national health strategy, *Quality and Fairness: A Health System for You* (DoHC 2001a), underlines the need to provide the financial and practical supports necessary for training and development of people employed in the health service. Health service employers are now expected to demonstrate their commitment to continuous learning by facilitating existing staff to undertake programmes that enhance the quality of patient/client care and contribute to employees' career development (DoHC/HSEA 2002).

While evidence of engagement with CPD is not currently required for continuing registration with An Bord Altranais, there are clear indications from government and the healthcare environment that healthcare professionals are expected to update their knowledge and skills. The

[2] The term CPD is often used interchangeably with continuing education (CE) and continuing professional education (CPE) in the nursing and midwifery literature. For the sake of clarity CPD will be used in this report, unless referring to or citing from specific literature where the individual author's or authors' preferred term differs.

Department of Health and Children (DoHC) notes that the delivery of high-quality, patient-centred services requires a renewed focus on education, training and development in the health sector (DoHC/HSEA 2002). Furthermore the DoHC suggests that the development of a changed approach to training and development requires a 'stocktaking' exercise at organisational level in each agency in order to establish existing practice. This exercise would also identify the extent, cost and nature of training, development and education and the benefits or return on investment which have arisen to date from the approaches to education, development and training initiatives in the health service.

In their national study of turnover in nursing and midwifery McCarthy et al (2002) found that a little more than half of the respondents (53%) reported experiencing some form of CPD, typically in the form of in-service education (25%) and study days/seminars (28%), with fewer respondents reporting having access to study leave (12%) and financial support (10%). The authors conclude that large numbers of nursing staff do not have access to professional updating.

Where training and development provision is concerned only with functional tasks such as intravenous drug administration and manual handling, nurses and midwives may not develop their knowledge and skills adequately to provide patient-/client-centred care (Dunmore 1999). The Office for Health Management has highlighted the importance of staff development and investment in people as critical factors in organisational performance and success, along with a number of other good practices in human resource management (2002). However, it also underlines the need for managers to be involved in identifying learning and development needs so that those needs arising at service delivery level can be co-ordinated and managed across the wider organisation.

Considerations for nurses and midwives

An Bord Altranais defines CE as 'a lifelong professional development process which takes place after the completion of the pre-registration nurse education programme. It consists of planned learning experiences, which are designed to augment the knowledge, skills and attitudes of registered nurses and midwives' (An Bord Altranais 1994 p.11).

Although evidence of CPD is not a mandatory requirement for continuing registration with An Bord Altranais, it is considered essential in order for nurses and midwives to acquire new knowledge and competence that will enable them to practise effectively in an ever-changing healthcare system (An Bord Altranais 2000a). The responsibility for CPD as outlined in the *Scope of Practice for Nursing and Midwifery Framework* (2000a) lies with the nurse or midwife. Responsibility for the assessment of the CPD needs of the profession and the provision of appropriate support for staff lies with healthcare organisations. This view is further supported and strengthened in the *Action Plan for People Management in the Health Service* (DoHC/HSEA 2002). The *Report of the Commission on Nursing* supported the need to ensure safe practice by all nurses and midwives and recommended that the Nurses Act 1985 be amended to entitle An Bord Altranais to require any nurse or midwife to satisfy it as to her or his relevant competencies, failing which the Board could require an up-date on skills and knowledge, as a condition of retention of name on the register: this is provided that the purpose would be the protection of the public even in the absence of any complaint (Government of Ireland 1998).

Box 2.4 Mandatory CPD: an example (United Kingdom)

Since 1995, the PREP (practice) standard has required that a nurse or midwife by virtue of his/her nursing, midwifery or health visiting registration should have practised for not less than one hundred days (750 hours) during the five years prior to renewal of registration.

If practising as a midwife he/she must have completed a minimum of one hundred days (750 hours) of practice and must continue to submit a notification of intention to practise form annually.

If both a nursing and a midwifery registration is held and the practitioner wishes to continue to practise as both a nurse and a midwife, he/she will need to have practised for one hundred days (750 hours) in respect of each nursing and midwifery registration. This means that practitioners wishing to maintain both nursing and midwifery registrations must have completed a minimum of two hundred days (1500 hours) of practice, divided equally between nursing and midwifery.

Practitioners need to declare on their *notification of practice form* that they have met the practice standard at the time of registration. If they do not meet this standard, they must undertake a return-to-practice course before renewal of registration is granted.

(Nursing and Midwifery Council 2000)

McCarthy et al in their *National Study of Turnover in Nursing and Midwifery* (2002) report that just over one half of those who left nursing/midwifery posts ('leavers') (53%) stated that they received some form of CPD which, the authors claim, indicates that large numbers of nursing staff do not have access to professional updating. *The Nursing Recruitment and Retention Group Report* published by the Dublin Academic Teaching Hospitals (DATHs 2000) cites CE as the fourth most important factor in encouraging nurses to remain in an organisation. This finding is confirmed by McCarthy et al (2002) who found that 12% of leavers left 'to pursue further studies in nursing' (p.79). Although the authors did not investigate these leavers' intention to return to nursing practice after studying, they concluded that because of the nature of the study undertaken they would continue to contribute to the healthcare service while pursuing various careers in midwifery, paediatric and critical care areas.

The degree of significance of adequate and appropriate education, including CE for nurses and midwives, is further supported in the recently published study carried out by Scott et al on behalf of the Department of Health and Children (DoHC 2003c). Education was an interweaving theme throughout the study *Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland*,

and was judged by the participants to be critical to empowerment. The report of the study recommends continued support for access to appropriate CPE through identifying and meeting resources and geographical requirements, through a greater use of informal and on-the-job learning and by a wider utilisation of personal development planning to facilitate learning which, for many nurses and midwives, takes place in the clinical setting.

Benefits of continuing professional education and development

Continuing professional development and education are believed to assist practitioners in the acquisition of knowledge and skills and/or the reinforcement or restoration of previously acquired knowledge and skills. The immediate objective of CPE is change in practice and its primary goal is improved professional practice and hence patient care (Blair and Ramones 1998, ANCI 1999). Many authors argue, however, that while nurses perceive that CPE improves patient/client care, there is in fact little empirical evidence to support this viewpoint (Barribal et al 1992, Furze and Pearcy 1999, Hicks and Hennessy 2001, Kingston 2001, Smith and Topping 2001). Studies investigating CPE have tended to evaluate the process of CPE activity rather than outcomes such as benefits to practitioners and impact on service delivery (Jordan et al 1999, Jordan 2000, Smith and Topping 2001). Nevertheless, there is agreement about the essential continuum of education: the process never ceases although it may take different forms at different times in an individual's personal and professional career (Maggs 1996).

Fleck and Fyffe (1997) contend that in order to achieve the greatest benefits for the health service it is essential that nurses acquire the skills to learn continuously, and that for managers there is seen to be a measurable change in a recommended practice or behaviour when this is necessary in light of the changing cost-orientated healthcare systems. McCarthy and Evans (2003) evaluated the impact of CE programmes on nurses and midwives and found that course participants reported both personal and professional benefits. In particular they indicated that new skills learnt during their courses by participants were transferable to their work environment, the new knowledge improved their confidence and communication skills with regard to patient management, and overall they were more aware of the need for research and evidence-based practice as part of their role within the clinical area.

Smith and Topping (2001) concur about the value and benefits of CPE but further contend that there may be frustration among participants in CPE courses if opportunities to progress in the clinical area are not available, thus affecting motivation. Barribal and While (1996b) suggest that, in the absence of learner motivation, participation in CPE is unlikely to secure improvements in patient care or changes in knowledge accumulation and personal and professional growth.

Meeting service needs through CPD

There is growing evidence of the need to link CPD with organisational goals: Lawton and Wimpenny (2003) caution that where this does not happen there may be tension about priorities for CPD between the individual and his or her employer. Organisations may focus on short-term skill development at the expense of lifelong learning in order to fill a clinical skills deficit as an immediate solution to staffing shortages, whereas individuals may focus on personal development that may have little immediate connection with role competencies. In a study designed to identify the development needs of medical and surgical nurses Gibson (1998) found that the main priorities of the participating nurses were skills development in essential clinical care, specialist nursing, changing roles and research and practice development. Factors restricting development were the lack of time, resources, support and recognition. However, the author suggests that professional development activity can take many forms. Furthermore, fostering an organisational climate in which development was inherent in everyday working practices was felt by the respondents to be as valuable as formal course attendance.

Hart and Rotem (1995) also reflect on the impact of the workplace environment on the professional development of registered nurses. They endorse the need to develop effective strategies to support professional autonomy, ensure that staff have the opportunity to negotiate and clarify their role and responsibilities at ward level, improve the quality of supervision and foster co-operative approaches to performance appraisal, support for formal and informal collegial activities, and enhance learning opportunities within the workplace by utilising experienced nurses more effectively as role models. McCarthy and Evans (2003) report that resistance to change from colleagues, managers and medical staff was the most frequently cited barrier to implementing change by nurses who had undertaken formal post-registration courses. The authors recommend that managers who facilitate staff to undertake postgraduate education should offer change management programmes to all staff working within their team, and initiatives to improve dissemination of information should be developed (McCarthy and Evans 2003). Actions 5.2, 5.3 and 5.4 of the *Action Plan for People Management in the Health Service*, outline the need to implement competency-based approaches to training, development and education, to develop further on-the-job and innovative learning delivery methods and forge stronger and more effective links with the education sector (DoHC/HSEA 2002, pp.32-34).

Access to CPD

Barribal and While (1996b) and Furze and Pearcey (1999) suggest that access to CPD varies enormously between different groups of qualified nurses. They assert that nurses working night duty or part-time hours attend fewer CPE activities than their more senior and full-time or day-duty colleagues. They further report that poor funding, low staffing levels and domestic responsibilities deter participation of nurses in CPE. Other factors such as lack of available places (Robinson et al 1997) and lack of encouragement from managers (Hogston 1995) also act as barriers to nurses and midwives in accessing further education. Ryan (2003) contends that decisions made by practitioners to access CPE may be affected by changes in personal or work circumstances. Recommendations include careful

consideration of scheduling, location and funding of CPE along with the quality and relevance of the education to the professional and personal development of practitioners: CPE must also be carried out in such a manner that the needs of both the service and the individual practitioner are considered (Barribal and While 1996b, Perry 1995, Furze and Pearcey 1999, Ryan 2003).

CPD activities

Activities that contribute to the CPD of nurses and midwives are not restricted to formal academic programmes and in-service development. Box 2.5 shows a wide variety of activities identified in the literature as enhancing the repertoire of skills needed for the delivery of nursing/midwifery care and services. These items were used in constructing a number of questions in the staff nurse/midwife project questionnaire in order to ascertain the range of activities being currently undertaken by staff nurses and midwives (see Chapter 4 and Appendix 2).

Competence

The use of the term 'competence' across a range of educational and training fields has led to an increase rather than a decrease in the variety of meanings (ANCI 1999, Storey 2001, Storey and Haigh 2002). Debated for many years (Storey et al 1995), there is still no single clear definition of what is meant by clinical competence (Griffin 2001, Storey and Haigh 2002, McMullan et al 2003). Furthermore its measurement is presented as a complex and multi-faceted phenomenon (Griffin 2001). That stated, An Bord Altranais defines competence as 'the ability of the registered nurse/midwife to practise safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice' (2000a). Storey (2001) proposes that 'competence is the knowledge, skills, abilities and behaviours that nurses need to perform their work to a professional standard, and is a key lever for achieving results that will enable the organisation to achieve its health care objectives'.

Components and attributes of competence resulting in effective and/or superior performance are referred to in box 2.6 and catergories of competence box 2.7.

The growing recognition that occupational groups need to ensure that members maintain their competence beyond initial registration has led to attempts to introduce procedures for assessing professional competence that provide a public statement of what it means to be competent in an occupation. A number of professions require that members undertake CPE (Duyff 1999, *Report of the National Task Force on Medical Staffing* (DoHC 2003d). Increasingly in nursing internationally there is a requirement for the practitioner to provide evidence of recency of practice (ANCI 1999). The assumption that professional education increases competence was acknowledged by the United Kingdom Central Council for Nursing and by Midwifery and Health Visiting (UKCC; now the Nursing and Midwifery Council (NMC)) and resulted in the introduction of the Post-Registration Education and Practice Project (PREPP) which emerged following an extensive consultation process (UKCC 1990,1994,1995).

Competence has been considered from the narrowest of perspectives: from lists of tasks to be completed – through to the more complex abstract abilities to provide an appropriate level of professional practice in a variety of contexts. The latter view of competence involves the ability to combine knowledge, attitudes and psychomotor skills appropriate to professional service delivery (Girot 1993). However, competence is a continuum along which people can move backwards as well as forwards and it must be acknowledged that in any clinical situation competence can deteriorate if not maintained (Storey 2001, Storey and Haigh 2002).

An Bord Altranais launched its *Introducing Competence Assessment* e-learning package in 2002 to support registered nurses, clinical mentors and clinical nurse managers in managing the changes in pre-registration nursing education. *The Domains of Competence* (An Bord Altranais 2002)

Box 2.5 Continuing professional development activities

- attending short courses, conferences, workshops and seminars
- undertaking courses accredited by third-level education providers or recognised authorities (full-time courses; part-time courses; distance learning; supported learning; certificate, diploma, baccalaureate (primary degree), postgraduate/higher/diploma/advanced diploma, postgraduate degree (master's, doctoral, post-doctoral)
- work-based learning (WBL) (including pre-designed learning packages in the work place)
- project work
- poster presentations
- small-scale research studies
- writing articles for in-house, regional, national or international publications
- following up on an identified (personal/unit/department) knowledge gap by undertaking a literature search and review in order to inform the implementation of new practice
- visiting other centres to compare practice or learn from other professionals about new techniques, practices or projects
- participating in action learning sets
- membership of reflective practice or clinical supervision groups
- participation in management activities such as staff selection and recruitment, performance review, policy development or service planning
- audit of practice or workload
- clinical practice meetings
- risk assessment and management activities
- in-service training, e.g. manual handling, intravenous drug administration.

Box 2.6 Components and attributes of competence resulting in effective and/or superior performance:

- practical and technical skills
- communication and interpersonal skills
- organisational and managerial skills
- the ability to practice safely and effectively, utilising evidence-based practice
- having a problem-solving approach to care, utilising critical thinking
- being part of the multidisciplinary team, demonstrating a professional attitude
- accepting responsibility
- being accountable for one's practice.

(Storey 2001)

represents a broad enabling framework to facilitate the assessment of pre-registration student nurses' clinical practice. Each domain consists of performance criteria and their relevant indicators. The indicators are further developed at local level with reference to the division of the register and the speciality.

Box 2.7 Categories of competence

- 'what people should be like'– models based on personal characteristics or on an individual's behaviour
- 'what people need to possess'– models based on acquiring knowledge, understanding and skills
- 'what people need to achieve in the workplace'– models based on outcomes and standards including underpinning knowledge and skills.

(Mitchell 1998)

Competency frameworks are an effective mechanism through which training, development and education needs can be identified and developed, in particular where there are generic core competencies required of particular job families or professions (DoHC/HSEA 2002). A nursing management competency framework has already been developed by the Office for Health Management (OHM 2000) and two competency user packs have also been published for health and social care professionals and for clerical/administrative managers (OHM 2003a, OHM 2003b): these have the potential to act as a mechanism through which people management skills for line managers can be developed. The prioritisation of resources towards the strengthening of line managers' competencies will play a key role in improving employee relations and staff performance, leading to improved patient care and service delivery.

Career choice

Definition of career

The term 'career' typically refers to paid work and implies continuous commitment to employment with a progression through a series of hierarchical positions in an occupation or given organisation (Robinson et al 1997). This view suggests vertical progression towards achieving increased status or reaching a senior level within an organisation, but realistically, for the majority of staff nurses and midwives, progress is more likely to be horizontal and involve a range of adult life experiences, typically domestic life, parenthood, leisure and work (Brannan and Moss 1991). This is more accurately encapsulated in the definition of nurses' careers as 'the sequence of events and experiences concerning employment in the years after qualification, and the way these intersect with other life events' (Robinson et al 1997).

Factors influencing career choice

The construction of career pathways in a healthcare system which is subject to radical and far-reaching change is an issue of growing importance to nurses and midwives. Nurses construct careers in a climate of continuing occupational and organisational change (Robinson et al 1997). Many reports and studies have evaluated and examined recruitment and retention issues and the experiences of nurses' working lives (DATHs 2000, DoHC 2002, McCarthy et al 2002) but very few published studies exist which address career choice and career planning for nurses (Robinson 1999). When examining the issue of career choice it is important to acknowledge that the economic and professional concerns of nurses may differ according to the stages in their life cycle or career development.

According to Shindul-Rothschild (1995) nurses' needs and aspirations vary according to three distinct life cycles or career development stages. These stages are outlined by the author as follows: (1) *early and idealistic*, (2) *middle* – requiring autonomy and control over individual practice, and (3) *late* – demanding career opportunity and improved quality of working life. Larocque and Caty (1997) report that student nurses graduating from a Canadian degree programme considered social issues such as family and friends when making their initial career choice; this is coupled with personal economic factors such as salary and accessing full-time employment. Only a small number of graduates considered professional issues such as autonomy, personal and professional growth and recognition of knowledge and skills in considering initial job or career opportunities. According to Robinson et al (1997) a key perspective in the study of careers is the extent to which individuals make choices and the extent to which they are subject to social and organisational constraints. Participation in both paid work and training are known to be influenced by domestic responsibilities owing to the fact that women form the largest proportion of the nursing workforce (Robinson et al 1997, Reid 1999, Dowswell et al 2000).

Durand and Randhawa (2002) examined the views of nurses who undertook a 'return to practice' programme following a career break. Results indicate that flexibility with regard to

working practices, increased salaries and demonstration by the employing institution that it values its staff were the most important aspects of returning to work. Another important finding of this study is confirmation of a general willingness among nurses who had taken a career break to return to practice as their family circumstances allowed them to do so (Durand and Randhawa 2002). However, career decisions are influenced not only by personal circumstances and preferences: issues such as changes and developments in the environment in which nurses practise are also important (Barribal and While 1996a). These will be discussed in the section on 'magnet' hospitals.

Career planning

The International Council of Nurses (2001) provides career guidance to the profession in a comprehensive document, *It's Your Career – Take Charge: Career Planning and Development.* The document is described as a training package that provides nurses with an overview of career planning and development and their importance to nurses. It depicts a five-phase career planning and development model including activities to guide career development. The main emphasis in this document is on the individual's values, choices, goals and plans. The authors suggest that career planning be seen as an integral part of nurses' professional development and not just an occasional act (ICN 2001, 2003).

Personal development planning

The *Action Plan for People Management in the Health Service* (DoHC/HSEA 2002) outlines the process required for the delivery of the objectives outlined in *Quality and Fairness: A Health System for You* (DoHC 2001a) and states that successful implementation of Action 5 (Investing in Training, Development and Education) will be dependent on the identification and development of a range of core competencies designed to help provide each health service employee with the ability to improve how work is done (DoHC/HSEA 2002). This can be achieved through the use of personal development planning, which involves individuals reviewing where they have been in relation to their career, reflecting on where they find themselves at present in order to determine where they would like to be in the future and determining how to set and achieve career goals and objectives.

Box 2.8 Personal development planning

A continuous development process that enables people to make the best use of their skills and helps advance both the individual's plans and the strategic goals of the organisation.

(Office for Health Management 2003c)

While the personal development plan (PDP) is "owned" primarily by the individual, it is developed voluntarily by the individual in collaboration with his/her front-line manager, thus providing the organisation with a mechanism for managing and developing people effectively, enhancing the quality of working life and supporting the provision of quality services on a value-for-money basis (Office for Health Management 2003c).

Professional portfolios

The literature provides positive indications for portfolio use in CPD in nursing and midwifery although much discussion surrounds the use of the portfolio as an assessment tool in pre-registration/undergraduate nursing education programmes (Gannon et al 2001, Storey 2001, Alexander et al 2002, McMullan et al 2003). The practice of maintaining a portfolio in order to demonstrate professional development and fitness to remain on the professional register is now a requirement of the Nursing and Midwifery Council (NMC) (formerly the UKCC; see Box 2.4). No such expectation exists in countries such as Australia, the USA and Ireland. However, in the USA the Pew Commission (1998) recommended that health professionals should be required to document competence in order to protect the public. This has resulted in a number of pilot studies investigating the development of a portfolio model (Meister et al 2002). The American Nurses Association (ANA) has established an expert panel to develop a Continuing Professional Nursing Competence Process based on the development of a professional nurse portfolio (Whittaker et al 2000).

Gannon et al (2001) and Mc Mullan et al (2003) assert that, in order for portfolios to be successful, users should receive clear guidelines on their purpose, content and structure. Getting started may be made easier by the provision of portfolio templates and examples in order to give users a clear idea of what is expected (Grant and Dornan 2001; see Box 2.10).

Box 2.9 Advantages and disadvantages of portfolios

Advantages

A portfolio:

- can 'showcase' varied competencies, special achievements, diverse experiences, performance evaluations and scholarly contributions
- provides tangible and marketable evidence to meet criteria for regulatory bodies, demonstrates employment proficiencies and nurses' intrinsic motivation to foster career growth
- is an assessment system congruent with applied learning, has real world validity and direct relevance to everyday practice
- attests to achievement and personal and professional development, by providing critical analysis of the contents of such achievement and development
- is both retrospective and prospective, as well as reflecting the current stage of development and activity of the individual.

Disadvantages

There may be:

- some difficulties in relation to reliability, validity and credibility of content
- issues of privacy and confidentiality.

(Brown 1995; Meister et al 2002; Storey 2001; Gannon et al 2001; Mc Mullan et al 2003)

Box 2.10 Guidelines for portfolio development: the contribution of the National Council

The National Council has published *Guidelines for Portfolio Development for Nurses and Midwives* (National Council 2003b) which aims to assist nurses and midwives to maintain a portfolio which reflects their CPD activities for their personal and professional use. The document defines a portfolio as follows:

> 'Literally … a folder or case for carrying loose sheets of paper. However, in recent years a portfolio used by nurses and midwives is generally understood to be an organised collection of documents chronicling an individual's career: these accumulated documents may then be drawn upon when applying for jobs or courses, or in order to demonstrate learning.'

The National Council document offers practical advice on how to get a portfolio started and outlines the many benefits that maintaining a portfolio can have for professional nurses and midwives. The guidelines are available in paper and CD-ROM formats and are also available to download from the National Council website, which makes access to the document very user-friendly: examples and templates are provided and are interactive.

Organisational factors influencing career choice - 'magnet' hospitals

Associations have been found between a number of organisational features and job satisfaction (Adams and Bond 2000). Stress is particularly associated with increasing workload, rising patient dependency levels and degenerating skill mix. Singularly and collectively these organisational features have been cited in the literature as sources and causes of job dissatisfaction (Blegan 1993, Adams and Bond 2000, Lovgren 2002, Mc Carthy et al 2002). Conversely job autonomy, recognition for performance, good inter- and intra-professional relationships, adequacy of nurse staffing levels all contribute to increased job satisfaction (Adams and Bond 2000, Kramer and Schmalenberg 2002, Lovgren 2002). Hackett (1995) identified some of the most important predictors of job success and satisfaction, namely those associated with work-related attitudes, habits and beliefs rather than with specific job skills. Adams and Bond (2000) found that the quality of the professional service which nurses consider they provide is also predictive of job satisfaction: conversely inability to provide a service at appropriate standards is cited among the reason for job dissatisfaction, stress and leaving nursing (Makay 1989, Kramer and Schmalenberg 2002). Adequate nurse staffing and proper skill mix has been associated with overall job satisfaction in many of the magnet studies and account for one of the major characteristics of magnetism in an organisation (Kramer and Hafner 1989, Kramer and Schmalenberg 1991, Adams and Bond 2000, Kramer and Schmalenberg 2002).

Ireland has not escaped the international shortage of nurses and midwives experienced by other countries. While there are many reasons for this shortage beyond the control of the profession and the health service, the profession is not exempt from the criticism found to apply elsewhere. In one national study a number of nurses and midwives cited factors such as deteriorating standards of care, bullying, lack of managerial support and lack of autonomy as reasons for leaving their current place of employment (Mc Carthy et al 2002).

The concept of magnet hospitals was developed in the early 1980s in the USA by the American Academy of Nursing (McClure et al 1983, Buchan 1994, 1999, Aiken 2002). It was observed that certain hospitals seemed to be 'immune' to the nursing shortages, which had become a persistent feature in many North American hospitals (Aiken 2002). Research undertaken over a period of fifteen years suggests that magnet hospitals are more successful than other hospitals in attracting and retaining nurses, largely because of the professional practice environments they have created which positively impact on nurses' job satisfaction and quality of care (Aiken 2002). Magnet recognition is the highest level of recognition that the American Nurses Credentialing Centre (ANCC) can award to organised nursing services (see Box 2.11). By 2002 twenty-three hospitals in the USA had been awarded magnet accreditation. The programme is expanding internationally (Condon 2004), with the Rochdale Healthcare NHS Trust in England being the first healthcare provider outside the USA to achieve magnet status (Buchan

Box 2.11 The Magnet Nursing Services Recognition Programme

The Magnet Nursing Services Recognition Programme for Excellence in Nursing Service was originally approved by the board of directors of the American Nurses Association (ANA) in December 1990. The programme was built on the original 1983 magnet hospital study (McClure et al 1983) and the baseline for its development was the Standards for Organised Nursing Services and Responsibilities of Nurse Administrators Across all Settings (ANA 1991). The programme provides a framework for recognising excellence in the following:

- the management philosophy and practices of nursing services
- adherence to standards for improving the quality of patient care
- leadership of the chief nurse executive in supporting professional practice and continued competence of nursing personnel
- attention to the cultural and ethnic diversity of patients and their significant others as well as the care providers in the system.

Magnet accreditation status is valid for a four-year period, after which the recipient must reapply (ANCC 2003). The recognition programme is administered by the ANCC's Commission on the Magnet Recognition Programme at the ANCC in Washington DC. Recipients of magnet accreditation may use the publicity associated with the status as a marketing strategy directed towards consumers and potential nursing personnel.

et al 2003).

Characteristics of magnet hospitals

Aiken (1995) reports that the 'singular finding of most studies of hospital nurses is that nurses love their work but hate their jobs'. She further suggests that this is because nurses perceive major problems with the structure of their work. The solution offered by Aiken and many of her supporters is a restructuring of hospitals with the goal of creating professional nursing practice opportunities. Magnet hospitals embody a set of organisational attributes that nurses find desirable and that create a work environment conducive to the provision of good nursing care, namely:

- low staff turnover
- adequate staffing levels
- flexible scheduling
- strong, supportive and visible nurse leadership
- recognition for excellence in practice
- participative management with open communication
- good relationships with physicians.

In essence a magnet hospital 'attracts and retains nurses who have high job satisfaction because they can give good quality care' (Kramer and Schmalenberg 2002). However, evidence exists which illuminates the contribution of nurse administrators and staff members to magnet status (Scott et al 1999). Initial research presented findings which can be designated within three major categories: (1) leadership attributes of the nursing administrators; (2) professional attributes of the staff nurses; and (3) the environment that supported professional practice. Subsequent research examined the attributes of nurse autonomy, control and collaborative relationships in magnet hospitals, and organisational and patient outcomes (Kramer and Schmalenberg 1987, Kramer and Schmalenberg 1988, Kramer 1990, Aiken et al 1994, Aiken et al 1997, Aiken et al 2001, Aiken et al 2002).

The evidence in support of superior outcomes for magnet hospitals is extensive. Substantially more favourable outcomes for patients and higher levels of staff retention have been demonstrated through research which first commenced in 1983. Magnet pilot studies have now extended on an international basis with countries such as Canada, Armenia, and Russia participating (Aiken 2002). Further research involving 168 hospitals in Pennsylvania, USA, demonstrated that in hospitals with higher proportions of nurses educated at baccalaureate level or higher, surgical patients experienced lower mortality (Aiken et al 2003).

Box 2.12 The 14 'Forces of Magnetism'

- quality of nursing leadership: it is crucial that leaders are perceived as strong risk-takers and convey a strong sense of advocacy and support on behalf of their staff.
- organisation structure: decisions should be made by the staff who are at the forefront. There should be decentralised nursing departments with strong nursing representation in the organisational committee structure.
- management style: should be participative, incorporating feedback from staff. Senior nurses should be visible and accessible.
- personnel policies and programmes: salaries and benefits should be competitive. There should be 'creative staffing and scheduling', e.g. allowing nurses with young children to work from 10 am to 2 pm while their children attend school.
- professional models of care: nurses are accountable for their own practice and are the co-ordinators of care.
- quality of care: providing quality care is a priority.
- quality improvement (QI): QI activities are viewed as educational.
- consultation and resources: there should be adequate consultation and peer support as well as the availability of knowledgeable experts.
- autonomy: nurses are permitted and expected to act autonomously.
- community: hospitals must maintain a strong community presence, i.e. through outreach programmes.
- nurses as teachers: teaching should be incorporated in all aspects of nursing practice.
- image of nursing: nurses are viewed as integral and there is respect for them from other healthcare professionals.
- interdisciplinary relationships: these are characterised as positive and respectful.
- professional development: significant emphasis on all aspects of education and career development. Opportunities for competency-based clinical advancement should exist.

(Condon 2004)

Summary

CPD as a subset of lifelong learning is gaining increasing recognition in both its personal and professional applications. It is widely viewed as playing a pivotal role in meeting health service delivery needs and the learning needs of individual healthcare professionals. However, many nurses and midwives encounter difficulties in gaining access to CPD, and those opportunities for CPD that are provided may be restricted to traditional methods such as formal academic programmes or in-service training concerned with the performance of functional tasks.

The development of competencies, personal development planning, lifelong learning, career guidance and choice, professional portfolio development and job satisfaction are all processes that are reflected positively in the literature: they are key components in the continuum of CPD.

The concept of magnet hospitals and the recent growth in their numbers is encouraging for the profession of nursing because these hospitals display organisational attributes that nurses and midwives find desirable. The literature confirms

the growing success and popularity of magnet hospitals, their recognition and accreditation of nursing services and their attractiveness as working environments for nurses.

CHAPTER 3

Focus Group Findings

Focus groups were conducted to explore issues in relation to competency and CPD on the basis that face-to-face discussions would yield a greater depth of information than questionnaires and would add richness to the information that would emerge from the questionnaire.

Two groups of staff nurses and staff midwives from each division of the register were convened at two separate locations as described in Chapter 1. A number of questions derived from the literature were formulated in advance and were used to lead the group discussion (see Appendix 1). Participants were invited to offer their ideas and thoughts freely on any aspect of the discussion. The responses from both groups were documented on a flip chart, verified at the end of the session with the participants for accuracy, and then analysed drawing together main themes and common ideas as presented.

Participants were asked to outline what they understood to be the meaning of and the main elements comprising competency. Knowledge, skills, abilities and behaviours were the principal descriptions offered; others included recognising one's own limitations, performing clinically to a high standard, being experienced and capable of 'doing the job'. Other themes discussed were confidence, education and the notion that a period of time was required before competency was at an optimum level.

Competency achievement

Participants were asked how they achieved a level of competence commensurate with their chosen area of clinical practice. The main themes related to practice/skills development, and mentoring by peers and colleagues in an environment of good communication, best practice and change management. Competency achievement involved opportunities to practice in a variety of settings. The skills observed in practice under supervision and CPD activities, clinical experiences and life experiences all assisted in achieving a level of competence for practice.

Competency maintenance

Participants were asked how they maintained their own competence; they were also asked if they felt that maintenance of competency levels was entirely their own responsibility. There was overall agreement that there is a dual responsibility relating to maintaining competence of the individual nurse or midwife, and the employer who has a key role in providing the necessary infrastructure to assist in maintaining competent staff. The provision of up-to-date, functioning equipment, appropriate training in the use of new and existing equipment, orientation programmes, in-service education, performance review and feedback and equitable opportunities for CPD were seen as the responsibility of the employer. Resources such as library facilities and access to information such as the internet were also cited as a necessary part of providing on-site up-to-date, evidence-based information to assist in competent clinical practice. In relation to maintaining competence from the participant's perspective, participants reported that the key was two-way communication with the ward manager or senior nurse/midwife in expressing needs related to competence. Participating in ward-based education, formal and informal practice review, peer support and networking were all deemed to be essential to maintaining their clinical competence.

Monitoring competency

Participants were asked how, and by whom, their competence was monitored. There was an overall negative reaction to this issue. There was agreement that no formal processes for monitoring or reviewing practice was in place in many organisations. Participants complained that they experienced ad hoc feedback in a very informal way. When asked who gave the feedback, they said it was given by the clinical nurse/midwife manager and sometimes by peers, patients and patients' relatives. They believed that they had responsibility to monitor their own competence and this was done by self-reflection and through informal de-briefing sessions.

Competence and the links to service

The link between competence and the service need within the organisation was explored with the participants. Many reported that competence was linked to the efficiency, cost-effectiveness and delivery of value-for-money service of the organisation. Their view was that more competent staff meant that patients/clients had a shorter hospital stay and mortality rates were decreased – this improved the image of the organisation and the morale and job satisfaction of the staff. Participants also expressed the view that demands from the consumer and increased client expectations had influenced the need for organisations and individuals to maintain a level of competence. They reported, however, that the current climate of staff shortages and poor skill mix had a negative impact on service delivery to the patient and the morale and job satisfaction of the staff.

Competence rating

Participants were asked how they rated their individual competence in relation to their clinical area of practice. The main themes to emerge touched on the following: nature of the work, type of client, range of clinical skills required to carry out the tasks of the role, the environment and the pace of change in the clinical environment. Participants stated that all these elements exerted influences on how they as individuals rated or considered their level of competence.

Influences on career choice

Participants were asked to share their experiences on what had influenced their choice of career. The majority of participants in both focus groups were in agreement that the biggest influence on their career choice was flexible working arrangements: this was followed closely by location and the convenience of their place of work to their home. Peer support, staff morale and a good working environment were the next important influences, followed by variety of work, pay and conditions. Promotional opportunities and career pathways were mentioned as having less influence or importance in making choices or decisions relating to career advancement.

Other issues

At the conclusion of the structured question session, participants were invited to raise any issue they felt was important to them which had not been included in the discussion. There were a number of issues raised. Firstly, equity of access to CPD as a means of maintaining competence was unanimously cited as a major problem. Many expressed dismay at the unplanned nature of the continuing professional activities at the local unit/ward level as well as at organisational level. They stated that study days and units of learning were not matched to individual needs in terms of education or relevance to practice area. They reported that often they did not know 'what the study day was about until they turned up at it', often the content was irrelevant to them or their clinical area and was 'a waste of time'.

Other problems such as professional jealousy and bullying were quoted as very real and still existing in many clinical environments. A degree of hostility towards individuals who had chosen to undertake further academic study was also reported. In some cases ward staff felt threatened by new knowledge and would resist any attempt to explore new practices or 'buy in' to any change in practice which might be instigated by a fellow colleague who had undertaken a degree or higher education. The issue of part-time working or job-sharing and participation in CPD activities was also discussed. One individual stated that although she job-shared she felt entitled to the same CPD opportunities afforded her full-time colleagues by the organisation. In reality this was not the case; as a job-sharer she was expected to undertake CPD in her off-time and had to 'wait' often for several weeks or months before time back was repaid. This issue was further debated in terms of career prospects for job-sharers and part-time employees. One participant had this to say:

> *'I fully intend to take up my career when my children are reared and move up the career ladder, but if I am not supported in maintaining my competence and have my CPD facilitated while I am job-sharing I will not be in the slightest bit interested in pursuing a career in nursing'* (the participant had undertaken an access to degree programme and had secured a place on a nursing degree programme).

Finally the issues of workload, stress, poor job satisfaction and burnout were raised. The majority of participants agreed that in reality, due to poor skill mix, rapid staff turnover and the pace of clinical life there was little time to participate in or instigate formal ward-based learning. One participant reported that:

> *'each day is a fire-fighting exercise (experience) and at the end of the shift you just leave work too exhausted to have any inclination to participate in further education'.*

Summary

At the conclusion of the focus group workshops participants were thanked for their co-operation and for providing honest and open views on the topics discussed. The overall mood of the participants was 'up beat' and they expressed their appreciation at being asked for their views in relation to their CPD.

Participants were fully cognisant of the important elements which comprise competence and they understood the meaning of the term. There was unanimous agreement as to how competence is achieved and subsequently maintained. Many of the factors which assist individuals in achieving competence were highlighted.

Monitoring competence was viewed by the focus groups as a major issue. As was the case in the data from the questionnaire, there was agreement that there are no formal processes in place to review clinical performance and provide feedback to staff. It was also suggested additionally that lack of formal feedback may negatively impact on the morale and job satisfaction of staff.

The majority of participants provided valuable insights into how they assessed their own level of competence. They identified the nature of their work and their working environment as having an influence on how they viewed the level of their own competence. When participants were asked to verbalise their level of competence with reference to the novice-to-expert continuum, the majority said they were proficient, while a small number admitted they felt expert in their field of practice. Career choice for the majority of the focus group revolved around three main factors, flexible working arrangements, location of job (closeness to home) and job satisfaction. These factors correlate with the findings of the questionnaire, where promotional opportunities and

career pathways had less influence on the decision to remain in current employment. All focus group participants agreed that access to further education and CPD is impeded by issues relating to work-load, skill mix, equity and organisation support. For the most part participants were motivated to pursue further education or CPD activities but not at any cost; family and financial constraints were a high priority when considering CPD of any kind. The responsibilities and activities of individual practitioners do not exist in a vacuum, however: even the most competent practitioners encounter difficulties in delivering high-quality care if the system is not organised in such a way as to allow them to do so. It is therefore important that institutions and healthcare systems play a role in ensuring that professional practice exists in a competence-friendly environment (Lundgren and Houseman 2002).

Questionnaire Findings

The findings from the questionnaire are presented in three sections – continuing professional development, organisational characteristics and competency development following registration. A mixture of open and closed statements was used in the questionnaire design in order to gather as wide a range of information from respondents as possible (appendix 2). Qualitative comments from the questionnaire are interspersed throughout the findings for the purpose of augmenting the quantitative data.[3]

Section 1 - Continuing professional development

The following findings reflect many aspects of CPD as described in the literature. However, there is a paucity of literature concerning the CPD activities and careers of staff nurses and midwives working in Ireland. Studies such as the *National Study of Turnover in Nursing and Midwifery* (McCarthy et al 2002) examined some aspects of CPD in the context of turnover rates of nurses and midwives and examined the issues related to 'leavers' as a group. Key issues reported by McCarthy et al (2002) related to facilitation of professional development where 'leavers' reported moderate access to CPD, and facilities provided by employers to meet CPD needs where slightly more than half of respondents (53%) reported being facilitated to undertake some form of CPD, typically in the form of in-service education (25%), study days/seminars (28%), study leave (12%) and financial support (10%). According to findings reported in the study, *Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland* (DOHC 2003c), education, skills, knowledge and self-confidence were perceived to enhance empowerment for the survey respondents. Adequate and appropriate education including CE was also judged by respondents as being critical to the issue of empowerment.

Further education

In this study respondents were asked to record academic post-registration education undertaken. The types of programmes undertaken are shown in Table 4.1.

Table 4.1 Further education

Education	%
Master's degree	3
Postgraduate/Higher Diploma in Nursing	4
Postgraduate/Higher Diploma in Sick Children's Nursing	5
Postgraduate/Higher Diploma in Midwifery	7
Other	10
Currently undertaking academic course	11
Postgraduate/Higher Diploma in Clinical/Specialist Practice (e.g. ICU, CCU, A&E, Peri-operative, Gerontology etc)	12

Motivation to undertake further study

Respondents were asked what motivated them to undertake further study (45% responded to this question). The overall themes were self-development, specialisation in a specific clinical area and career preparation and progression. Comments included the following:

'to broaden my knowledge'

'a need to continue personal development'

'improve patient care'

'keep up to date'

'chance of increase in pay'

'a desire to further my career'.

[3] Please note that where findings are presented in tables and figures totals may not always be 100%. This is due to the choice of multiple options, rounding of figures and missing values.

A small number of respondents said they had undertaken further education for the reasons stated below:

> *'boredom with work'*
>
> *'everyone else is doing it'*
>
> *'as a means to leave nursing'*
>
> *'to leave ward level work'.*

The international experience shows similar themes of improved knowledge and improved patient care. Professional relationships as reported by Smith and Topping (2001) when they asked participants undertaking further education about their motivation to undertake the course. Hardwick and Jordan (2002) confirm this but report some negative aspects such as low motivation in relation to acquiring research skills and examples of coercion of staff by managers to 'get a degree'.

Frequency and relevance of CPD activities

Nurses and midwives rated the frequency and relevance of their CPD activities in relation to the following list of recognised CPD activities (Tables 4.2 and 4.3).

Table 4.2 Frequency of CPD activities (%)

Activity	Ad hoc	Every 1-3 mths	Every 3-6 mths	Every 6-12 mths	Yearly	Never
In-service education (e.g. manual handling, IV drug administration, etc)	19	5	5	11	53	3
Work-based learning	18	6	5	8	11	31
Academic study	24	3	2	4	18	27
Short course	24	2	4	9	21	23
Visiting other clinical centres to compare practice, policies or projects	10	1	1	2	7	64
Membership of reflective practice or clinical supervision group	6	3	2	3	5	62
Audit of practice or workload	13	7	4	5	11	44
Clinical practice meetings	13	14	8	7	5	35
Attending seminars/workshops/conferences	21	7	11	20	21	11
Following up on an identified knowledge gap (personal, unit, department) through literature review on best practice	21	11	6	7	8	32
Review of clinical practice issue	22	10	8	7	11	28
Implementation of change following review of clinical practice issue	22	7	7	7	12	27
Engaging in project work	13	4	3.	4	10	50
Participation in journal club	7	4	2	2	4	65
Participation in policy development or service planning	15	5	3	5	10	47
Participation in performance review and feedback	14	8	5	7	9	42
Participation in staff selection and recruitment	4	1	1	2	4	73
Risk assessment and management activities	17	8	4	3	9	44
Writing articles for in-house or national or international journals	4	1	1	1	3	76
Small-scale research studies	9	1	1	2	7	63

Table 4.3 Frequency of respondent involvement in CPD activities (%)

Activity	Entirely relevant	Relevant	Some Relevance	Not relevant
In-service education (e.g. manual handling, IV drug administration, etc)	72	17	3	.5
Work-based learning	24	24	10	4
Academic study	28	28	11	4
Short course	24	31	12	4
Visiting other clinical centres to compare practice, policies or projects	11	18	17	10
Membership of reflective practice or clinical supervision group	7	15	7	10
Audit of practice or workload	17	21	11.	7
Clinical practice meetings	21	22	10	5
Attending seminars/workshops/conferences	32	32	10	2
Following up on an identified knowledge gap (personal, unit, department) through literature review on best practice	23	25	10	4
Review of clinical practice issue	22	27	8	3
Implementation of change following review of clinical practice issue	24	25	7	3
Engaging in project work	7	17	17	10
Participation in journal club	5	11	16	17
Participation in policy development or service planning	14	19	13	8
Participation in performance review and feedback	16	20	12	7
Participation in staff selection and recruitment	7	9	12	19
Risk assessment and management activities	20	20	11	7
Writing articles for in-house or national or international journals	4	8	15	21
Small-scale research studies	6	12	15	14

Fifty-three percent of respondents said they participated in in-service education on a yearly basis and 72% of those felt that this education was entirely relevant to their area of clinical practice. Work-based learning, academic study and visiting other clinical centres were viewed as relevant or entirely relevant by 48%-50% of respondents: however between 32% and 63% of respondents said they never participated in these CPD activities.

Comments made included the following:

'I feel there is peer pressure to be continually doing courses that are not applicable to everyone all the time'

'I feel CPD is very important but it is not encouraged or offered enough, advice should also be offered on career pathways that are available'

'In the UK it is compulsory to maintain your professional development by completing five study days every three years relevant to your area of work. The same policy could be adapted here. It helps discard ritualistic practice and incorporates evidence-based practice'.

Planning and facilitating CPD

Nurses and midwives indicated which factors in their place of work facilitated CPD (Table 4.4). Tenure and support provided by the organisation were also compared to determine whether or not nurses and midwives were facilitated differently on the basis of their tenure. There were significant differences found between the support received by temporary full-time staff and that received by permanent or job-sharing staff particularly when facilitating study leave, providing financial support and providing information on formal policies for support (see Tables 4.4 and 4.5).

Table 4.4 Type of support provided by organisation

Type of support	%
Do not know what support is provided	29
Formal policies for financial support	53
Financial support from organisation	62
Formal policies for study leave	62
Study leave to attend further education (diploma/degree)	75
Study leave to attend seminars, workshops, conferences (outside organisation)	80
Study days/seminars (in-house)	88
In-service education	89

Table 4.5 Tenure and support by organisation

Type of support	Temporary full-time	Temporary part-time	Permanent full-time	Permanent part-time	Job-share
In-service education	93%	94%	97%	94%	96%
Study days/seminars (in-house)	92%	92%	94%	95%	92%
Study leave to attend seminars, workshops, conferences (outside organisation)	82%	88%	90%	92%	91%
Study leave to attend further education (diploma/degree)	76%	83%	91%	90%	90%
Financial support from organisation	63%	73%	83%	78%	76%
Formal policies for financial support	55%	68%	76%	74%	69%
Formal policies for study leave	74%	79%	84%	82%	81%

Support from the organisation was also examined according to location of nurses and midwives and the findings showed significant differences between support for study leave outside of the organisation, financial support and formal policies for study leave and financial support (see Table 4.6).

Table 4.6 Type of support by organisation according to location of respondents

Type of support	City	Town	Rural
In-service education	96%	95%	92%
Study days/seminars (in-house)	95%	90%	85%
Study leave to attend seminars, workshops, conferences (outside organisation)	90%	86%	76%
Study leave to attend further education (diploma/degree)	89%	85%	77%
Financial support from organisation	80%	72%	65%
Formal policies for financial support	73%	69%	53%
Formal policies for study leave	83%	76%	66%

Respondents were further asked who and/or what facilitated their CPD needs in terms of financial assistance and support from professional colleagues. Fifty-six percent of respondents said they funded their own professional development, 35% cited their line manager as facilitating their CPD needs, with family assisting 33% of the time. The director of nursing/ midwifery (or equivalent) was seen to assist by 31% of respondents; peers accounted for 25% of support while the nursing practice development coordinator assisted 19% of the time. Other financial support through grants accounted for 33% of funding, with the National Council CE funding supporting respondents in 10% of cases.

Respondents were asked how their professional development was planned. Fifty-four percent of respondents said that CPD was mandatory in their organisation, that there was no personal input and that it was organised without prior consultation. Fifty-one percent indicated that CPD activities were planned in consultation with their line manger with relevance to the clinical area of practice. Forty-six percent of respondents, however, reported that their CPD was self-directed with no in-put from the line manager and involved attending study days, workshops and seminars which were planned by the individual with relevance to her/his own professional development.

Using a Likert scale, respondents were asked to respond to a number of statements relating to their CPD activities (Table 4.7).

Table 4.7 Continuing professional development activities (%)

	Strongly agree	Agree	Disagree	Strongly Disagree	Not Applicable
I am self-motivated in relation to CPD activities	25	55	10	1	2
CPD activity enables me to evaluate my own area of practice	23	60	5	1	2
I plan my activities to progress along a planned career pathway	14	44	24	3	4
CPD enables me to contribute to developments in nursing/midwifery practice	19	57	9	2	3
CPD helps me to improve the quality of patient/client care	39	47	3	1	1
I have no input into my attendance at in-service CPD activities	5	18	46	15	4
CPD enhances my clinical leadership skills	19	55	11	1	3
I have little or no time for CPD activities	3	17	44	23	3
I value education which involves members of the multidisciplinary team	36	52	2	4	1
CPD is essential for survival in clinical practice	3	51	7	9	9
CPD activities are time consuming and expensive	11	34	32	11	2
CPD enhances my clinical supervision and mentorship skills	22	56	6	8	3
My career planning/career choice has been assisted by my CPD activities	12	40	27	4	5.3
My CPD activities are dictated by the service needs of the organisation in which I am employed	11	46	24	5	3
There are no structured CPD activities within my place of work	7	16	46	17	3.0

Comments made included the following:

> *'all my professional development has been initiated by me – no initiation by managers. I like my job as a professional delivering a high standard of care'*
>
> *'at this stage of my life my family comes first and my job pays the bills; I do enjoy my work but have no desire to study further at present'*
>
> *'I feel strongly that CPD is essential to ensure a high level of nursing care; to stand still in nursing is to go backwards'.*

Inhibitors of CPD

Respondents were asked to list what factors inhibited their access to CPD. Several themes emerged from the responses offered, namely:

- family/home commitments
- finance/funding/paid time off
- accessibility/shift patterns/rosters
- availability of places/appropriate courses
- lack of organisational support
- lack of incentive from the professional perspective
- human element.

The following comment is worth noting:

> *'I would love to spend more time developing and expanding my professional knowledge and skills but find that it is expensive by the time you take childcare costs, travel and course fees into consideration; there are very few financial incentives to pursue further education'.*

The literature suggests that qualified nurses experience difficulties in accessing opportunities for professional development. Low staffing levels, difficulty obtaining study leave, lack of support from managers, lack of funding and late advertisement of CPD events are all obstacles to participation in CPD activities (Barribal and While 1996b). Other studies support the finding that family and home commitments influence the uptake by some nurses and midwives of CPD opportunities (Robinson et al 1997, Reid 1999, Dowswell et al 2000).

Section 1 - Summary

In-service education was assessed as entirely relevant for 72% of nurses and midwives. This activity occurred on a yearly basis for over half of the respondents while 19% said it occurred on an ad hoc basis. CPD activities were assessed as relevant or entirely relevant by the majority of respondents. However, in excess of 60% of respondents said that they never engaged in six out of the twenty recognised CPD activities listed in the questionnaire.

Organisations supported nurses and midwives by providing in-service education for 89% of them. Over half of the respondents reported that there was positive support for and formal policies in relation to study leave and financial assistance in their organisations. Temporary full-time staff, however, did not enjoy the same support as their permanent full-time or job-sharing colleagues.

CPD planning involved organisation input for over half of respondents (54%). However, 46% of nurses and midwives said their CPD was entirely self-directed. Seventy-six percent of participants indicated they were self-motivated in relation to CPD, 80% valued CPD in relation to their ability to evaluate and deliver optimum nursing/midwifery care, with 82% strongly agreeing and agreeing that CPD is essential for survival in clinical practice.

Inhibitors to CPD were outlined as family commitments, financial constraints, availability of appropriate education, accessibility and ability to attend further education and lack of organisation support. Provision of access to and uptake of CPD activities by respondents located in rural areas was significantly lower than that of staff working in towns or cities.

From the information offered by respondents in relation to their CPD it would appear that the majority of participants are engaging in CPD activities to some extent. It also would appear, however, that the majority participate in in-service education and other CPD activities on an ad hoc and mainly infrequent basis. Participants appear to be motivated to engage in activities that they view as relevant to their career or clinical practice area. Some respondents expressed their motivation to participate in CPD or obtain a further qualification as a means to leaving nursing or midwifery. The findings in this section support the literature related to CPD and CPE for nurses and midwives. Barribal et al (1992), Nolan et al (1995), Perry (1995), Furze and Pearcey (1999) all report on the disparity in provision of CPE for nurses and midwives between authorities and regions. They further discuss the inequitable nature of CPE which, depending on grade, shift pattern and tenure, may also disadvantage certain groups of staff. Throughout the literature motivation to engage in CE is linked to increased job competence and the increasing professionalisation of nursing (Barribal et al 1996a, Furze and Pearcey 1999, Ryan 2003).

Section 2 - Organisational characteristics

This section presents the respondents' perceptions of their organisation, using some of the magnet hospital principles as discussed in Chapter 2. Job satisfaction and perceptions of respondents' contribution to healthcare delivery in their current place of employment are explored.

Magnet characteristics

Each respondent was asked to identify if the characteristics shown in Table 4.8 were present in the organisation in which he/she was currently working.

Table 4.8 Magnet characteristics

Administration	True %	Fasle %
Participatory and supportive management style	56	27
Decentralised organisational structures (divisions/directorates)	47	25
Suitably qualified senior nurse/midwife managers	69	15
Adequate nursing/midwifery staffing levels	38	44
Flexible working schedules	65	20
Employment of clinical specialists	65	17
Clinical career opportunities exist	53	29
Professional practice		
Nursing/midwifery models of patient/client care utilised	63	19
Professional autonomy and responsibility	70	14
Availability of specialist nursing/midwifery advice	70	14
Emphasis on teaching responsibilities of staff	64	20
Professional development		
Planned orientation of staff	66	19
Emphasis on service/CE needs	59	25
Competency-based clinical ladders	40	38
Management development programmes provided	36	43

Job satisfaction

Nurses and midwives responded to eight statements regarding satisfaction with their current job (Table 4.9). Over 91% of participants answered all statements. McCarthy et al (2002) administered the same group of questions to nurse and midwife 'leavers', with similar results.

Table 4.9 Job satisfaction (%)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
I find real enjoyment in my job	24	45	19	4	1
I consider my job rather unpleasant	2	4	13	48	26
I enjoy my job more than my leisure time	2	5	18	35	33
I am often bored with my job	3	12	16	45	16
I am fairly satisfied with my job	12	59	12	6	2
I definitely dislike my job	1	1	8	40	42
Each day on my job seems like it will never end	2	4	14	42	29
Most days I am enthusiastic about my job	22	54	13	4	1

The following comments were made with regard to job satisfaction:

> *'I'm working in exactly the way I like to work and planned to work, in an area that is my speciality; there is flexibility in that I have a regular three days a week, good management'*
>
> *'I am quite happy in my nursing profession, giving a quality of care which is professional, competent and adheres to the code of practice for nursing'*
>
> *'Initially when I qualified I did enjoy nursing. I still do, I am almost six years qualified. I feel that the pressures on clinical staff are increasing. Management is expecting us to take greater workloads with very little support'.*

Respondents' contribution to mission of organisation

Eighty-seven percent of respondents answered positively when asked if they felt they made a positive contribution to the service and mission goals of the organisation in which they worked.

Reasons to remain in present employment

Work-related factors were explored by McCarthy et al (2002) based on previous work carried out by Bevan (1991). The factors listed in this questionnaire were further augmented to include issues such as adequate parking facilities and good canteen facilities. Respondents were asked to indicate if any of the factors listed positively affected or influenced their decision to remain in their current employment.

Table 4.10 shows the percentage of respondents indicating the factors that positively influenced their decision to stay in current employment. The responses correlate with the literature on job satisfaction and principles of magnetism, they also reiterate the importance of delivering quality care, autonomy over care delivered and opportunities to develop professionally (McClure et al 1983, McClure and Hinshaw 2002).

Surprisingly, pay, workload, canteen and car parking facilities were not seen as important as other factors. Childcare facilities were bottom of the list but when job satisfaction and flexible working conditions are considered it is likely that those who require child minding arrange that without it being an issue related to the facilities offered by their place of employment.

Table 4.10 Factors which affect or influence decision to remain in current employment

Factor	%
Professional approach to delivery of care	78
Responsibility	67
Ease of communication with immediate supervisor	66
Variety of work	65
Autonomy and control over care delivered	65
Opportunities to develop skills	64
Access to CPD	59
Flexible working hours	58
Access to job sharing	51
Quality of management	50
Attitude of managers	49
Resources which help you do your job	49
Availability of part-time working	48
Opportunity for career pathway	45
Opportunities to take on a different role	41
Opportunities for career breaks	41
Pay	38
Work load	37
Transfer opportunities to various clinical areas	34
Adequate car parking facilities	37
Good canteen facilities	29
Promotion prospects	26
Childcare facilities	7

Section 2 - Summary

In excess of 65% of respondents viewed their organisations as having magnet characteristics. There was a negative response in terms of adequate nursing/midwifery staffing levels. The majority of respondents expressed a high level of job satisfaction: over half said that they were enthusiastic about their job. When asked what influenced their decision to remain in their current employment over 70% of nurses and midwives said it was the professional approach to the delivery of care in their organisation. A further 67% said it was the responsible nature of their job while 65% said it was the variety of work available to them. Factors such as pay, adequate childcare, good canteen and car parking facilities were evaluated as least important influences on decisions to stay.

Comments offered by participants ranged from a desire for *'more in-service education'* to equity of access to CPD by part-time or job-sharing nurses/midwives. The provision of a career guidance officer in all hospitals was suggested by a number of respondents.

The majority of respondents would appear to be satisfied with the support, opportunities and work environment offered by the organisations in which they are employed.

There were some negative comments in relation to staffing levels, skill mix and equity of access to CPD activities. These factors are well supported in the literature, particularly in the magnet studies (Kramer and Schmalenberg 1991, 2002, Aiken 2001).

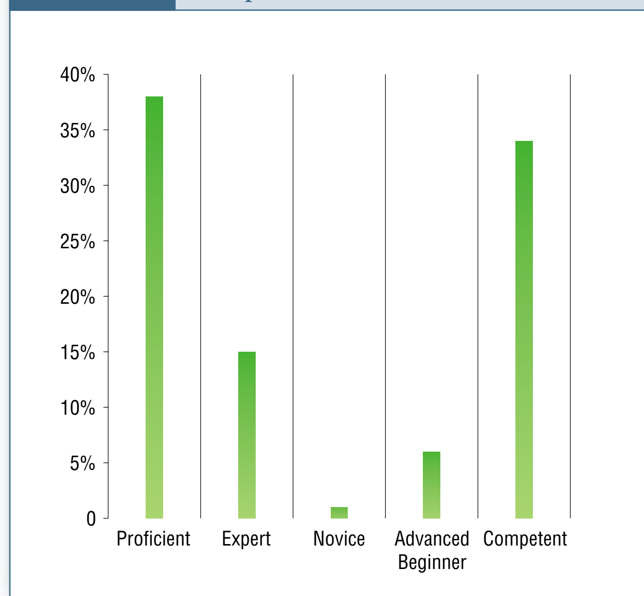
Section 3 - Competence development following registration

This section reviews the issues related to competence, performance review and feedback. Several indicators of competence are outlined in the literature: the most frequently applied indicator is CPE (ANC 1999, Whittaker et al 2000). Other indicators include competence assessment by a supervisor, performance appraisal by a peer, self-assessment and self-completion of a declaration of competence, and maintaining a professional portfolio. Storey (2001) and Storey and Haigh (2002) emphasise the value that maintaining a professional portfolio can have for nurses in relation to demonstrating and recording competence. The authors also outline the potential for competency frameworks to be adapted to individual job specifications, thus leading to competency-based job descriptions which allow for individual talent and innovation in practice.

Individual perception of competence

Participants were asked to assess their own level of competence in relation to their current clinical practice area utilising Benner's (1984) Continuum of Novice to Expert.

FIGURE 4.1 Competence assessment



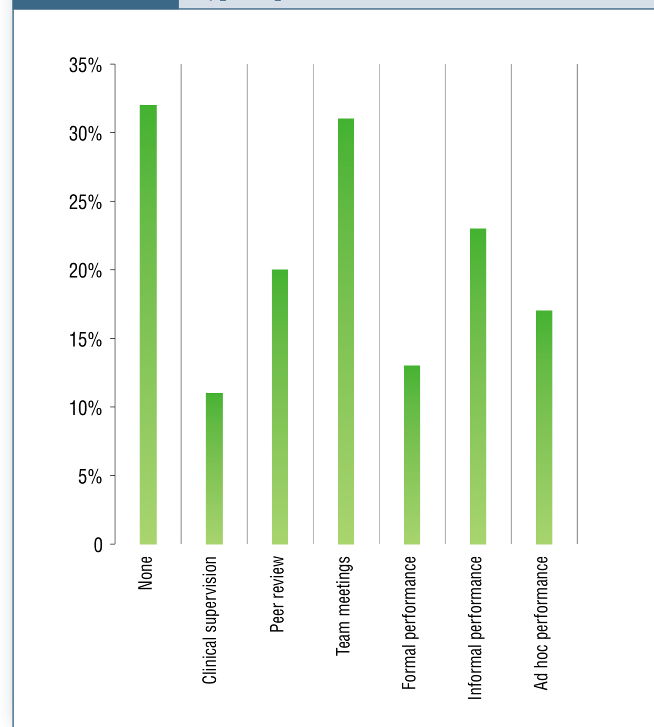
Over 38% of respondents assessed themselves as proficient, with 34% assessing themselves as competent, 14% assessing themselves as expert in their area of clinical practice and 6% regarding themselves as advanced beginners.

Further exploration of competence is presented in Chapter 3 as part of the focus group findings.

Review and clinical performance feedback

Respondents were asked what type of feedback or performance review they received in their place of work. Thirty-two percent of respondents said they received no performance review or feedback in their place of work. Thirty percent indicated that they received feedback through team meetings, 22% said they experienced informal performance review and 17% stated that they had ad hoc performance review.

FIGURE 4.2 Type of performance review and feedback (%)



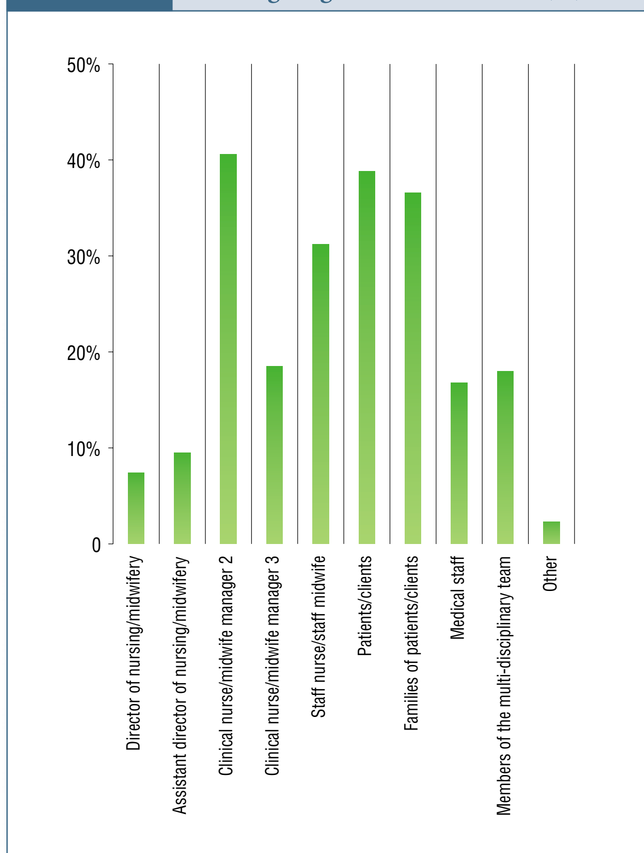
Comments such as the following were made:

> *'Formal performance appraisal would encourage and assist me to participate in CPD'*
>
> *'I believe that formal constructive regular staff appraisals would be extremely beneficial'.*

Person providing feedback

Respondents were asked from whom they received performance review or feedback. Figure 4.3 illustrates this information. When asked about the frequency of feedback the majority of respondents said feedback or review was on an ad hoc basis with some respondents stating that patients and clients provided feedback on a daily basis. Other responses reported frequency levels ranging from 'twice monthly' to 'two-three times a year', 'annually', 'as needed', 'at contract renewal', and 'occasionally'. Forty-three percent of respondents stated that they had made a change in their clinical practice as a result of their review or performance feedback.

FIGURE 4.3 Person giving feedback or review (%)



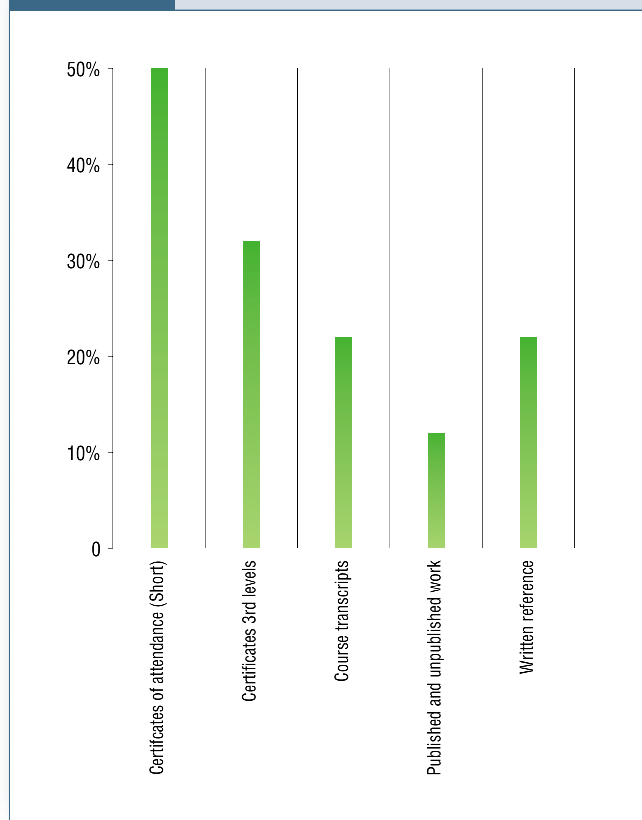
The following comment was made:

> *'It is difficult to motivate self-development and learning without a structured framework and assessment of your current skills, and competency performance review would improve this'.*

Career planning and portfolios

Participants were asked if they had a personal development plan (PDP). Fourteen percent were unsure what a PDP was. Thirty-five percent said they had a PDP. Forty-five percent of participants stated that they hold a personal portfolio. Figure 4.4 outlines what was kept in portfolios by nurses and midwives.

FIGURE 4.4 Portfolio contents (%)



Comments such as the following were offered:

> *'I intend to commence a portfolio as soon as possible'*
>
> *'I did keep a personal portfolio whilst in the UK and it was very useful, especially in interviews because it was very professional looking and answered a lot of questions re career'.*

Section 3 - Summary

Almost 40% of respondents assessed themselves as proficient in relation to their level of competence in their area of clinical practice. Fourteen percent felt they were expert in their field while only 1% viewed themselves as novice professionals. One-third of the respondents indicated they received no form of performance review or feedback in their place of work; a further one-third felt they received feedback through team meetings in their clinical area. Over 40% of respondents reported that feedback, when they received it, was from their clinical nurse/midwife manager but it was on an ad hoc basis. Patients/clients and their families were the only group cited by nurses and midwives as giving performance feedback on a daily basis.

Forty-two percent of respondents reported that they made a change in their clinical practice following feedback or review. In excess of forty percent of respondents said they did not have a PDP; fourteen percent were unsure what a PDP was, while 45% said they held a portfolio. Of the staff nurses /midwives who had portfolios 41% said they maintained and held their own portfolio.

Comments from respondents were generally in support of formal performance review and feedback, and some comments supported the idea of personal development planning and maintaining a personal portfolio as a means of career development.

The majority of respondents reported that performance review and feedback occurs in an ad hoc fashion if at all, while the most frequent feedback is given by patients and their relatives. Clinical nurse managers provide feedback most commonly but the frequency of review is ad hoc and unplanned. Personal development plans and portfolios are not commonly used by respondents but there was support for the introduction of both.

CHAPTER 5

Conclusion and Recommendations

A desire for major change and reform in the Irish healthcare system has been evident since the launch of the national health strategy, *Quality and Fairness: A Health System for You* (DoHC 2001a).

Subsequent reports have re-emphasised and strengthened the rationale for improving the way healthcare is delivered, given the continued fiscal policy and the growing demands to deliver value for money and high quality service to the consumer (DoHC 2003b). Staff nurses and staff midwives are integral to this process of health service change, and have a proven track record of engagement in CPD to support change. Employers, through appropriate education and training needs analyses, can ensure that relevant professional development activities will be provided in a responsive, planned, coherent and equitable manner.

The concepts of CPD and lifelong learning are widely accepted as necessary for health care professionals to update and adapt their practice in order to deliver high-quality, appropriate care to patients and clients. Competency-based approaches to professional development and learning are advocated in the nursing and midwifery literature. Benefits such as acquisition of skills, improved patient/client care and impact of service delivery are described. However, there is a need to embrace empirical methods to evaluate the outcomes of CPD that is provided in terms of patient/client outcomes. Participants in the focus groups of the present study linked competence with efficiency, cost-effectiveness and delivery of a 'value for money' service by the organisation.

The present study

The National Council acknowledges that nurses and midwives have engaged enthusiastically in CPD activities and have overcome many obstacles to do so. In the present study it was found that staff nurses and midwives certainly recognised the need for competency achievement and maintenance and many had undertaken or were currently undertaking professional postgraduate education programmes leading to an academic award (see Table 4.1). However, in-service training provided by employers appeared to be the most frequent source of professional updating. While such provision was deemed to be 'entirely relevant' by 72% of those who participated in it, only ten per cent received in-service training at least once every six months and fifty-three per cent indicated that they received it once a year (see Table 4.2). The nurses and midwives taking part in this study appeared to be well motivated to participate in CPD, with 56% funding their own activities and 46% stating that they planned their professional development without assistance from their managers. This was despite the fact that 54% reported that CPD was mandatory in their organisation.

Concern was expressed regarding issues such as equity of access, relevance to practice, integration of new knowledge into practice and limited opportunities to access and engage in CPD. Organisations' facilitation of nurses and midwives to engage in CPD activities was reported to vary between geographic location and tenure of employment, with no pre-determined professional development plans for the individual, ward or unit.

The Office for Health Management has provided clear guidelines on the identification of learning and development needs targeted at all levels within organisations, from corporate to individual level. It also underlines the need for managers to be involved in identifying learning and development needs arising at service delivery level so that these can be co-ordinated and managed across the wider organisation. This approach when linked with the service planning process can give rise to a more equitable, appropriate and relevant system of funding continuing education. Individual nurses and midwives can also engage in this process through personal development planning and professional career planning. The majority of respondents to the questionnaire and participants in the focus groups considered that performance review and feedback needed to be introduced more widely. Nurses and midwives primarily received feedback on their clinical performance from patients/clients and their relatives. Few organisations actively encouraged the use of portfolios and many participants and respondents did not have a personal development plan.

The importance of career planning is widely acknowledged to be integral to nurses' and midwives' professional development. In the present study 52% of the respondents agreed that their career planning/career choice was assisted by CPD activities. Forty-five percent suggested that the opportunity to follow a career pathway influenced their decision to remain in their current employment. Participants valued the magnet characteristics of their respective organisations. They felt that these characteristics contributed positively to the service goals and mission of their organisations: this suggested a high degree of job satisfaction amongst the group surveyed. They reported, however, that staffing levels in particular continue to be a barrier to CPD.

Job satisfaction has been found to be associated with personal and organisational characteristics. The majority of respondents in this study were enthusiastic about and found real satisfaction in their job, but indicated that they would like to have more support from their line managers. Line managers are a critical support in the development of PDPs and career planning for individual nurses and midwives. Line managers are both mentors and role models, in their turn they may may need to undertake CPD in areas such as career development and personal development planning in order to support staff nurses and midwives.

The professional and personal development of staff nurses and staff midwives will determine, and is determined by, their career pathways. There are many influences, challenges and opportunities which direct the decision-making of the nurse/midwife in relation to her/his career choice. In addition there is constant interaction for the employee within health service organisations between competence, continuing to maintain competence and the delivery of quality care. Ultimately the quality of care the client or patient receives is the result of the continued growth and personal and professional development of the individual providing the care.

This project has examined CPD issues relevant to staff nurses and staff midwives and has identified

- the CPD activities of registered staff nurses and midwives working in various health sectors in Ireland
- their views on achieving and maintaining competency in their practice that is relevant both to service need and their personal professional development needs
- their career choices and how these relate to CPD.

The implications of the findings for nurses' and midwives' CPD and for stakeholders are incorporated into the following recommendations.

Recommendations

Desired outcomes

There are several interlinked desired outcomes of the recommendations emerging from this project. These are enhancement of career development and job satisfaction among nurses and midwives, retention of valued staff, enhancement of nursing and midwifery practice, and hence enhancement of service provision.

Key objectives

The key objectives of the recommendations are:

1. Fair and equitable provision and uptake of CPD by nurses and midwives at a local level
2. Fair and equitable provision and uptake of CPD by nurses and midwives at regional and national levels
3. Maintenance and enhancement of nursing/midwifery competencies
4. Development of a wide range of education and training activities for nurses and midwives
5. Greater responsibility and increased engagement in CPD activities by individual nurses and midwives.

Table 5.2 details deliverables and responsibilities relating to these objectives.

Stakeholders in achieving the outcomes and objectives

Provision of a fair and equitable system of CPD presents many opportunities to develop strong links between groups of services, across health care sectors, across the health and education sectors and regionally and nationally. The National Council has published guidelines for health service providers for the selection of nurses and midwives who might apply for financial support in seeking opportunities to pursue further education (National Council 2003c).

Responsibility lies with individual nurses and midwives to take measures to develop and maintain the competence necessary for their professional practice (An Bord Altranais 2000b). They can be proactive in this to a certain extent by taking part, for example, in PDP and 'fair and transparent' performance management programmes (DoHC 2001a p.123). However, they also require guidance from and support at national, regional, service and departmental levels.

At a national level the National Council will continue to provide the strategic direction required by health service providers and associated agencies for developing fair and equitable CPD systems. Responsibilities of other stakeholders who have important contributions to make to achieving the objectives above are outlined.

The stakeholders identified in Table 5.1 can promote the achievement of the desired outcomes of the recommendations both individually or in collaboration with others at local, regional and national level.

Recommendations for health service providers

Health service providers have a key role in ensuring fair and equitable provision and uptake of CPD by nurses and midwives. A strategic approach to this will ensure the effective use of resources for CPD, enhanced service provision and competent nursing and midwifery practice. This will also enhance career development and job satisfaction among nurses and midwives, and contribute to staff retention.

1. The provision of CPD should reflect an education and training needs analysis, and should have broader concerns than functional tasks. CPD could be an agreed process between corporate learning at health board level, directors of nursing and midwifery planning and development units, the education providers, directors of nursing and midwifery and front-line managers.
2. Health service providers should ensure that there is a fair and equitable distribution of nurses and midwives undertaking further education. An education needs analysis approach linked to the service planning process should support this.
3. Each health service provider should have a policy on applying for funding for CPD. This policy should detail criteria for funding, eligibility, payment of fees, study and exam leave, guidelines for line managers and a learning contract.
4. Job descriptions should be developed collaboratively and become more competency-based.
5. Part-time and job-sharing staff should become a targeted group for medium to long-term career planning.

Recommendations for line managers

Line managers also have a pivotal role in ensuring fair and equitable provision and uptake of CPD by nurses and midwives. A strategic approach to this at unit level will ensure the effective use of resources for CPD, enhanced service provision and competent nursing and midwifery practice. Supporting career development is a key management task which will improve job satisfaction among nurses and midwives, and contribute to staff retention. In their turn, line managers will need support to gain the competencies of career planning and career management.

1. Formal orientation programmes aimed at integrating newly recruited and newly-qualified staff into clinical settings should be made available.
2. Line managers should play a key role in encouraging and supporting nurses and midwives to engage in PDP and the use of portfolios. (The National Council has published guidelines for portfolio development which can be downloaded from www.ncnm.ie)
3. Peer-focused learning activities should be planned to take advantage of and build on nurses' and midwives' various areas of expertise.
4. Unit-based learning packages should be utilised along with the introduction of journal clubs and reflective practice groups at unit level. These activities would improve the dissemination of information to a larger number of clinical staff while keeping staff in their own clinical location.
5. Line managers should be competent in career planning development. This competency should be a requirement of their job discription.

Recommendations for education providers

Education providers also have a central role in ensuring fair and equitable provision and uptake of CPD by nurses and midwives. A strategic approach to this at national, regional and local level will ensure the effective use of resources for CPD to ensure competent nursing and midwifery practice. They may also play a role in providing the support and any further training needed by line managers.

1. New and innovative ideas for the delivery of equitable CPD programmes are required in order to address difficulties experienced by staff living and working in rural areas. Education providers should give consideration to the use of web-based programmes, teleconferencing and modular education programmes to facilitate those in isolated regions.
2. Centres of nurse education should have a major role in the strategic planning and delivery of in-service education, with special regard to specific groups such as job-sharers, part-time and temporary staff and those working night shift or weekends on a permanent basis.
3. Education providers and service providers should collaborate and work closely in reviewing and identifying education and learning needs.

Recommendations for individual nurses and midwives

Individual nurses and midwives have a professional responsibility to engage in CPD activities, primarily to deliver safe, competent and evidence-based nursing/midwifery care to patients/clients.

1. Staff nurses and midwives should take advantage of existing opportunities for CPD while at the same time identifying further areas for development. This can be achieved through the use of personal development planning and maintaining a personal professional portfolio.
2. Staff nurses and midwives should actively contribute to education and training needs analysis at both unit and organisational levels.

The current Health Strategy has promoted a culture within the health services that emphasises the value of continuous learning and improvement in the skills and experience of everyone working in the system. Nurses and midwives have been shown to have anticipated this trend and to welcome developments in this area. The National Council looks forward to working with nurses and midwives at all levels and with other stakeholders in all sectors in ensuring that those working at the forefront of patient/client care can continue to meet existing and new challenges within the changing healthcare environment.

Table 5.1 Stakeholders

Local level	Regional level	National level
• Individual nurses and midwives	• Nursing and midwifery planning and development units	• National Council for the Professional Development of Nursing and Midwifery
• Line managers	• Centres of nurse education	• An Bord Altranais
• Department managers	• Third-level education providers	• Third-level education providers
• Service managers		• Other agencies
• Centres of nurse education		
• Service training departments		
• Third-level education providers		

Table 5.2 Recommendations: objectives, deliverables and responsibilities of stakeholders

OBJECTIVE	DELIVERABLE	RESPONSIBILITY					
		Health service providers	Education providers	Line managers	Individual nurses and midwives	NMPDUs	Centres of Nurse Education
1. Fair and equitable provision and uptake of CPD by nurses and midwives at *local* level	Effective use of resources for CPD through education and training needs analysis	✔	✔	✔		✔	✔
	Published policy on funding of CPD	✔				✔	
	Published protocols and/or criteria relating to applying for funding, eligibility, payment of fees, study and examination leave, line managers' roles and learning contracts	✔				✔	
	Support for career development	✔	✔	✔		✔	✔
	Targeting of part-time and job-sharing staff in education and training needs analysis	✔	✔	✔		✔	✔
	Strategic approach developed collaboratively by health boards, NMPDUs, education providers, directors of nursing/midwifery and front-line managers	✔	✔	✔		✔	✔
2. Fair and equitable provision and uptake of CPD by nurses and midwives at *regional* and *national* levels	Education and training needs analyses reflecting changing healthcare and further education environment, specific professional education trends, and inclusive approach to patient/client needs and all sectors of the health service	✔	✔			✔	✔
	Targeting of nurses and midwives working in remote and/or isolated areas, and/or on part-time/job-sharing bases, etc	✔	✔			✔	✔
	Introduction and/or development of modular, distance and web-based programmes	✔	✔			✔	✔
	Collaboration between third-level and service-based education providers	✔	✔			✔	✔
3. Maintenance and enhancement of nursing/midwifery competencies	Regular education and training needs analyses reflecting changing healthcare environment	✔	✔	✔		✔	✔
	Availability of a wide range of CPD activities, including unit-based learning activities	✔	✔	✔			✔
	Development and expansion of in-service training and other learning activities	✔	✔	✔			✔
	Education and training needs analysis linked with personal development planning	✔	✔	✔	✔		✔
	Collaborative development of competency-based job descriptions	✔		✔			
	Development and implementation of performance review systems that incorporate personal development planning and professional requirements for competency development	✔		✔	✔		

Table 5.2 Recommendations: objectives, deliverables and responsibilities of stakeholders (cont.)

OBJECTIVE	DELIVERABLE	RESPONSIBILITY					
		Health service providers	Education providers	Line managers	Individual nurses and midwives	NMPDUs	Centres of Nurse Education
4. Development of a wide range of education and training activities for nurses and midwives	Education and training needs analysis linked with review of 'state of the art' teaching and learning methodologies	✔	✔	✔		✔	✔
	Support for career development through training in career management and career planning	✔	✔	✔		✔	✔
	Development and implementation of formal orientation programmes aimed at integrating newly-recruited and newly-qualified staff into clinical settings	✔	✔	✔	✔		✔
	Support for use of portfolios for career and personal development planning by nurses and midwives	✔	✔	✔	✔	✔	✔
	Inclusion of competency in career development in line managers' job descriptions	✔					
	Development of and support for service-, department- and unit-based learning activities such as journal clubs, peer review, etc	✔		✔	✔		✔
5. Greater responsibility and increased engagement in CPD activities by individual nurses and midwives	Engagement in existing opportunities for CPD			✔	✔		✔
	Identification of further areas for professional development through engagement in personal development planning and/or use of portfolios			✔	✔		✔
	Participation in education and training needs analysis			✔	✔		✔

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APPENDIX 1

List of Questions for Focus Groups

Staff nurse/midwife continuing professional development project

Focus group terms of reference

To investigate professional development issues relevant to registered nurses and midwives by examining

a. staff nurses'/midwives' understanding of the term 'competency' and essential elements

b. competency achievement and maintenance with relevance to service need and personal professional development

c. career choice with relevance to CPD and competency.

Key questions for focus groups (staff nurses/midwives)

- Number of participants =

- Can you comment on the general atmosphere of the session?

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- Any other observations of interest?

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1. What are the main elements related to competency?
2. How is clinical competency achieved? (period of time in clinical area? variety of clinical settings and exposure to various environments?)
3. How do you maintain competence? (who facilitates your competency maintenance, self? employer? other?)
4. How is competency monitored? (by whom?)
5. Is competency linked to service need in your organisation?
6. How do you rate your own competence in relation to clinical area and responsibilities of role or post?
7. What has influenced your career choice? (institution, promotional opportunity, career pathway (self-directed or other)
8. Has CPD assisted you in making career choice?

- Issues raised during focus group meeting

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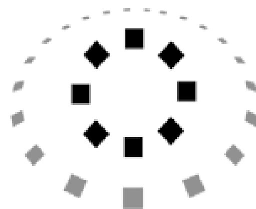
Questionnaire



National Council for the Professional Development of Nursing and Midwifery

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

Staff Nurse/Midwife Research Project Questionnaire

Purpose of Project
To investigate professional development issues relevant to registered staff nurses and staff midwives by examining their continuing professional development activities, career choice and competency achievement and maintenance with relevance to service need and personal professional development.

Instructions:
Please follow the instructions for each question carefully and answer **ALL** questions that are relevant to you. Information gathered from the questionnaire will be collated and a report will be published in early 2004 and will be available on the council's website www.ncnm.ie. Your contribution to the project is much appreciated and will be acknowledged in the final report.
The information you provide in this questionnaire will be treated with strictest confidence.

The questionnaire will take approximately 20 minutes to complete.

Please return the completed questionnaire to the designated **Project Link Person** in your organisation before **8th October 2003**.

Project Link Person____

Location____

Q1. In which of the following care settings do you work?
(*Please choose one* ***only)***
Hospital ☐ Community ☐
Hospital & community ☐ Other (please specify) ☐ ____________

Q2. Which of the following describes your current area of practice?
(Please choose one ***only)***
General Nursing ☐

____
(*Specify clinical practice area e.g. medical, surgical, Care of Elderly, etc.)*

Psychiatric Nursing ☐ Sick Children's Nursing ☐
Midwifery ☐
Mental Handicap Nursing ☐

Q3. In which division(s) of An Bord Altranais register are you registered?
(You may choose more than one option)
RGN ☐ RM ☐ RSCN ☐ RPN ☐ RMHN ☐ RPHN ☐
RNT ☐

Q4. How long since you first registered in the division you currently practice in?
Less than 1yr ☐ 1-5 yrs ☐ 6-11 yrs ☐ 12-17 yrs ☐
18-23 yrs ☐ 24yrs-29yrs ☐ 30 yrs-35yrs ☐

Q5. Please indicate to which age group you belong
21-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ 41-45 ☐ 46-50 ☐
51-55 ☐ 56-60 ☐ 61-65 ☐

Q6. Gender.
Male ☐ Female ☐

Q7. What geographical location best describes where you work ?
City ☐ Town ☐ Rural ☐

Q8. Approximate number of beds in your organisation? (if appropriate)

____

Q9. Please indicate how long you have worked for your current employer
(Please choose one ***only)***
Less than 6 months ☐ Between 6 and 12 months ☐
Between 1 and 2 yrs ☐ Between 3 and 5 yrs ☐
More than 5 yrs ☐ Other (specify) ☐ ____________

Q10. Please indicate which type of employment tenure applies to you?
*(Please choose one **only**)*

Temporary full-time ☐ Temporary part-time ☐ Permanent full-time ☐
Permanent part-time ☐ Job Share ☐ Other ☐

____
(please specify)

Q.11 Please indicate which of the following describes the type of shift pattern which *closely* applies to you? *(Please choose one **only**)*

A. Full rotational (all day shifts including week-ends, night duty)	
B. Semi-rotational (all day shifts including week-ends but **excluding** night duty)	
C. Partial rotation (all day shifts **excluding** week-ends and night duty)	
D. Non-rotational (regular day excluding week-ends and night duty)	
E. None of the above (specify)	

Q. 12 Which of the following qualifications do you hold? *(You may choose more than one option)*

1	Registration / Certificate in Nursing (3 yrs)	
2	Registration /Diploma in Nursing (3 yrs)	
3	Diploma in Nursing	
4	Primary degree in Nursing (e.g. BSc /BNS)	
5	Postgraduate/Higher Diploma in Nursing	
6	Postgraduate/Higher Diploma in Midwifery	
7	Postgraduate/Higher Diploma in Sick Children's Nursing	
8	Postgraduate/Higher Diploma in Clinical/Specialist Practice (e.g. ICU, CCU, A&E, Peri-operative, Gerontology etc)	
9	Master's degree (please specify)	
10	Currently undertaking academic course (Please specify)	
11	Other academic course (nursing/midwifery or other)*. (Please specify)	

*** Only courses of at least one year's duration & for which an award was made by a recognised third level institution**

Q.13 If you have undertaken formal academic education, indicate how soon following your initial registration you did this- (*Please choose one **only***)

Less than 6 months ☐ Between 6 and 12 months ☐
Between 1 and 2 yrs ☐ Between 3 and 5 yrs ☐
More than 5 yrs ☐ Other (please specify) _______________________

Q.14 What motivated you to engage in post-registration academic education?

____
____
____
____

Q.15 List all courses you have completed other than those listed in Q 12
You may include non-nursing courses, i.e. yoga, aromatherapy, etc-

____
____
____
____

Q.16 The term *Continuing Professional Development* (CPD) refers to any activity that contributes to your professional development. The following is a list of CPD activities. How often would you engage in each or any of the following activities?

	Ad Hoc	Every 1-3 mths	Every 3-6 mths	Every 6-12 mths	Yearly	Never
1. In-service education (e.g. manual handling, i.v. drug administration, etc)						
2. Work-based learning (pre-designed work based packages)						
3. Academic study						
4. Short course						
5. Visiting other clinical centres to compare practice, policies or projects						
6. Membership of reflective practice or clinical supervision group						
7. Audit of practice or workload						
8. Clinical practice meetings						
9. Attending seminars/ workshops/conferences						
10. Following up on an identified knowledge gap (personal, unit, department) through literature review on best practice						
11. Review of clinical practice issue						
12. Implementation of change following review of clinical practice issue						
13. Engaging in project work						
14. Participation in journal club						
15. Participation in policy development or service planning						
16. Participation in performance review and feedback						
17. Participation in staff selection and recruitment						
18. Risk assessment and management activities						
19. Writing articles for in-house or other national or international journals						
20. Small-scale research studies						
Other (please specify)						

Q.17 Which of the following are provided in your place of work?
(You may choose more than one option)

		Yes	No
1	In-service education		
2	Study days/seminars (In-house)		
3	Study leave to attend seminars, workshops, conferences (outside organisation)		
4	Study leave to attend further education (diploma/degree)		
5	Financial support from organisation		
6	Formal policies for financial support		
7	Formal policies for study leave		
8	Do not know what support is provided		

Q 18. Please indicate who and/or what assists in facilitating your continuing professional development needs?

		Yes	No
1	Self-funding		
2	Grant (health board or other)		
3	Research project grant		
4	National Council's continuing education funding		
5	Director of Nursing/Midwifery (or equivalent)		
6	Line manager		
7	Nursing Practice Development Co-ordinator		
8	CPD facilitator		
9	Peers		
10	Family		

Q 19.Please list what inhibits you accessing/engaging in continuing professional development activities-

A.
B.
C.
D.

Q.20 How is your continuing professional development planned?
(You may choose more than one option)

		Yes	No
A.	In consultation with line manager with relevance to clinical area? (e.g. tutorials, workshops related to clinical area of practice)		
B.	In consultation with line manager with relevance to the organisation or service need? (e.g. team building, corporate study days, leadership programmes)		
C.	Mandatory in your organisation with no personal input/consultation with individual staff (e.g. i.v. drug administration, manual handling, study days workshops etc)		
D.	Self-directed with no input from line manager (e.g. workshops, study days, seminars which you feel contribute to your own professional development)		
E.	No personal input or choice in selecting activity		

Q.21 Tick any of the continuing professional development activities listed below in which you are/have engaged, indicating how relevant they are to your practice-

	Entirely relevant	Relevant	Some Relevance	Not relevant
1. In-service education (e.g. manual handling, i.v drug administration etc)				
2. Work-based learning (pre-designed work based packages)				
3. Academic study				
4. Short course				
5. Visiting other clinical centres to compare practice, policies or projects				
6. Membership of reflective practice or clinical supervision group				
7. Audit of practice or workload				
8. Clinical practice meetings				
9. Attending seminars/ workshops/conferences				
10. Following up on an identified knowledge gap (personal, unit, department) through literature review on best practice				
11. Review of clinical practice issue				
12. Implementation of change following review of clinical practice issue				
13. Engaging in project work				
14. Participation in journal club				
15. Participation in policy development or service planning				
16. Participation in performance review and feedback				
17. Participation in staff selection and recruitment				
18. Risk assessment and management activities				
19. Writing articles for in-house or other national or international journals				
20. Small-scale research studies				
Other (please specify)				

Q.22 Please tick one box to indicate to what extent you agree/disagree with each of the following statements relating to your engagement in Continuing Professional Development activities-

(Choose one box per statement)

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
A. I am self-motivated in relation to CPD activities					
B. CPD activity enables me to evaluate my own area of practice					
C. I plan my activities to progress along a planned career pathway					
D. CPD enables me to contribute to developments in nursing/midwifery practice					
E. CPD helps me improve the quality of patient/client care					
F. I have no input into my attendance at in-service CPD activities					
G. CPD enhances my clinical leadership skills					
H. I have little or no time for CPD activities					
I. I value education which involves members of the multi-disciplinary team					
J. CPD is essential for survival in clinical practice					
K. CPD activities are time consuming and expensive					
L. CPD enhances my clinical supervision and mentorship skills					
M. My career planning/career choice has been assisted by my CPD activities					
N. My CPD activities are dictated by the service needs of the organisation in which I am employed					
O. There are no structured CPD activities within my place of work					

Q 23. Using the 'true' or 'false' answer-tick the characteristics which most closely resemble those of the organisation you are currently employed in-
(You may choose more than one option)

Administration	**True**	**False**
A. Participatory and supportive management style		
B. Decentralised organisational structures (Divisions/Directorates)		
C. Suitably qualified senior nurse/midwife managers		
D. Adequate nursing/midwifery staffing levels		
E. Flexible working schedules		
F. Employment of clinical specialists		
G. Clinical career opportunities exist		
Professional Practice		
H. Nursing/midwifery models of patient/client care utilised		
I. Professional autonomy and responsibility		
J. Availability of specialist nursing/midwifery advice		
K. Emphasis on teaching responsibilities of staff		
Professional Development		
L. Planned orientation of staff		
M. Emphasis on service/continuing education needs		
N. Competency-based clinical ladders		
O. Management development programmes provided		

Q 24. To what extent do you agree or disagree with each of the following statements about your job?
(Please tick one box for each statement)

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
A. I find real enjoyment in my job					
B. I consider my job rather unpleasant					
C. I enjoy my job more than my leisure time					
D. I am often bored with my job					
E. I am fairly satisfied with my job					
F. I definitely dislike my job					
G. Each day on my job seems like it will never end					
H. Most days I am enthusiastic about my job					

Q 25. Do you feel you positively contribute to the delivery of high quality nursing care in line with the mission statement and goals of the organisation in which you work?

Yes	
No	

Q 26. Please indicate which (if any) of the following positively affects OR influences your decision to work as a nurse/midwife in your current place of employment?
(You may choose more than one option)

	Yes	No		Yes	No
1. Promotion prospects			13. Autonomy and control over care you deliver		
2. Resources which help you do your job			14. Professional approach to delivery of care		
3. Opportunities to develop your skills			15. Access to continuing professional development		
4. Child care facilities			16. Opportunities to take on a different role		
5. Availability of part-time working			17. Ease of communication with immediate supervisor		
6. Flexible working hours			18. Quality of management		
7. Access to job sharing			19. Attitude of managers		
8. Opportunity for career pathway			20. Transfer opportunities to various clinical areas		
9. Work load			21. Variety of work		
10. Pay			22. Responsibility		
11. Opportunities for career breaks			23. Good canteen facilities		
12. Adequate car parking facilities			24. Nothing		

Other (please specify)

Q.27 Please rate your clinical competence with relevance to your current clinical area of practice by ticking the appropriate box below –

Novice	Advanced Beginner	Competent	Proficient	Expert

Q 28. In relation to your professional and clinical competence, what type of review or feedback do you receive?
(You may choose more than one option)

	Yes	No
A. None		
B. Clinical supervision group meetings		
C. Peer review		
D. Team meetings		
E. Formal performance review		
F. Informal performance review		
G. Ad hoc performance review		
H. Other (please specify)		

Q 29. If you receive feedback or review, from whom do you receive it? How often do you receive it? *(You may choose more than one option)*

	Person giving feedback	*Frequency of feedback*
1. Director of nursing/midwifery		
2. Assistant director of nursing/midwifery		
3. Clinical nurse/midwife manager 2		
4. Clinical nurse/midwife manager 3		
5. Staff nurses/staff midwives		
6. Patients/clients		
7. Families of patients/clients		
8. Medical staff		
9. Members of the multi-disciplinary team		
10. Other (please specify)		

Q 30. Have you made a change in your clinical practice/or practice area based on the review or feedback?

Yes	
No	

Q 31. Do you have a Personal Development Plan?

Yes	
No	
Unsure what a personal development plan is-	

Q 32. A Professional Portfolio is a private collection of evidence which demonstrates the continuing acquisition of skills, knowledge, attitudes, understanding and achievements. Do you maintain a professional portfolio?

Yes	
No	

Q 33. If 'YES' to Q 32,please tick any of the following statements as they apply-
(You may choose more than one option)

	Yes	**No**
1. My professional portfolio is provided by my employer as a means of assessing my clinical competence and career pathway		
2. My employer provides and holds my portfolio		
3. My employer provides and I hold my own portfolio		
4. I personally maintain a professional portfolio as a method of collecting relevant documentation demonstrating my professional career development		

Q 34. If you maintain a portfolio, what do you put in it?
(You may choose more than one option)

	Yes	No
a. Certificates of attendance (short courses, workshops, conferences, seminars)		
b. Certificates awarded by third level education providers		
c. Written transcripts from course co-ordinator verifying modules, hours of study and results		
d. Copies of unpublished and published work that you have written or contributed to		
e. Written references		
f. Other (please specify)		

Comments

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End of Questionnaire

THANK YOU -for taking the time to complete this questionnaire. Your contribution is much appreciated.