CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Research is conducted to generate new knowledge, answer questions, solve problems and/or validate existing knowledge or practices (Polit & Beck, 2012). In this chapter, the literature related to continuing professional development (CPD) for critical care nurses was reviewed to answer the research questions. The extensive literature review was conducted using a systematic approach of mainly primary and some secondary sources. The key words used to conduct the literature search were continuing professional development, lifelong learning, critical care nurses development, post registration certification, competency and patient outcomes. The literature review was done from computer and manual data bases, with sources ranging from 1982 – 2012. Themes identified in this literature review were linked to the research questions and are described as follows:

- continuous professional development (CPD) related to critical care nursing, (including lifelong learning, competency, shortages and the expanded role of the critical care nurse, post registration certification and CPD programs)
- participation in CPD programs (including intrinsic and extrinsic factors)
- barriers to critical care nursing CPD programs (including physical, structural and attitudinal barriers)
2.2 CONTINUOUS PROFESSIONAL DEVELOPMENT IN RELATION TO CRITICAL CARE NURSING

Continuous Professional Development (CPD) is the updating of knowledge, skills, information, supportive and motivational, sharing of new or in depth knowledge and provides recognition and adds prestige to professions (Ellis & Nolan, 2004; Huggins, 2003; Reu & Maple, 2003). According to Skees (2010), CPD is considered a hallmark of a nursing care speciality. The International Council of Nurses (ICN) position statement on CPD is “the overriding purpose of assuring the continuing competence of nurses is the protection of the public” (ICN: 2006). CPD is crucial to the development and progression of professions and individuals. Numerous global studies have reported on the contribution that updated critical care nurses make to the positive outcome of patients (Ball & McElligot, 2003; Skees, 2010; Watts, 2010). In South Africa, Healthcare professions, except the nursing profession, have embraced and implemented CPD systems.

Management of the Intensive care unit (ICU) patient is dynamic, demanding and challenging with rapid advances in research, technology and evidence based practices in the health care field. Critical care nurses are required to provide world class care, in state of the art ICUs.

2.2.1 Lifelong Learning

A definition given by the American Nurses Association for lifelong learning is cited by Skees (2010) as being “learning activities designed to augment the knowledge, skill and attitudes of nurses and therefore enrich the nurses’ contributions to quality healthcare” and
these learning activities can be formal or informal (Bahn, 2006; Skees, 2010). Lifelong learning is supported by continuing professional development (Ellis & Nolan, 2004; Huggins, 2003). The three critical pillars of learning, namely, knowledge, skill and attitude, are all three essential for effective learning to occur, otherwise the activity becomes a task (Fowler, 2007). Critical care nursing requires critical thinking, problem solving, accurate decision making, responsibility and accountability and thus requires meaningful learning to occur to prevent unsafe practice (Ball et al, 2004; Schmollgruber, 2007; Watts, 2010).

A number of influencing factors contribute to the changes taking place in nursing, for example, the redesign of countries healthcare services, emerging illnesses and multi drug resistant organisms, new research and subsequent numerous therapeutic options, with accessibility, dissemination, and easier communication of international information, global economic demands, worldwide nurse and healthcare provider shortages, consumer-driven healthcare and litigation (Ball & McElligot, 2003; Skees, 2010; Watts, 2010). Learning should not cease once the nurse has achieved her/ his initial registration, as going forward, nurses cannot rely on old knowledge to manage new developments (Bench et al., 2003; Skees, 2010). Through the dynamics of change and the impact thereof in all spheres of life, nurses need to keep up to date to ensure that quality nursing care is promoted and patient outcomes improved (Ball et al, 2003; Loyola, 2010; Watts, 2010).

Benner’s (1984) five stages of competency development model from novice, advanced beginner, competent, proficient to expert, is applicable and useful to critical care nursing (Badger, 2008; Skees, 2010). The learning and development cycle of a critical care nurse is a constant process as new technology and therapies emerge at a fast pace, critical care
nurses, regardless of how qualified, experienced or expert they are, will always be in
different stages of development and often will be a novice in some area. Lifelong learning
is needed for a nurse to develop competency, (Huggins, 2003; Skees, 2010) to move from
being a novice to an expert (Benner, 1984; Race & Skees, 2010), to ensure improved
patient outcomes and for the profession to grow (AACCN, 2008; Skees, 2010).

Formal and informal formats exist for lifelong learning to take place (Bahn, 2006; Skees,
2010). Formal learning is more classroom or academic based and the critical care nurse can
attend courses, conferences, symposiums, seminars and workshops and in some instances
acquire a qualification (Bahn, 2006; Gould et al, 2006). Informal learning occurs mainly in
the workplace via role models, mentors, preceptors, product specialists and the
multidisciplinary team (Clarke & Copeland, 2003; Gould et al, 2006).

Critical care nursing is primarily bedside nursing and the majority of learning takes place
in the work environment and is self-directed (Skees, 2010; Swallow & Coates, 2003).
Learning is not new to critical care nurses as all critical care nurses have had learning at
some point in their careers, the focus is to maintain and improve it (Huggins, 2003).
Experience forms the basis of learning for this nursing speciality (Fowler, 2007; Huggins,
2003). Three types of learning are associated with workplace learning, namely, specific,
transferable and personal development (Huggins, 2003). Specific skills are skills essential
and specific to critical care nursing practice, both clinical and managerial. The critical care
nursing skills need to be transferable from role models and experts to the developing
critical care nurses or else, critical care nursing will be stagnant and lead to higher patient
risks. Personal development learning allows the learner to learn something new and
develop confidence and competency and the mentor/role model to develop self esteem and to be recognized as an expert (Farnell & Dawson, 2004; Race & Skees, 2010).

Progressive learning, the matrix of experience and reflection, is well suited to adult learners and particularly nursing which is a practice based profession (Fowler, 2007). Critical care nurses are adult learners and learn mainly by doing, actively participating and reflecting in the learning process (Fowler, 2007). The ICU provides a suitable environment for this type of learning thereby allowing the critical care nurse to grow both personally and professionally (Ulrich, Lavandero, Hart, Woods, Leggett, Friedman, D’Aurizio & Edwards, 2009).

The international evolution and development of critical care nursing to meet the changing health needs of countries is described in the 2007 second worldwide review of critical care nursing (Williams, Chaboyer, Alberto, Thorsteinsdottir, Schmollgruber, Fulbrook, Chan & Bost). It is inspiring to perceive from this report the impact that lifelong learners in critical care nursing around the globe have had and continue to have, on the speciality. From the response to illnesses in the 1950’s, critical care nursing has developed into a vital role in the care of the critically ill patients in all spheres, for example, closed and open ICU’s, transport of ICU patients, military nursing, disaster nursing, and specialized ICU nursing of cardiac, respiratory, neurology, burns and surgical. This universal commitment to critical care nursing, striving to improve quality patient care, sharing of knowledge and skills and support for developing countries, demonstrates the positive effects of lifelong learning by critical care nurses.
2.2.2 Competency

In relation to critical care nursing, Riitta-Liisa, Suominen and Leino-Kilpi (2007) defined two types of competency required for critical care nursing, namely, clinical and professional competency and in combination defined them as “specific knowledge base, skill base, attitude and value base and experience base of intensive and critical care nursing”. They then differentiated clinical competency as “principles of nursing care, clinical guidelines and nursing interventions” and professional competency as “ethical activity, decision making, development work and collaboration” (2007). Competency focuses on current practices.

Clinical competency is the standard of critical care nursing care given to patients. Principles of nursing care relate to patients charter of rights and a nurses duty to care (SANC, 2011). The International Council of Nurses (ICCN, 2004) states that “continuing competence is a professional responsibility and a public right” to provide safe quality patient care. The critical care nurse has a responsibility to the patient and their significant others, the profession, the team and the employer to provide competent, safe, quality nursing care of a high standard through current practices (Ball et al, 2003). Clinical guidelines provide an evidence based approach and standardised practice method to ensure safe practice. Nursing interventions are the planned and unplanned interventions for a critically ill patient in response to their changing needs. The interventions are implemented according to clinical guidelines to improve patient outcomes.

Professional competency is the characteristics associated with the profession and professionals and influences they way in which critical care nurses act and react (Riitta et
Richards & Potgieter (2010) refer to the four components of professional competency as being knowledge competence, cognitive competence, business competence and ethical and/or personal behavioural competence. Ethical competence/activity is related to values and knowing right from wrong. Cognitive competence or decision making is using critical thinking skills to effectively problem solve and consistently make the right judgements, at the right time for the right reasons and to take responsibility and accountability for the action. Development work or knowledge competency refers to the critical care nurses knowledge and self development and includes development of others, of the speciality and of the unit and organization. Business competence or collaboration is teamwork, interpersonal relationships and unity, to pro-actively meet the patients’ and their significant others expectations (Richards & Potgieter, 2010; Riitta et al, 2007).

Critical care nurses substantially benefit from developing competency in current practices, they develop confidence, self worth, feel part of the team, achieve job satisfaction, remain in ICU and become willing to participate and share in others competency development (Richards & Potgieter, 2010; Skees, 2010; Watts, 2010).

In the unity of the team that is created through CPD participation, learning, mentorship and self esteem is promoted, thereby assisting in removing barriers between colleagues (Race & Skees, 2010). The Charter of Nursing (SANC: 2004) has based CPD on adult learning which aligns to the synergy model of patient care whereby the patient and the nurse are matched for optimized patient outcome (AACCN, 2003).

The critical care nursing profession requires competency from the critical care nurses in validation of the speciality and to give surety to the public that practices and patients are
safe in ICUs’ (Skees, 2010; Watts, 2010). By determining standards of and guidelines for competent critical nursing care, the specialty receives recognition, benchmarks practice and develops the specialty to safely and cost effectively meet the patients expectations and increasing changes in healthcare.

Escalating healthcare costs, managed care and economic variables are influencing employers demand for competent critical care nurses. Just because a critical care nurse always comes on duty or has worked in the unit a long time, does not mean she/ he is competent (Skees, 2010). Employers require evidence of competency by means of assessments or portfolio’s (AACCN, 2003, Skees, 2010; Watts, 2010). These competency requirements form part of the employees’ contract of service and performance appraisals and can influence the employee remaining in ICU or have a financial impact.

In this twenty first century, there might soon be the need in healthcare to consider having another advanced stage of competency development added to Benner’s five stages (1984), that of ‘world class’. World class care is “generally taken to mean that one has achieved a level of performance excellence that ranks among the very best in the world” (Kizer, 2010). With healthcare institutions competing for marketability and hospital ratings, and their missions statements stating they provide world class care, organizations are demanding competency and excellence from critical care nurses. Lifelong learning is supported by CPD and through it can develop the critical care nurse’s competency and quality care (Skees, 2010, Watts, 2010).

The positive impact that competent critical care nurses have on the recovery of critically ill patients has been proven (Ball et al., 2003; Scribante & Bhagwanjee, 2007; Skees, 2010).
This evidence has been accepted by all stakeholders and especially patients. This is an achievement for critical care nurses work in difficult times and critical care nurses cannot now become complacent.

Consumer driven healthcare has led to patients and their significant others demanding competency from critical care nurses (Richards & Potgieter, 2010; Watts, 2010). Consumers are more aware of their health, their rights and of the processes to ensure that they receive the best nursing care (Richards & Potgieter, 2010; Watts, 2010). Medical aids schemes are also forcing their members to take responsibility for their health and the related costs. This in turn drives the consumer to be more alert to the standard of nursing care and the consistency thereof. The critical care nurse cannot afford to claim ignorance or disinterested in CPD, she/ he needs to realize the personal and professional value of CPD (Skees, 2010; Watts, 2010).

South Africa (RSA), as a third world developing country, with a high rate of transmissible illnesses, trauma, maternal and infant deaths, critical care nursing needs to be supported by an organized, structured CPD program to best benefit the critically ill patients in the country’s ICU’s (SANC, 2011). In 2007, Scribante and Bhagwanjee, conducted a national audit of critical care resources in the country and described the low morale of critical care nurses and no continuing professional development program.
2.2.3 Shortage of Critical Care Nurses

Exacerbating the daily complexities of ICU’s is the world wide nursing shortage (WHO: 2006). The current shortage of critical care nurses has resulted in the ICU speciality being listed as a national scarce skill, which is in high demand (Development policy research unit, 2007). Shortages of staff create challenges for participation in CPD. The 2011 mid year South African population and year end registered nurses statistics showed a ratio of 1 registered nurse to 428 persons in South Africa. In Gauteng where this study was done, it is estimated that the ratio is 1 registered nurse for every 368 persons (SANC, 2011). These figures are questionable as the SANC statistics regarding registered nurses does not reflect the number of registered nurses who are actively practising or are in other positions in nursing that have no direct patient care or are non practising, and these factors can influence this ratio dramatically (SANC, 2011; Scribante & Bhagwanjee, 2007).

The aging nursing population, who are the role models in nursing, is a growing concern. The South African Nursing Council (SANC, 2011) statistics show at the end of 2011 compared to 2009 an alarming 4% increase in the age group of 50 – 59 years who account for 30% of the total registered nurses and a 1% increase in the age group of 60 – 69 years who are 13% of the total, with these two groups soon to be exiting from nursing (SANC, 2011). Other concerns are the static age group of below 30 years who are only 4% of total, over 69 years who remain static at 3% of the total and the 1% decrease in both the age groups 30 – 39 years (19% total) and 40 - 49 years (30% total) (SANC, 2011). The aging critical care nurse her/ himself runs the risk of health problems due to associated physical work, stress, fatigue, occupational health risks and the natural aging process (Scribante & Bhagwanjee, 2007).
The statistics do not show how many of the registered nurses are critical care nurses, but statistics do show that the following numbers of additional qualifications for general critical care nursing were registered in South Africa (SANC, 2011): in 2011 of 5,858 additional qualifications registered only 288 (4.9%) were for general critical care nursing, 2010 of 5,331 additional qualifications only 265 (4.9%) were for critical care nursing and in 2009: of 4,334 additional qualifications registered only 297 (6.8%) were for critical care nursing. These statistics reflect a national decrease in newly qualifying critical care nurses. Coupled with the aging nursing population and an estimated 12% population growth over the last 9 years there is a shortage of critical care nurses. The increasing population brings with it added health risks and increases the demands for ICU beds which leads to overstretching of the active critical care nurse and a risk of increased workload and burnout (Scribante & Bhagwanjee, 2007). There is a wealth of knowledge in critical care nursing and it needs to be managed before the aging critical care nurses exit the speciality and a huge gap in South African critical care nursing develops (Anderson & Wilson, 2009). CPD provides a means to harvest, share, develop and store this valuable knowledge.

To relieve the staff shortage, newly qualified nurses and subcategory nurses are placed in ICU which dilutes the specialized knowledge and skill required for the specialized nursing of ICU patients (Skees, 2010; Scribante & Bhagwanjee, 2007). Mentoring of new nurses to critical care nursing is imperative as Farnell and Dawson describe the experiences of new nurses to ICU as “It’s not like the wards” (2004). These authors report that “critical care is both emotionally and intellectually challenging” and there needs to be a “balance between technical mastery and personal support” (2004). Bonuel, Cesario and Cabading (2010) describe a hybrid nurse that has subsequently been developed in response to the shortage of renal transplantation nurses whereby new nurses are fast tracked to learn the basics of
critical care nursing. If CPD does not take place in critical care nursing, the risk of a large pool of incompetent novice critical care nurses with subsequent increased errors in care is a major concern. A CPD program specifically for critical care nurses is seen to support and develop the required specialized workplace knowledge, skills and attitudes (Badger, 2008; Skees, 2010).

Within critical care nursing there are a number of generations and this in itself can pose challenges in learning. The Baby Boomers, born 1940 – 1959, (over 50 years age group) prefer trainers to train them, dislike role-play and prefer hard copies of training material whereas the X generation, born 1960 – 1979, (30 – 49 years), prefer to work on their own with clearly defined goals, like feedback and are concerned more with the outcome and not how it gets done, they also like role-play and interactive learning (Paterson, 2010). The Y generation, born 1980 – 1999, also known as the Net generation, are more technologically inclined, need more supervision, concerned with money and like teamwork (Paterson, 2010). In assessing the age of registered nurses as stated above, the majority are generation X and Baby Boomers, with some Y generations. This poses challenges in learning as ICU’s are complex, busy, demanding, high-tech units with shortages of staff, requiring independent, interdependent and dependent nursing functions with generational staff with different learning needs at different competency stages. Paterson states (2010), “generational differences in nursing have the potential to create unnecessary friction and conflict”. Organized CPD programs, that take the learners needs into consideration can provide all generations with appropriate learning opportunities, for example, the aging nurse who is not as computer/technologically competent will be anxious about new technology being introduced which could impact on her/his care delivery, however, she/
he can safely learn these new skills through CPD (Notarianni, Curry-Lourenco, Barham, & Palmer, 2009; Paterson, 2010).

A common denominator that is noted in all generations is the basic human need for recognition (Kaplow, 2011; Ryan, 2003). Recognition of development and achievement builds self esteem, passion, respect and contributes to the journey of self actualization (Kaplow, 2011; Skees, 2010). When clinical and technical skill is mastered, competency develops with the spin off of self esteem development. Recognition of personal and professional development is important to job satisfaction and retention of staff (Ryan, 2003; Skees, 2010). Retention of critical care nurses in ICU’s is vitally important and all means of enhancing job satisfaction should be used. CPD is a proven means in the development of competency and confidence, job satisfaction and improved patient care. CPD can reduce anxiety, frustration and stress in the critical care nurse which leads to job satisfaction, a willingness to learn and competency.

2.2.4 Complexities and the expanded role of the critical care nurse

Internationally there is a current shortage of all disciplines of healthcare providers and an increase in chronic illnesses, emerging diseases and an increase in the demand for ICU beds, which is expanding the role of the critical care nurse (Coombs, Chaboyer & Sole, 2007). In South Africa the shortage of ICU team members, those of specialized medical doctors, perfusionists, physiotherapists, renal technicians, occupational and speech therapists and psychologists, requires that these reduced number of team members have to provide service to a number of ICU’s and are time limited in each ICU (Department of
Health, 2008). The critical care nurse, a constant in the unit, is thus required to expand her/ his role and take on functions of these team members as well as still carry out her/ his pivotal role at a high standard to ensure safe, quality, cost effective patient care (Ball et al, 2004).

As new modalities of care emerge, so the role of the nurse keeps expanding, for example, adult extracorporeal membrane oxygenation (ECMO), previously used in cardiothoracic surgery and which is in the scope of practice of perfusionists, is now a modality for ICU respiratory care (Freeman, Nault, Mowry & Balridge, 2012) and is also used in advanced life support response (Chillcott, Stahovich, Earnhardt & Dembitsky, 2008). Due to the shortage of perfusionists, the critical care nurse takes on the responsibility for the patient on ECMO and further expands her nursing role (Freeman et al, 2012). Every aspect of critical care is continually developing whether it is new ventilators, new medications, new cannulas or new wound care, there is always something new in critical care. As well as advancing mechanical ventilation modalities (Haas & Bauser, 2012), all the other ICU and point of care technology and her/ his critical care nursing responsibilities of nursing critically ill unstable patients, she/ he has to manage the turbulences that these continual changes bring and also has to manage her/ his own mental, physical, emotional and spiritual fatigue. The critical care nurse is being stretched beyond the realms of nursing and needs the support of CPD to assist her/ him in providing updated, zero error, quality patient care.

The expanding role of the critical care nurse has brought about a new category of nursing, the advanced clinical nurse specialist (Harris & Chaboyer, 2002). This new role in critical care is considered, by a collaborative study in 2007, by Coombs (UK), Chaboyer
(Australia) and Lou Sole (USA), to have challenges regarding the competencies required. Currently RSA critical care nurses do not have a specific critical care nursing scope of practice which regulates their practice and so continue to practice under the general registered nurses scope of practice which is open to interpretation, which in itself causes confusion (Scribante, Muller & Lipman, 1995). This new role for critical care nursing can have an impact on patient care as the critical care nurse may not as yet be adequately prepared for the current role, let alone the expanding role, or advanced role. The cost associated with the lack of critical care nursing competency to all stakeholders, namely patient, community, employer and critical care nurse, is too high not to have a CPD system for critical care nurses.

2.2.5 Post registration certification and CPD programs

Various reasons for the introduction of post registration nursing CPD have been described in the literature, but universally the main objective is to provide safe quality patient care (Doerksen, 2010; Roxburgh, 2009; UKCC, 2000). The high risks and rapid advances in ICU nursing involving complicated life saving vaso-active medications, modes of ventilation, support machines and devices, for example, pacemakers, intra-aortic balloon pump, dialysis, requires the critical care nurse to be up to date, informed and competent on the current standard of practice to safely perform patient centred care (Ball & McElligott, 2003; Scribante 2007). Scribante and Bhangwanjee (2007) noted that “the quality of nursing directly affects patient outcomes”.

In South Africa, no regulated, or accredited, CPD program exists for critical care nurses. In fact, no accredited regulated CPD program exists for any level of nursing as yet. The nurse
regulator, the South African Nursing Council (SANC), and the national nurse association affiliated to the ICN, the Democratic Nursing Organization of South Africa (DENOSA), have as yet, not addressed a CPD system for nurses. This lack of CPD framework poses a dilemma for critical care nurse competency assurance. The lack of a developmental program for critical care nurses exacerbates the sub-standard of care delivered to patients in ICUs (Scribante & Bhagwanjee, 2007).

Management of the ICU patient is dynamic and challenging with rapid advances in research, technology and evidence based practices in the health care field. Critical care nurses are required to provide world class care, in state of the art ICUs. Post registration CPD can be used, formally or informally, to update and refresh the critical care nurse’s knowledge and skills for her/him to keep up with these changes in health care and maintain current competencies (Riitta-Liisa, 2007).

CPD can be either mandatory or developmental, either forced or natural. In a number of countries, for example, in the United States of America (USA), nursing is initially a process of licensing to practice followed by regular mandatory credentialing which ensures continuing professional development (AACCN, 2003). The USA reported that CPD credentialed critical care nurses improve the quality care of patients due to the critical care nurse having developed the necessary knowledge and skills to meet the needs of the critically ill patient (AACCN, 2003; Ball & McElligot, 2003). Hospitals promoting CPD have been identified and recognized as providing excellent care which provides a standard for the public (AACCN, 2003). The critical care nurses benefit is the recognition of expertise, professional growth with career advancement and job satisfaction (AACCN, 2003).
The United Kingdom (UK) has reviewed the effectiveness of its mandatory credentialing and found a number of advantages and challenges associated with it (Gould, Berridge & Kelly, 2006). Since the introduction of nursing CPD in the United Kingdom (UK) in the 1980’s, their CPD system has evolved to a mandatory requirement for practice, known as PREP, Post Registration Education and Practice (UK DoH, 1989-2003). The UK assessed their certification process and found that it did not yield a satisfactory return on investment (UK DoH, 2000).

In 2007, a study was conducted in Scotland to assess their post-registration programme (Roxburgh, Lauder, Topping, Holland, Johnson & Watson). This study found that the ‘Flying Start NHS’ programme which is linked to salary progression, did show retention of staff but poor quality career advice and appeared to be more resourcing based than developmental (Roxburgh et al, 2007). Ireland’s 2004 study on their non mandatory CPD found that the expectation of nurses to participate in CPD is met by utilising professional portfolios (National council for the professional development of nursing and midwifery). Australia followed the USA post registration certification process but has questioned the competency tools and noted challenges related to geographical locations (Hegney et al, 2009; Marshall & Fisher, 2005). Hendry et al, alludes to China’s competency model based on risk trends (2009). Malaysia’s 2010 study as to their mandatory CPD showed that although the nurses value CPD the opportunities are too costly, there is a lack of space, demographics play an important role, and the nurses learning needs need to be planned for (Chong, Sellick, Francis & Abdullah).

Internationally the nursing regulatory body of each country is responsible for regulating nursing CPD. The ICN states that part of Government’s role with regards to nursing CPD
is to “establish regulatory bodies; facilitate development of legislation and regulatory systems that assess continuing competence” (ICN, 2006).

In South Africa, health care legislation makes reference to promoting a CPD program for nurses, as stipulated by the Department of Health’s (DoH) Nursing Strategy for South Africa 2008. The DoH also indicates that the South African Nursing Council (SANC) is to regulate CPD for nurses, with the national and provincial DoH as implementation partners (2008). The RSA health care system is being redesigned with the National Health Insurance System (NHS) being introduced which impacts on nursing to change to align to the new system (DoH, 2008).

As described in the Charter of Nursing (2004), the South African Nursing Council (SANC) is currently in the process of transformation regarding the nursing act, regulations, scope of practices and education to meet the changing health needs of the country. SANC has not introduced an accrediting CPD system for nurses thus CPD is not mandatory in RSA as yet.

Further regulation of nursing CPD is by the South African Qualifications Authority (SAQA) who registered a unit standard, number 252146, titled “Take responsibility for own personal and professional development and contribute to the growth of the nursing profession” (SAQA, 2007). The unit standard clearly describes CPD specifically for nursing. The unit standard also acknowledged that there is no provider accredited to offer this course. This unit standard has subsequently expired and still SANC has as yet not communicated any strategic plan towards regulating and accrediting a CPD system for nurses.
SANC’s transformational period gives critical care nurses the opportunity to prepare for CPD by assessing what they perceive as their CPD needs and those of the speciality. As a developing country, RSA can use this time and opportunity to look internationally and review the best practices of post registration credentialing and lessons learned from developed countries such as the United Kingdom (UK), United States of America (USA), Europe and other developing countries such as Australia and Africa.

This window period can also be used to promote consultation with SANC with regards to developing an appropriate CPD framework for this complex nursing speciality and to develop standards of practice to match patient needs (Bench, Crowe, Day, Jones & Wilebore, 2003). A general nursing CPD system of “one size fits all approach” (Cooper, 2009) is not recommended as Ball et al (2004) explains that “In critical care the nurse is a constant presence, whereas all other members of the multidisciplinary team are present only on an intermittent basis. It is this that makes the profession’s contribution unique in this era of multi-tasking”. This statement is also relevant in comparing critical care nursing with general nursing. Ball and McElligot (2003) confirmed in their study that critical care nurses make a positive contribution to the recovery of critically ill patients. As part of its regulatory role, the ICN has published a “Framework of Competencies for the Nurse Specialist” and the focus is on the clinical nurse practitioner (ICN, 2009). This framework can be applied to critical care nursing and possibly utilized as a framework for CPD.

Various methods for certification of competency are used by different countries but the trend is to move from the assessment of competency standards to professional portfolio’s of evidence (Doerksen, 2010; Riitta-Liisa, 2007). This approach is more suitable for the implementation of the synergy model of patient care and adult learning in the critical care
units (AACCN, 2008). A CPD framework will need to be designed specifically for the ICU speciality, bearing in mind the learners needs, the extensive geographical locations of ICU’s, access and affordability to CPD.

The task of post registration credentialing, regulation and monitoring of certification will impact on SANC regarding human resources and finances. SANC will need to identify a professional nursing body, including representation of the all specialities, to conduct and control these functions. In planning to make CPD mandatory, SANC will need to develop an effective ICU nursing CPD framework that is cost effective as well as determine the most appropriate method of assessment to be used for post registration competency certification.

The content of the competency will also need to be examined. Evidence based practice needs to be communicated and integrated into workplace practices for it to be applicable to the critical care nurse (Skees, 2010). Standardized content that addresses the different competency levels of critical care nurses will need to be designed.

How the CPD programs are to be presented will impact on the outcome of the program. The method of presentation, the content, the facilitator, the environment and the critical care nurse are all variables as to the transfer of knowledge and the retention thereof, as well as the implementation of the new knowledge at the bedside (Skees, 2010). Methods of presentation include conferences, symposiums, seminars, didactic lectures, grand ward rounds, workshops, mentorships and e-learning. These learning methods do not guarantee that the critical care nurse will understand, interpret correctly, internalize nor retain this new knowledge. Regular reflection in the workplace, integration of the new knowledge into the workplace and refresher courses will assist in the retention of this new knowledge.
and skills learnt (Skees, 2010). CPD formats will also need to consider the green effect they have and this can impact on learners’ methods of learning.

A CPD program that is based on an accumulation of specific hours does not imply that learning has taken place (Joyce & Cowman, 2007). In America, where there is a recognized, registered accredited CPD system in place, an online nursing competency survey conducted in 2007, the question asked “Are the nurses you work with competent?” results showed “52% of respondents (n=1410) answered no” (Alspach, 2008). That is an alarming response, especially when considering the risk implications for patients and the community’s health.

Due to healthcare staff shortages, cost containment and in an attempt to reduce barriers experienced by the critical care nurse to attend CPD events, the trend is to try and have as many learning opportunities, formal and informal, available on site for the critical care nurse to participate in (Cooper, 2009; Skees, 2010). On site training is supported by the rapid development of information technology which provides a myriad of choices of learning available to the critical care nurse, for example, computer based learning, electronic distance education, research and nursing journal availability (Anderson & Wilson, 2009; Chong et al, 2010; Skees, 2010).

For effective CPD to occur, all stakeholders need to be committed to the program (Munro, 2008; Williams, 2007). Stakeholders include the nurse, the employer, the CPD provider and the regulatory body. The ICN expands nursing CPD responsibilities to the nurse regulator, individual nurse, employer, education community and the national nurse associations (ICN, 2006). Professional development needs to mutually benefit and meet the
needs of both the critical care nurse and those of the healthcare organization (Munro, 2008).

Cooper (2009) describes healthcare institutions implementing CPD as a method to address the shortage of nurses, improve job satisfaction and patient care. Employers and more especially managers are required to be supportive and committed to CPD programs in terms of staff needs, staff replacements while on training, planning for programs and financial support which currently are managerial challenges (Cooper, 2009; Munro, 2008). The current omission of a recognised CPD program for nursing may contribute to what Munro (2008) describes as “some issues and tensions that currently challenge the profession, individual nurses and their employers when considering the need for CPD”.

2.3 PARTICIPATION IN CRITICAL CARE NURSING CPD

According to the American Association of Critical-Care Nurses (2008) “As issues relating to patient care become increasingly complex and new technologies and treatments are introduced, critical care nurses will need to become ever more knowledgeable”.

The rapid advancements in the health care field can be overwhelming to the critical care nurse. CPD programs can assist and support the critical care nurse to remain up to date with the latest modalities of speciality nursing practice, apply evidence based practice, share best practices, network and problem solve common issues (Briggs, 2006). Studies have shown that nurses perceive CPD to be supportive, improving competency and confidence and generally beneficial but barriers or deterrents do exist (Chong et al, 2010;
Richards & Potgieter, 2010). Participation in CPD is influenced by intrinsic and extrinsic factors (Schweitzer & Krassa, 2010).

2.3.1 Intrinsic factors

“Critical care nurses have high levels of motivation for professional development” was reported in 2001 by Heath, Andrews and Graham-Garcia. Ryan (2003) compared nurses, occupational therapists and physiotherapists’ motivation to participate in CPD and found that “there were no observable differences between the professions and seeking CPD is intrinsically driven”.

A survey of personality characteristics of critical care nurses by Levine, Wilson and Guido (1988) showed that critical care nurses tended to be “assertive, competitive, persevering, moralistic, resourceful and mechanical” as well as having higher levels of self-esteem compared to nurses in general wards. In spite of this there does not however appear to be a relationship between commitment to nursing and CPD (Gould & Drey, 2009). Chong et al (2010) study showed that nurses with ‘postbasic qualifications showed higher levels of participation’ in CPD. The critical care environment and the personal traits of critical care nurses are conducive for CPD.

Personal motivating factors that influence nurses’ participation in CPD are for personal benefit and based on Maslow’s theory of human behaviour (Ryan, 2003). The critical care nurse participates in CPD to develop competency and confidence, obtain recognition, improve marketability, career progression, time out of ICU, earn a qualification/
certificate, become a mentor, job satisfaction and in some instances linked to financial gain (Joyce & Cowman, 2009; Richards & Potgieter, 2010).

Successful CPD needs to address the learner’s needs. The individual needs to gain something useful and interesting from the event, so that they can remember it and apply it. If the critical care nurses learning needs are not identified and addressed in a CPD program, the inappropriate CPD will lead to frustration, resistance and possible career change (Doerksen, 2010; Loyola, 2010; Watts, 2010).

In keeping with the personal characteristics of critical care nurses, in spite of no statutory CPD or certification process, critical care nurses are attending a bouquet of independent CPD programs that are available. This self directed learning demonstrates the need of the critical care nurse to up date and remain competent according to the current evidence based practices. The drawback is that the majority of these CPD programs are mainly medical practitioner or allied health professionals orientated. These programs, either nursing or other professions, advertise that they are accredited. The programs are usually based on a CPD point system, as utilized by the Health Professional Council of South Africa (HPCSA, 2009) however, not recognised by the nursing regulatory body, SANC. This contradiction of recognition of professional development is confusing to the critical care nurse and may lead to a lack of motivation to develop her/him self. The lagging behind of professional critical care nursing development may be detrimental to the image of the nursing speciality and its professional status, as well as to quality patient care. The Critical Care Society of Southern Africa has identified the critical care nurse, as well as ICU speciality nursing’s need to develop and so established a substructure, the Critical Care Nurse’s Forum, which also has an Outreach Program.
2.3.2 Extrinsic factors

Participation in CPD programs have a number of influencing factors, namely, the readiness of the learner to learn, motivation, adequate time, mentors, learning environment. These factors can have a positive effect on the critical care nurse or they can become barriers to participation in CPD (Schweitzer & Krassa, 2010).

Baumann (2007), on the topic of, Advancing Positive Practice Environments, describes the “climate of learning sets the stage for a positive and safe work environment”. Further reference is made to developing “learning organizations” and the effect they have on the employees “knowledge, skills and judgement” (2007). Organizations, in keeping with CPD practices, should conduct a needs analysis of their staff so as to allow the critical care nurse to identify her/his developmental area.

The disparity between the nursing professional regulating body, the employer and critical care nurses on the CPD topic, leads to the employer taking the leadership of a nursing CPD program as “every employer (including the public sector) must demand the best in the profession not just the available” (HASA, 2009). According to the National Skills Development Act (1998 & 2003), healthcare organizations are legally required to have a workplace skills plan (WSP) which promotes employee development. The healthcare organizations set target numbers for training interventions annually and on achieving these targets at year end they receive reimbursement from the government.

The researcher has observed that private healthcare employers WSP translates to what is commonly known as a CPD program and tends to focus on addressing competency skills
gaps related to organizational risks, while the critical care nurse is perceived as wanting to learn new knowledge and skills, that can be applied to her/his nursing. This difference in CPD goals between the employer and critical care nurse can lead to a gap developing which can “contribute to the breakdown of the psychological contract between employer and employee” and job dissatisfaction (Baumann, 2007).

The SANC’s policy on ‘The Rights of Nurses’, allows nurses to enter into “negotiation with the employer for such continuing professional education as may be directly or indirectly related to his/her responsibilities” (SANC, 2005). The critical care nurse has an opportunity to collaborate with the relevant stakeholders in developing a nursing CPD program that benefits all role players. Critical care nurses could be assisted in this program development by the nursing branch of the Critical Care Society of South Africa. Critical care nurses should take responsibility for their CPD program before non nurses or non critical care nurses decide on a program for them.

Career advancement of a clinical critical care nurse usually results in the movement out of the ICU of the experienced practitioner. A career ladder that allows the expert to remain in the ICU and the new category of advanced nurse specialist allows for recognition of the critical care nurse’s expertise and retains the specialist in the ICU. This expertise provides leadership, improves quality and standards and facilitates mentoring in the ICU. Mentorship in itself is recognized as CPD and can be strategically used in career progression (Race & Skees, 2010). Professional development needs to mutually benefit and meet the needs of both the critical care nurse and those of the healthcare organization (Munro, 2008).
The hospital nursing manager and ICU nursing unit manager have pivotal roles in CPD. These managers need to embrace CPD and support critical care nurses in CPD otherwise the managers become the barrier to CPD (Cooper, 2009; Watts, 2010).

Managing the challenges of staff shortages and time related to CPD events, requires a supportive and committed nursing and unit management team. It is difficult to organize planned learning in an ICU due to the unpredictability of the ICU and patient changes in illness severity (Huggins, 2003). Delegation of the workload needs to be balanced so as to support a learning environment. Commitment to time for CPD is important. Appropriate budget planning and allocation of funds is imperative for a successful CPD program. Munro (2008) describes the charity paradigm, a partnership to achieve a win – win situation between the employee and employer for CPD participation. The charity paradigm involves the employee and employer compromising wherein employee agrees for example, to attend CPD at own cost and the employer agrees to credit the employee with the time (Munro, 2008).

2.4 BARRIERS TO CRITICAL CARE NURSING CPD PROGRAMS

Participation in speciality CPD programs may be hampered by physical, structural and attitudinal barriers (Chong et al, 2010; Roxburgh et al, 2009).

2.4.1 Physical barriers

Physical barriers are to do with one’s situation. The increased demand for ICU care and the shortage of critical care nurses increases the workload and fatigue of the critical care nurse.
reducing her/his eagerness and time to learn. The nursing shortage results in overtime being worked which reduces the critical care nurse’s training and development time thereby limiting time for self development (Munro, 2008). If successful strategies for CPD are not implemented the staffing ratio and the dilution of current knowledge and skills will put more pressure onto the already scarce entity, the critical care nurse. Other physical barriers include: not having access to transport, traffic stress, no internet access, lack of computer skills, family or domestic responsibilities, lack of support by families, and financial constraints (Chong et al, 2010; Richards & Potgieter, 2010; Skees 2010).

2.4.2 Structural barriers

Structural barriers relate to institutional factors. The organizational policies regarding selection and study leave, geographical locations, financial constraints, accessibility, inappropriate CPD content and ineffectual presentation, time CPD event held all contribute to deterring CPD participation (Chong et al, 2010; Richards & Potgieter, 2010; Skees 2010). If CPD events are not advertised in time or widely, have challenging entry requirements and are not work related, CPD will not be valued. The cost of CPD events will deter participation. These factors will need to be assessed and the CPD methods of presentation and access thereof be investigated (Chong et al, 2010; Skees, 2010). Managers not using selection criteria, not using fair practices or being indifferent to CPD will be a severe barrier to CPD (Richards & Potgieter, 2010; Skees 2010).
2.4.3 Attitudinal barriers

Attitudinal barriers are opinions related to CPD. Factors affecting critical care nurses from participating in CPD programs include, for example, past experiences, low self esteem, lack of ambition, and a negative attitude towards the employer (Richards & Potgieter, 2010; Skees, 2010). These factors will need to be assessed and the CPD methods of presentation and access thereof be investigated (Roxburgh et al, 2009; Skees, 2010). The critical care nurses’s opinions without factual information or understanding regarding CPD will be a barrier. Critical care nursing without passion will impede CPD (Skees, 2010).

2.5 SUMMARY

In this chapter the reader was introduced to the literature review, the approach used and the themes were linked to the research questions. CPD related to critical care nursing was described and included lifelong learning, competency, shortages and the expanded role of the critical care nurse, post registration certification and CPD programs. Participation in CPD programs including intrinsic and extrinsic factors were described. Barriers to critical care nursing CPD programs including physical, structural and attitudinal barriers were also described. The next chapter will review the data collection for the study.