AUTHOR(S): CASEY, M., COONEY, A., O'CONNELL, R., HEGARTY, J.-M., BRADY, A.-M., O'REILLY, P., KENNEDY, C., HEFFERNAN, E., FEALY, G., MCNAMARA, M. and O'CONNOR, L.

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Aim. To present the qualitative findings from a national consultation and analysis study on the development of scheme(s) to provide evidence of maintenance of professional competence for nurses and midwives.

Background. Key issues in maintenance of professional competence include notions of self-assessment, verification of engagement and practice hours, provision of an evidential record, the role of the employer and articulation of possible consequences for non-adherence with the requirements. Schemes to demonstrate the maintenance of professional competence have application to nurses, midwives and regulatory bodies and healthcare employers worldwide.

Design. A mixed methods approach was used. This included an online survey of nurses and midwives and focus groups with nurses and midwives and other key stakeholders. The qualitative data are reported in this paper.

Methods. Focus groups were conducted among a purposive sample of nurses, midwives and key stakeholders from January to May 2015. A total of thirteen focus groups with 91 participants contributed to the study.

Findings. Four major themes were identified: Definitions and Characteristics of Competence; Continuing Professional Development and Demonstrating Competence; Assessment of Competence; The Nursing and Midwifery Board of Ireland and employers as regulators and enablers of maintaining professional competence.

Conclusion. Competence incorporates knowledge, skills, attitudes, professionalism, application of evidence and translating learning into practice. It is specific to the nurse's/ midwife's role, organisational needs, patient's needs and the individual nurse's/midwife's learning needs. Competencies develop over time and change as nurses and midwives work in different practice areas. Thus role specific competence is linked to recent engagement in practice.

Key Words

Focus Groups, Midwifery, Policy, Professional Regulation, Nursing, Qualtiative Research,

Summary Statements

Why is this research needed?

- Developing a framework for competence provides evidence of nurses and midwives suitability to provide effective nursing and midwifery care.
- This research offers new insight into the essential criteria to develop a framework for competence.

What are the key findings?

- Responsibility to promote and monitor continuing professional competence is tripartite involving the regulatory body, the individual and the employer.
- A framework for continuing professional competence should include; self-assessment, specified number of practice hours, a portfolio of evidence, evidence of CPD and evidence of learning through use of reflection

How should the findings be used to influence policy/practice/research/education?

- Findings will influence policy development in terms of a national framework for monitoring and maintaining continuing professional competence of nurses and midwives in order to protect the public.
- Increased professional awareness of the roles of the Regulatory body, the employer and the individual nurse and midwife in developing and maintaining professional competence.

Introduction

Monitoring the continuing professional competence of health care professionals is necessary to protect the public and competence is one way to establish the suitability of a registered nurse or midwife to provide effective nursing/midwifery care. Indeed, the absence of competence has been linked to suboptimal care and serious consequences for the patient (Institute of Medicine 2010). Continuing professional competence is concerned with the lifelong process of maintaining and documenting competence over time, by maintaining and increasing knowledge and skills to ensure high quality care in a dynamic and rapidly changing healthcare environment (Fereday & Muir-Cochrane 2006; Takase 2013). This requires engagement with nurses, midwives, regulatory and policy representatives and indeed the public to develop a competency framework that ensures nurses and midwives maintain their ability to perform safely according to their scope of practice, workplace requirements and areas of specialisation (Tabari-Khomeiran *et al*. 2006).

Background

Competencies are concerned with assessing defined indicators of learning and development, and developing the individual's scope of practice, to enable nurses and midwives to increase their knowledge and ability and meet required standards of practice (Nkosi and Ulys 2005; Vernon *et al*. 2013). The WHO (2009) defines nurses' competence as a framework of skills which reflect knowledge, attitudes and psychomotor and psychosocial aspects of care provision. Competence is often attributed to educational qualifications and practical abilities (Tabari-Khomeiran *et al*. 2007; Kendall-Gallagher & Blegden 2009). The Canadian Nurses Association (CNA 2000) refer to the use of judgement and personal attributes, the National Council of State Boards of Nursing (NCSBN 2009) to the application of knowledge and interpersonal decision making, and The Australian Nursing and Midwifery Accreditation Council (ANMAC 2009) to effective or superior performance in the context of practice. Axley (2008) outlines six defining attributes of competency as: knowledge, actions, professional standards, internal regulation, and dynamic state. As competence is a context and time specific notion (Garside & Nhemachena 2013), nurses and midwives must engage in practice and in the development of their competencies within the context of their scope of practice and area of

practice to exhibit continuing professional competence (Vernon *et al.* 2013). The concept of continuing competence (or professional competence) has been described as 'the ongoing commitment of a registered nurse to integrate and apply the knowledge, skills, and judgment with the attitudes, values, and beliefs required to practice safely, effectively, and ethically in a designated role and setting' (Case Di Leonardi & Biel 2012, p. 350). The mechanisms which support the maintenance of continuing professional competence include continuing competence frameworks, processes of assessing competence, continuing professional development, engagement in practice and portfolios. Frameworks are useful in ensuring quality and consistency of care and promoting patient safety (Bassendowski and Petrucka, 2009). There is a growing awareness of the need for structured systems to promote professional competence (Vernon *et al.*, 2013)

A professional competence scheme ensures the delivery of evidenced based, safe, ethical and competent care (CNA, 2007). It creates a common language where terms are defined to reduce potential barriers and facilitates understanding outside the disciplines of nursing and midwifery (CNA 2000). According to Vernon *et al.* (2013) in New Zealand, the requirements of the Continuing Competence Framework, necessary for annual recertification include evidence collated in portfolios of practice hours, ongoing professional development, and a self-declaration of competence. In the United State, Canada, Australia, New Zealand and the requirements vary between countries. In the UK registered nurses/midwives were required to meet the PREP (practice) standard of a minimum of 450 hours in the previous three years (NMC 2010) which, apart from direct patient care could be achieved through managerial, administrative, supervisory teaching and research roles. In New Zealand 60 days or 450 hours of practice in the previous three years is required (NCNZ 2011), and in Australia a minimum of three months practice in five years is requested (NMBA 2010). Whereas, the SRNA in Canada require registered nurses to undertake 1,125 hours of practice in the previous five years.

Competence programs are necessary for annual renewal of membership by the Saskatchewan Registered Nurses' Association. This program requires provision of details of clinical experience, and

a comprehensive portfolio consisting of a learning plan, evidence of professional development and education, feedback reports, self-assessment and other appropriate documentation (Bassendowski & Petrucka, 2009). Bassendowski and Petrucka (2009) explored nurses' attitudes to continuous competence programmes in Saskatchewan province by means of pre- and post- programme evaluations (n=123). Responses were positive as 97% stated that continuing competence was essential for practice, with reflection, learning and good integration of theory and practice rated as important for achieving this. Furthermore, up to 94% felt that nurses had a central role in their own professional development and competency, and were committed to maintaining their own competence. However, a widely held view was that continuing competence was difficult to achieve without support from the working environment. More recently, Smith (2012) explored attitudes to a continuing competency framework used in the credentialing process among midwives in Australia and suggestions for improvement included streamlining the process, promoting a more positive attitude to the scheme, providing easier access to documentation and implementing strategies to support staff through the process.

Methods used to evaluate continuing competence include: self-assessment questionnaires (Beauvais *et al.*, 2011; Bahreini *et al*., 2011; Akamine *et al*., 2013; Karlstedt *et al.*, 2015); competency measures based upon measurement of competences linked to a particular competence framework (Bentley & Dandy Hughes 2010; De Clercq *et al*. 2011; Homer *et al*. 2012); simulation (Arefah 2011; Przybyl *et al.* 2015); Objective Structured Clinical Examination's (Holland *et al.* 2009); problem based/case based e learning programmes (Brydges *et al*. 2010; Kim and Shin 2014); assessments based upon responses to hypothetical scenarios (Fleming *et al.*, 2011) and portfolios (Andre 2010; Bahreini *et al.* 2013; Green *et al*. 2014). The Pharmaceutical Society of Ireland (PSI) (2013) refers to six domains of competence (professional practice, personal skills, supply of medicines, safe and rational use of medicines, public health, organisation and management skills) and has promoted a self-reflective model linked with an ePortfolio and a Core Competency Self-Assessment Tool, along with practice reviews and knowledge assessment.

Other methods can be used to support continuing competence including: coaching (Johnson *et al*. 2011; Narayanasamy and Penney 2014); performance appraisal and observation (Goran 2011) and clinical case conferences (Loewenstein 2011). Sastre-Fullana *et al*. (2014) identified competency dimensions such as: research, clinical and professional leadership, mentoring and coaching, change management, collaboration and interprofessional relationships, communication, cultural competencies, expert clinical judgement, evidence-based practice, professional autonomy, ethical and legal practice, advocacy, education and teaching, quality management and safety, consulting, care management and health promotion. Based on the literature, it is clear that an effective and acceptable professional competence scheme for the maintenance of continuing professional competence in Ireland requires consultation, assessment, development, implementation and evaluation similar to the process that have occurred in Canada, Australia and New Zealand (CNA, 2000; ANMC, 2009; NMBA; 2010; NCNZ; 2010).

The Study

Aim

To consult with nurses, midwives and key stakeholders to ascertain their perspectives on types of schema that could be used for demonstrating the maintenance of Professional Competence of nurses and midwives in Ireland.

Design

A mixed methods approach (Creswell and Plano Clark 2007) using an online survey of nurses and midwives and focus groups with nurses, midwives and key stakeholders were used. The qualitative data is reported in this paper.

Participants

A convenience sample was used to secure the perspectives of practicing nurses and midwives from all the divisions of the register and in varying roles. Key stakeholders were targeted using purposeful sampling from patient groups, the Nursing Midwifery Body of Ireland, Department of Health, the

Health Service Executive, the Health Information and Quality Authority, unions and other representative bodies. In total 13 focus groups with 91 participants were undertaken.

Data Collection

Data collection took place between January to May 2015. The focus group aimed to explore what participants thought should be put in place to enable nurses and midwives to demonstrate the maintenance of professional competence. Focus groups were guided by a topic guide, which was informed by the literature review. Questions were open-ended, and supported by a series of probes which were used to generate discussion if needed.

Ethical considerations

Ethical approval for this research was obtained from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (CREC). All participants received an information sheet about the purpose of the study and written consent was obtained prior to participation in the study. Consent was obtained to audio record the sessions. Data was collected by means of taped semi-structured interviews. All data was anonymised and pseudonyms were used when discussing the findings.

Data analysis

Focus group interviews were transcribed verbatim. Data analysis was guided by the constant comparative technique (Corbin and Strauss 2008), to ensure that all data were systematically compared to all other data to enable the recognition of emerging themes. The initial open codes broke the data down into smaller units of analysis. During axial coding these codes were collapsed into categories. These categories were compared using selective coding. This process resulted in the clustering and collapsing of codes and the final identification of four major themes. NVivo version 10, qualitative data research software, was used to manage the data (QSR International). Demographic data for participants were entered into Statistical Package for the Social Sciences© (SPSS version 20) software (SPSS Inc., Chicago, IL, USA) for data handling.

Dependability, reliability and credibility

Dependability of the focus groups was enhanced by the use of a topic guide that was based on the literature. Three of the research team were responsible for data analysis. To ensure consistency, the three researchers analysed the same transcript and agreed a coding framework. This coding framework was used to code the remaining interviews. Reliability of the data was gained through the quality of the transcripts where details of 'intonation and prosody' were included (Silverman 2006, p. 289) Credibility was achieved by reading each transcript closely, using the constant comparative analysis to ensure that all content was accounted for based on similarity of content and substance and that there was no duplication of content thereby providing internal consistency.

Findings

A total 13 focus groups were held with 91 participants. Three focus groups were held via teleconference. Focus group sizes ranged from 3-11 participants and three focus groups were held via teleconference. The majority of focus groups were mini focus groups (Krueger and Casey 2009) which maximised participants opportunities to contribute to the discussion. The participants' level of education is indicated in Table 1 which shows that 4.4% (n= 4.4) had a certificate qualification, 15.5% (n=14) had a bachelor degree, 43.3% (n=39) had a master's degree with the remaining participants having completed a range of postgraduate qualifications.

Table 1. Characteristics of the respondents

As seen in Table 2, slightly more than half of the participants were female nurses over 50 years.

Table 2 Respondents' Age, Gender and Category

All divisions of the Register were represented and General Nurses were in the majority (83% n=64) as would be anticipated. The Staff nurse/midwife roles were poorly represented 6.1% (n= 4).

Table 3 Division of the Register and Respondents' Role

Participants at Assistant/Director of Nursing/ Assistant Director of Midwifery roles accounted for (16.7% n=11), with Public Health Nurses (1.5% n=1), and those in education roles at (19.7% n= 13).

Table 4 shows that over half of participants were employed by the Health Service Executive 68.8% (n=53) with 15.6% (n=12) employed in third level institutions.

Table 4 Employment of Respondents

Four major themes were identified and confirmed through data analysis as follows: (1) definitions and Characteristics of Competence; (2) continuing professional development and demonstrating competence: (3) assessment of competence and (4) the Nursing and Midwifery Board of Ireland and employers as regulators and enablers of maintaining professional competence

Theme 1 Definitions and Characteristics of Competence

Participants were aware of the need to continuously maintain and develop their competency. Participants found it easier to articulate why it is important to maintain competence rather than to define competence *per se*. Their definitions tended to focus on clinical skills development but set in context of developing theoretical knowledge, communication skills and decision-making skills.

'[Competency involves demonstrating] … how they are applying it (learning) so it is not just theory and it is not just clinical … so your reflective diary is something that is a continuing rolling basis so it shows the person learning but it also demonstrates that you actually broaden your competence' (FG 10).

The main factors stimulated nurses and midwives engagement in activities to maintain or develop their competence were:(1) to satisfy the public's expectation and maintain the public's trust in nurses/midwives.

[It is about] 'keeping up your level of competence to do the job that you are required to do. I started off with the level of competence … if I stayed a staff nurse I keep my competence for the patient area that I am working (in) but if I move to a different area, say CNS, then I have a different set of competencies based on the role I am doing' (FG 9).

(2) to enhance the quality of patient care and to respond to changing practice(s) '…'it's a safety issue as well, because we're in a very fast paced environment and what we learnt 10 years ago may not have any relevance in today's world …' (FG 8).

(4) to meet personal or other professional developmental goals. The 'core' competencies were thought to vary across disciplines. For example,

'…there are baseline competencies that all nurses (require),... I work in a child and adolescent mental health service in the community, there are loads of mental health nurses who work with older persons with mental illness, …what somebody needs to work in each of those settings is very different. The basic competencies are the ones you have to know about mental illness,… They're the core of it, but when you are working in a specialist area that's a different ball game, because there are specific things that you have to develop and maintain competency in, ...' (FG 13).

Theme 2 Continuing Professional Development (CPD) and Demonstrating Professional Competence

Participants indicated that CPD should be ongoing and continuous and that CPD was critical to maintaining competence.

‘…there should be a theoretical component to updating your knowledge and skills...There should be some form of upgrade on a yearly basis and then there is what do you do (with) that piece of knowledge, ... or how do you use it…? (FG 9).

Secondly CPD must be grounded in theoretical learning and/or skills development and it must be applied in practice and related to the individual nurse or midwife’s role and their professional development.

‘--attending a lecture, and getting a piece of paper doesn’t necessarily mean that you’ve actually learnt anything or changed anything in your practice’ (FG 8).

Finally, CPD should be service-driven and some participants recognised that it was useful to discuss their learning needs with their employer.

‘I have the responsibility to ensure that I maintain my competence and my employer has responsibility to assist me in trying to achieve that. … (FG 2).

Assessment of Competence

Self-assessment, was envisaged as a key component of a competence framework. ‘…self-declaration would acknowledge my responsibility supported by recognition of learning’ (FG 10).

Others flagged that self-declaration alone had limitations. And a suggested method of verification was joint sign-off between the individual nurse/midwife and manager.

‘Self-assessment is usually quite valuable but you would need to back it up with facts … So you go back to, ‘Have you done this? Have you followed the policy? Have you actually done the task that you were asked to do?’ …you do need an element of producing facts.’ (FG 9).

Clinical supervision was mentioned as particularly relevant in some roles such working as advanced practitioners or as self-employed community midwives. One participant who was involved in clinical supervision commented:

'…clinical supervision is absolutely fabulous in the right context but it takes an awful lot of hours. ... It is time consuming, you have to be on duty (at the same time) and you need an [private] area [to maintain] confidentiality … then where would the paper trail go afterwards' (FG 5).

Peer review was also mentioned as a possibility:

'peer review is a very good thing because if somebody is autonomous to that extent, peer review is very useful and they could organise supervision between each other' (FG 3).

Participants considered that a wide range of evidence could be presented to demonstrate learning (self-directed learning, theoretical learning, and practice-based learning) which could be presented in a portfolio. Reflection may be an element of this.

'My experience in the UK, …there was a reflective practice component to that as well so it would demonstrate what learning you've had from events … maybe something that happened on a ward and how you learnt from that critical event' (FG 11).

Preparing a portfolio of evidence was identified as the best way of demonstrating ongoing competence. Incorporation of reflection into a portfolio to demonstrate both self-awareness and application of learning into practice was considered an important criterion for providing evidence of competence:

'[Nurses and midwives could] do all the courses and be totally up to date but if you are not self-aware and reflective as a practitioner you might not get competent. You could get all the certificates and

degrees and higher degrees and diplomas but unless you think about it, so certainly reflective practice you know and self-awareness is very much part' (FG 2).

The Nursing and Midwifery Board of Ireland and employers as enablers and regulators of maintaining professional competence.

There was consensus that the Nursing Midwifery Board of Ireland (NMBI) should provide a framework for continuing competence development and determine the requirements to ensure that expectations were understood. It was suggested that the requirement to meet minimal standards should be over a three or five year period.

'We need to link whatever systems we have got so that people can easily get the evidence and easily … make the submissions we don't want to be creating huge portfolios over 3 years or whatever' (FG 2).

All participants had the expectation that documentation could be kept electronically. However, the importance of a flexible approach, to allow scope for the individual nurse/midwife to self-identify his/her learning needs was highlighted

'… the NMBI has to establish some kind of baseline, because otherwise we'll all do our own thing (but) there has to be a degree of flexibility [to meet individual needs]' (FG 13).

Participants indicated that the hours or time commitment required for each nurse and midwife to meet continuing education requirements should be realistic if staff release to facilitate these requirements is to be achievable.

'… time has always been a factor and those of us who have been involved in managing teams of nurses …and sometimes nurses will go and do (study days/courses) then you've to find a way to reimburse them their time …' (FG 11).

Employers were considered to have responsibility for ensuring that staff are (1) released (2) replaced and (3) provided with opportunities for mandatory skills training.

'If we're looking at this system where you know every nurse is responsible … for a certain level of professional development, then build that in … The organisation is responsible for assisting that … there's a lack of motivation to get them to go (to anything that is not mandatory), a…', and nothing is going to move that unless your governing body has that in place' (FG 11).

Discussion

Defining 'continuing professional competence'

Competence can be defined as a potential capability for undertaking a role and its manifestations may differ depending on context (Cowan *et al.,* 2007; 2008). In this study, a holistic definition is favoured where competence is individual, specific to the nurse's/ midwife's role, organisational needs and to his/her learning needs. At the same time the individual nurse / midwife is aware of the boundaries of his/her own competence with reference to his/her scope of practice, patients' needs, workplace requirements and areas of specialisation. However, similar to scope of practice frameworks, continuing professional competency frameworks "should enable role expansion within and with reference to the core functions and values of nursing and midwifery and the best interest of the patient."(Casey *et al.* 2015). Without this consideration, there is a danger of a behaviourist reductionist approach where competency development is linked to clinical tasks.

According to Wakefield *et al*., 2005; Smith *et al*., 2007 and Okuyama *et al*., 2011) there is a need for significant improvement in patient safety, quality care and tracking of continuing professional competence of health care professionals. The current study supports these views in that the participants stated that engagement in competence related activities is to (1)maintain public trust, (2)

to enhance the quality of patient care (3) to meet professional obligations and (4) to meet personal and professional developmental goals.

Continuing professional development and demonstrating competence

Participants suggested that there is a strong relationship between CPD and maintaining and demonstrating competence and that nurses / midwives must be able to elicit the appropriateness of CPD activities to align with competence requirements. Such an articulation of CPD requirements is supported in the literature (ANMC, 2009; NCNZ, 2012). Some regulatory bodies, state boards of nursing and professional organisations require registered nurses and midwives to maintain a portfolio or profile for continuing licensure or recertification (Mills, 2009; ANMC, 2009; NMBA, 2010; NMC, 2011; NCNZ, 2011). Portfolios are a body of evidence used to: display professional work; the background, skills, and achievements accrued by the individual over time; facilitate self-monitoring; allow the individual to highlight areas for improvement serving as a catalyst to action; profile the scope and depth of the practitioner's practice competence allowing difficult to assess competencies to be evaluated (NCNM, 2005; Byrne and Waters., 2008). The e-portfolio is a collection of 'electronic evidence assembled and managed by an end user usually on the web that has the ability to longitudinally capture and visually display competency attainment data over time' (Chertoff 2015). Factors which contribute to the success of portfolios include: clearly communicated goals, processes and procedures; flexible structure; support through mentoring, and measures to heighten feasibility and reduce required time to complete portfolio documentation requirements (Driessen *et al*., 2007). Furthermore e-portfolios offer greater options for customisation, options for data manipulation, and augmented ability to share and transfer information (Tochel *et al*., 2009).

In the current study, participants favoured the maintenance of a self-reflective, e-portfolio of all pertinent activities relating to the continuing competence scheme. There was broad consensus that this portfolio should include identification of learning needs, an action plan to meet those needs, evidence of CPD activities, and evidence of application of learning in practice.

Assessment of Competence

In this study self-assessment of competence was favoured by the majority of participants and the popularity of this method is well supported (SRNA, 2006; CNA, 2000; ANMAC; 2009). Self-assessment can be informal or formal utilising tools to identify strengths, weaknesses, opportunities for learning; therefore self-assessment can promote accountability and is encouraged by regulatory authorities (CNA, 2000; SRNA, 2006; ANMAC, 2009; NMC, 2011; NCSBN, 2010; NCNZ, 2011).

Assessment of competence by another person(s) can be facilitated in a number of ways: practice assessments, peer assessment, discussions with co-workers and service users; clinical observations by peers; case reviews that evaluate outcomes for nursing interventions; group practice feedback involving discussion of practice issues or documentation that is submitted to a peer review panel; examinations and assessed simulations (CNA, 2000; SRNA, 2006; CNA, 2007; NCNZ, 2011). Key issues identified as contributing to the debate regarding assessment of professional competence in nursing and midwifery include: the validity of perceptions of good performance as adequate indicators of level of competence (Meretoja *et al*., 2004). Key challenge in any competence assessment process is ensuring objectivity, replication, reliability and scalability (Brightwell and Grant, 2013).

In this study, participants noted that competence frameworks specific to the registration and role of the nurse/ midwife are more beneficial than generic approaches. This viewpoint is supported by Delamare le Deist and Winterton (2005) who attest that multi-dimensional, targeted, holistic competence frameworks are more useful in identifying the combination of competences that are necessary for particular occupational roles and functions.

The Nursing and Midwifery Board of Ireland and employers as regulators and enablers of maintaining professional competence

In Ireland the NMBI has been tasked, through legislation, with developing scheme(s) for the purposes of monitoring the maintenance of professional competence of registered nurses and registered midwives. In this study, the regulator was viewed as having responsibility for introducing and

regulating competence development in addition to the individual and the employer, who were viewed as having three distinct responsibilities related to the ongoing development of competence. Moreover, the majority of participants favoured the completion of a minimum number of defined hours within the previous 3 years as part of their continuing competence requirements. This view matches well with competence requirements in many countries, where prior to nurses renewing their registration nurses/midwives are required to practice a predetermined number of hours within a specific timeframe (ANMC, 2009; NMBA, 2010; NMC, 2011; NCNZ, 2011). In relation to continuous professional competence development, providing evidence of learning and engagement in practice were highlighted as important in this stud. However, as recency of practice does not denote or provide an adequate indicator of safe practice or competence when utilised independently (NCNZ 2010) it should be one of a number of constituent elements of an assessment of competence framework.

Limitations

While a wide range of views were obtained from the 91 participants who attended one of the 13 focus group interviews, the majority of participants were senior members of staff in management, education and administrative roles. The views of staff nurses and staff midwives were not well represented in this data. In addition, during the period of data collection there was some disquiet among the profession regarding a proposed increase in the registration fee. Specifically nurses and midwives, through their representative organisations, expressed their concerns regarding the quantum of the proposed increase and the manner in which it was communicated. This may have raised awareness among the profession regarding the role and function of NMBI, as it pertains to continuing registration.

Conclusion

The role of any professional nursing/midwifery regulatory body world-wide is to protect the health and safety of the public by setting standards and ensuring that nurses and midwives are competent practitioners and Ireland is no different in that regard. It is well established that competence incorporates knowledge, skills, attitudes, professionalism, application of current evidence and

translating learning into practice. Furthermore, competence is specific to the nurse's/ midwife's role, organisational needs, patient's needs and the individual's learning needs. Ongoing maintenance and development of competence must be linked with recent engagement in practice in that practitioner's practice context.

The relationship between CPD and maintaining and demonstrating competence is clear and CPD should have a positive impact on service provision, the patient experience and patient safety. A practical approach to CPD was recommended which would incorporate a wide range of learning activities that nurses/ midwives could engage with as part of their professional roles. As healthcare organisations have overall responsibility for patient safety, they should contribute to decisions about nurses/midwives learning needs and their CPD plans should be made jointly in the context of service needs and the line manager's wider knowledge of: the nurse/midwife's practice, the health system and processes and their ability to support the individual nurse/midwife. In this context, responsibility for the maintenance of continuing professional competence rests with the regulator (NMBI), the individual and the employer.

A self-reflective, professional portfolio is the proposed method for demonstrating evidence of continuing competency and ensuring quality patient care. While issues around data protection and access to the personal portfolios did surface in discussions, there was no consensus as to where or with whom these e-portfolios would be located.

The role of the regulatory body in developing a useable framework to meet the needs of the profession in the wide variety of practice contexts is evident. In addition, there is a clear need for regulatory guidance on the competence requirements and on the structure of such portfolios. A system of random audit of portfolios to ensure concordance with continuous competence requirements is recommended and consideration is also required to distinguish between participants to do not obtain competence and those who fail to comply with these competency requirements.

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Tables

Highest level of Education	N	**%**
Certificate	51	(5.2)
Diploma	63	(6.4)
Bachelor Degree (BSc)	203	(20.7)
Post-graduate Qualification (e.g. certificate, diploma)	238	(24.3)
Masters Degree	375	(38.3)
Doctoral Degree	48	(4.9)
Other	2	(0.2)
Total	980	

Table 1. Characteristics of the respondents

		N	**%**
Age group	20 - 39 Years 40 - 49 Years 50 - 59 Years 60+ Years Missing	9 26 38 4 14	11.7% 33.7 49.4% 5.2%
Gender	Female Male Missing	84 4 3	95.4% 4.6%
Category represented*	Nurse Midwife Other** Missing	52 19 24 8	62.7% 22.9% 28.9%

Table 2 Respondents' Age, Gender and Category

Registration Division*	Registered General Nurse	64	83.1%
	Registered Children's Nurse	7	9.1%
	Registered Midwife	30	39.0%
	Registered Psychiatric Nurse	7	9.1%
	Registered Nurse Intellectual Disability	1	1.3%
	Public Health Nurse	6	7.8%
	Registered Nurse Tutor	18	23.4%
	RNP (Registered Nurse Prescriber)	6	7.8%
	Advanced Nurse Practitioner	1	1.3%
	Advanced Midwife Practitioner	1	1.3%
	Missing	14	
Role	Staff Nurse	3	4.6%
	Staff Midwife	1	1.5%
	Senior Staff Midwife	2	3.0%
	Clinical Nurse Manager II (CNM2)	7	10.6%
	Clinical Nurse Manager III (CNM3)	2	3.0%
	Clinical Midwife Manager II (CMM2)	1	1.5%
	Clinical Midwife Manager III (CMM3)	1	1.5%
	Clinical Nurse Specialist (CNS)	2	3.0%
	Advanced Nurse Practitioner (ANP)	1	1.5%
	Advanced Midwife Practitioner (AMP)	1	1.5%
	Assistant Director of Nursing (ADON)	7	10.6%
	Director of Nursing (DON)	3	4.6%
	Assistant Director of Midwifery (ADOM)	1	1.5%
	Clinical Facilitator/Clinical Placement Coordinator	6	9.1%
	Practice Development Coordinator	3	4.6%
	Public Health Nurse	1	1.5%
	Community Midwife	5	7.6%
	Practice Nurse	1	1.5%
	Working in education	13	19.7%
	Working in research	3	4.6%
	Working in an administrative post	2	3.0%
	Other**	19	
	Missing	25	

Table 3 Division of the Register and Respondents' Role

Employer	Health Service Executive (HSE)	53	68.8%
	Voluntary Sector	5	6.5%
	Private Sector	6	7.8%
	Charitable Organisation	1	1.3%
	Third Level Institution	12	15.6%
	Missing	14	
Total		91	

Table 4 Employment of Respondents