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Authors	Casey, Mary;Cooney, Adeline;O'Connell, Rhona;Hegarty, Josephine;Brady, Anne-Marie;O'Reilly, Pauline;Kennedy, Catriona;Heffernan, Elizabeth;Fealy, Gerard;Mcnamara, Martin;O'Connor, Laserina
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Nurses', midwives' and key stakeholders' experiences and perceptions on requirements to demonstrate the maintenance of professional competence

CASEY Mary MMedSci (Nurs) PhD RN
Associate Dean for Taught Graduate and CPD Programmes
UCD School of Nursing, Midwifery & Health Systems, University College Dublin,
Belfield, Ireland

COONEY Adeline RN.PhD.
Head of School
School of Nursing and Midwifery
NUI Galway

O' CONNELL, Rhona.,
Lecturer
Catherine McAuley School of Nursing and Midwifery, University College Cork,
Ireland

HEGARTY Josephine MSc PhD RN
Professor of Nursing
Catherine McAuley School of Nursing and Midwifery, University College Cork,
Ireland

BRADY Anne-Marie BSc PhD RN
Director of Trinity Centre Practice & Healthcare Innovation, School of Nursing & Midwifery
Trinity College Dublin

O'REILLY Pauline MA PhD
Head of School
Department of Nursing and Midwifery, University of Limerick, Ireland

KENNEDY Catriona PhD RN
Professor of Nursing
School of Nursing and Midwifery, Robert Gordon University
Aberdeen, Scotland

HEFFERNAN, Elizabeth. BSc. MA
Director of Nurse and Midwifery Education, Kerry Centre of Nurse and Midwifery Education, Kerry General Hospital, Tralee

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FEALY Gerard BNS PhD RN
Professor of Nursing
UCD School of Nursing, Midwifery & Health Systems, University College Dublin

McNAMARA Martin BSc EdD RN
Dean and Head of School
UCD School of Nursing, Midwifery &Health Systems, Dublin

O' CONNOR, Laserina, RN, PhD
Clinical Professor
UCD School of Nursing, Midwifery &Health Systems, Dublin

Contact Details of corresponding author

Dr Mary Casey
Associate Dean for Taught Graduate and CPD Programmes
UCD School of Nursing, Midwifery & Health Systems, University College Dublin,
Belfield, Ireland
Mary.Casey@ucd.ie

Phone Number 00353 1 7122473

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This paper is based on a national Consultation and Analysis for Guidance Documents emanating from the Review of the Scope of Practice Framework, Code of Professional Conduct and Ethics and the Review of Undergraduate Programmes and Consultation and analysis for the development of a Scheme(s) to demonstrate Maintenance of Professional Competence for Nurses and Midwives commissioned and funded by the Nursing and Midwifery Board of Ireland (NMBI).

Conflict of interest

No conflict of interest has been declared by the authors.

Aim. To present the qualitative findings from a 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

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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 - 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, nurse practitioners, policy, professional regulation, qualitative research

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Summary Statements

Why is this research needed?

- 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 continuing competence development.

What are the key findings?

- Responsibility to promote and monitor continuing professional competence is tripartite involving the regulatory body, the individual nurse/midwife 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 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.

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Introduction

Monitoring the continuing professional competence of health care professionals is necessary to protect the public and competence helps to establish the suitability of a nurse/ midwife to provide effective care. Indeed, the absence of competence has been linked to suboptimal care and serious consequences for patients (Institute of Medicine 2010). Continuing professional competence is concerned with the lifelong process of sustaining and documenting competence, by maintaining and increasing knowledge and skills to ensure high quality care in a changing healthcare environment (Fereday & Muir-Cochrane 2006, Takase 2013). This requires 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 (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,

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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 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 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 of practice hours, ongoing professional development and a self-declaration of competence collated in portfolios. 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

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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 programmes are necessary for annual renewal of membership by the Saskatchewan Registered Nurses' Association. This programme 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 and found that continuing competence was essential for practice, with reflection, learning and good integration of theory and practice rated as important. Furthermore, up to 94% felt that nurses were responsible for their own professional development and competency. 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 on 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

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Examination's (Holland *et al.* 2009); problem based/case based e learning programmes (Brydges *et al*. 2010, Kim and Shin 2014); assessments based on responses to hypothetical scenarios (Fleming *et al.* 2011) and portfolios (Andre 2010, Bahreini *et al.* 2013, Green *et al*. 2014).

Other methods to support continuing competence include: 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 requires consultation, assessment, development, implementation and evaluation similar to Canada, Australia and New Zealand (CNA 2000, ANMC 2009, NMBA 2010, NCNZ 2010).

The Study

Aim

To consult with nurses, midwives and key stakeholders on the development of schemes to demonstrate maintenance of professional competence of nurses and midwives in Ireland.

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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 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 Board 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 and May 2015. The focus groups explored what participants thought should be put in place to enable nurses/ midwives to demonstrate the maintenance of professional competence. Focus groups were guided by a topic guide which focused on areas such as understandings of maintenance of professional competence, perspectives of practice hours and professional competency, role of the nurse/midwife/role of employer/role of regulator in a continuing professional competence scheme. Perspectives of the benefits/facilitators of a continuing professional competence scheme were also gleaned. Questions were open-ended and supported by a series of probes if needed.

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Ethical considerations

Ethical approval for this research was obtained from the Clinical Research Ethics Committee of the Cork Teaching Hospitals. 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 were collected using taped semi-structured interviews; data were anonymised.

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 with 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. Three members 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

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(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 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) had a certificate qualification, 15.5% (n=14) held a bachelor degree, 43.3% (n=39) held a master's degree.

Approximately 96% (n=84) of the sample were female which is to be expected in a predominantly female profession. The majority of participants were over 49 years as seen in Table 2.

All divisions of the Register were represented and the majority were General Nurses (83% n=64). However as seen in Table 3, most participants were in education roles (19.7% n= 13), in Assistant/Director of Nursing/Midwifery roles (16.7% n=11). Participants in staff nurse/midwife roles were poorly represented 6.1% (n= 4). 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 as seen from Table 4.

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Thus the majority of participants were older, well-educated females working in the public health service in senior management roles or in the third level sector in academic roles. In this context, the participants could be considered experienced with well- informed perspectives and four major themes emerged from the analysis of their perspectives as shown in Table 5.

Theme 1 Definitions and Characteristics of Competence

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 in context of developing theoretical knowledge, communication skills and decision-making skills as seen in the following excerpt:

> [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).

Factors that stimulated nurses/midwives to maintain their competence were to satisfy public expectation trust and to respond to changing practices as highlighted in the following excerpt.

> [It is about] keeping up your level of competence to do the job that you are required to do. … 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).

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Another stated that 'it's a safety issue…, 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). A fourth motivating factor to develop or maintain competence was the desire to meet personal or professional developmental goals. For example,

> …what somebody needs to work in each of those settings is very different. The basic competencies are the ones you have to know about,… 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).

Overall participants acknowledged that a core definition of competence and associated skills would be helpful but argued that any meaningful definition of competence must be contextualised and specific to the nurse's/midwife's role, service/organisational needs and the individual nurse's/midwife's personal interests and learning needs.

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

Participants indicated that CPD should be ongoing and is critical to maintaining competence and must be grounded in theoretical learning and/or skills development and it must be applied in practice. This is highlighted in the following excerpts

> …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).

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--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).

Participants regarded work-based learning as important as theoretical-based learning and suggested that it should be acknowledged and given weighting in the demonstration of competence. Others argued that learning needs should be determined in partnership between the nurse/midwife and the line manager. The need to be accountable for patient-safety by ensuring nurses/midwives have the required competencies to deliver optimal care was seen as important as seen in the following excerpt.

…if the nurse does something wrong, the portfolio, the level of competence will be the first thing that heads to court, so the onus will come back on the line manager, 'why didn't you know the competence' … there has to be some tripartite approach - practice development and line management together with the nurse, once a year, to review or once every second year... not beating you with a stick, it's this-what can we do to help you and support you…(FG 13).

Another indicated that CPD should be service-driven and 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).

To summarise, participants indicated that CPD should be: (1) ongoing and continuous, (2) grounded in theory and/or skills development, (3) applied in practice, (4) relevant to the individual's role and professional development and (5) service driven.

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Assessment of Competence

Formal assessment was generally viewed as a normal part of formal education or e-learning programmes but considered to be difficult to implement. Some participants viewed skills assessment to be critical and felt that it should be incorporated into the professional competence framework. Several possibilities for assessment were suggested including: self-assessment, clinical supervision, mentorship, peer review, simulation, reflection and a portfolio of evidence. Self-assessment, was envisaged as a key component of a competence framework and a suggested method of verification was joint sign-off between the individual nurse/midwife and manager as highlighted in the following account.

> 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 for advanced practitioners or as self-employed community midwives. Peer review was also mentioned and participants considered that a wide range of evidence could be presented to demonstrate learning which could be included in a portfolio. Many participants stated that reflection had a key role in continuous competence development as indicated in the following statement.

> 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).

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One participant suggested that a portfolio of evidence incorporating reflection as the best way of demonstrating ongoing competence as highlighted in the following account

> [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).

In summary, perceptions of assessment of competence focused on types of assessment such as self and peer assessment, clinical supervision and having to produce evidence of feedback with a third party. Engaging in reflective practice was seen as essential and participants were clear that whatever system is chosen to demonstrate continuous competence development it should be user-friendly and preferably electronic.

The Nursing and Midwifery Board of Ireland (NMBI) 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 and determine the minimum requirements to ensure clarity. Suggestions for what the requirements should look like included: defining a specific number of hours, defining the breakdown between mandatory and professional development hours and defining the required number of practice hours. Defining minimum requirements was viewed as important because it simultaneously set a benchmark as seen in the following excerpt.

> I'd say you'd have a minimal …for example … 30 CEU's [continuous educational units}is what you need and (if) you've only 20 from the formal avenues from the lectures that you got signed off on and then I have my own

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> home grown (learning) which would we think equate to 10, but you're signing to say that you feel that that's sufficient, then that's all traceable and you have it in your portfolio … (FG 9).

It was suggested that the requirement to meet minimal standards should be over a three or five year period and all participants had the expectation that documentation could be kept electronically. The importance of a flexible approach, to allow scope for the individual nurse/midwife to self-identify his/her learning needs was highlighted in the following account.

> … 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 time commitment for each nurse and midwife to meet continuing education requirements should be realistic if releasing staff to facilitate these requirements is to be achieved. Employers were considered to have responsibility for ensuring that staff are released, replaced and provided with opportunities for mandatory skills training as indicated in the following statement.

> 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).

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To summarise, the NMBI and employers were viewed as having distinct responsibilities for facilitating nurses and midwives to maintain and develop competence. The NMBI was also viewed as having responsibility to specify the baseline competency standards.

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.

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Continuing professional development and demonstrating competence

Participants suggested that there is a strong relationship between CPD and maintaining and 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 this 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.

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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 using tools to identify strengths, weaknesses, and 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 several 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, CAN 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. Wilson's (2012) evaluated the midwives perceived level of competency in perineal repair post an in-

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service educational intervention using an already validated tool. This work clearly provides a performance rating scale and descriptors of achievement as a means of assessing levels of competence. However, in this study, while work-based learning was mentioned, tools for assessment of levels of competence attainment were not mentioned. A possible explanation for this may be related to the overall focus of the study which was on the development of schemes to demonstrate maintenance of professional competence, therefore participants emphasised the macro level which included both theoretical and work-based skills learning and the direct assessment of the actual level of performance was subsumed in ideas of self and peer assessment and objective assessment.

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. Wilson (2012) concluded that professional bodies need to set national standards and guidelines for the assessment and accreditation. This study supports this as the regulator was viewed as having responsibility for introducing and regulating competence development. Moreover, the majority of participants favoured the completion of a minimum number of defined hours in the previous 3 years as part of their continuing competence requirements. This view matches 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). Providing evidence of learning and engagement in practice were highlighted as important in this study. However, as recency of practice does not denote or provide an

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adequate indicator of safe practice or competence when used independently (NCNZ 2010) it should be one of several and constituent elements of an assessment of competence framework.

Limitations

While a wide range of views were obtained from the 91 participants, the majority of participants were senior members of staff in management and education roles. The views of staff nurses and staff midwives were not well represented. This limitation needs to be seen in the context of some disquiet among the profession during the period of data collection 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. While this may have raised awareness regarding the role and function of NMBI, as it pertains to continuing registration, it may also account for the reduced levels of participation from the less paid and more vulnerable grades among the professions.

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 context specific and linked with recent engagement in practice.

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CPD has a key role in maintaining and demonstrating and should have a positive impact on service provision, the patient experience and patient safety. 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. Arguably, a holistic approach to competence development was put forward incorporating a wide range of mechanisms. As there is currently no standardised national assessment frameworks to assess competency development for nurses and midwives beyond entry level, it may be that tools for assessing different levels of competency was incorporated by the participants within the totality of requirements or frameworks to demonstrate the maintenance of professional competence.

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 and there is a clear need for regulatory guidance on competency requirements and the structure of portfolios. Finally, a system to ensure concordance with continuous competence requirements is needed and consideration is also required to distinguish between participants to do not obtain competence and those who fail to comply with these competency requirements. Effective management of

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these issues, whilst significantly different in their possible outcomes, primary responsibility rests with the practitioner under explicit guidance from the regulatory body.

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1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

2) drafting the article or revising it critically for important intellectual content.

* http://www.icmje.org/recommendations/

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Level of education	Certificate	4	4.4%
	Diploma	4	4.4%
	Bachelor Degree (BSc)	14	15.5%
	Postgraduate Qualification (certificate/ diploma)	17	18.9%
	Master's Degree	39	43.3%
	Doctoral Degree	10	11.1%
	Other	2	2.2%
	Missing	1	

Table 1. Characteristics of the respondents

Age group	20 - 39 Years	9	11.7%
	40 - 49 Years	26	33.7
	50 - 59 Years	38	49.4%
	60+ Years	4	5.2%
	Missing	14	

Table 2 Respondents' Age range

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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	6	

Table 3 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	

Table 4 Name of respondents' employer

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Theme 1	Definitions and characteristics of competence
Theme 2	Continuing professional development and demonstrating competence
Theme 3	Assessment of competence
Theme 4	Nursing and Midwifery Board of Ireland and employers as regulators and enablers of maintaining professional competence

Table 5 List of themes from qualitative data analysis

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