Abstract

Objectives: This paper provides insight into the impact of Safeguarding of Vulnerable Adults Continuing Professional Development training.

Settings and Participants: The participants for this study comprised of nurses (n=51) working in East England.

Methods: A 50-item questionnaire was designed to seek participants’ views the acquisition of knowledge, skills and any perceived changes in practice plus any challenges.

Results: The findings indicated that the primary reason for participants to access the training was for the acquisition of knowledge and to update their skills. Despite the benefits of the training, some participants described how the potential positive effects were curtailed by the challenges they have since experienced with bringing changes into their practice settings.

Conclusions: The study highlighted key benefits of the training and concludes by suggesting the need for employers to provide an environment in which staff supported for CPD can trigger and sustain change in order to improve patient care.

Key words: CPD; Safeguarding; on-line questionnaire; benefits of CPD; Change management
Introduction

The professional standard bodies – such as the Nursing and Midwifery Council (NMC) and Health Care Professionals Council (HCPC) – expect nurses to stay up to date in their professional practice by engaging in CPD and developing their skills and awareness in order to deliver safe, effective, and patient-centred care in all aspects of their role (Arungwa, 2014). Continuing professional development in the UK has therefore become an essential component of health and social care practice, with it being predominantly aligned to the roles and responsibilities of an individual practitioner and the objectives of an organisation or unit (DeSilets, 2007; Gallagher, 2006; Hegney et al., 2010). In Liberating the NHS: Developing the Healthcare Workforce (DH, 2010), the UK government proposed a strategy for workforce development for healthcare workers, committing to support the delivery of high quality education and training that supports safe, high quality care and greater flexibility.

Although the budget for CPD in England has recently been significantly reduced (Greatbatch, 2016), CPD continues to be seen as a key strategy for healthcare workers in terms of maintaining and improving skills and knowledge for the benefit of both the patients and the profession (Billett et al., 2012; NMC, 2014). Indeed, a number of studies have demonstrated that there exists links between having access to CPD and staff satisfaction (Shields and Ward, 2001), with opportunities for CPD leading to staff retention. Other studies have also highlighted that CPD has the potential for increasing productivity, reducing accidents and errors in the delivery of healthcare, creating a better work environment and increasing job satisfaction (Chakraborty et al., 2006; Marzuki et al., 2012).

Although the provision of CPD has increased, studies assessing its effectiveness in producing changes in behaviour and improved outcomes for patients remain inconclusive (Carpenter et al., 2004; Lagare, 2011; Sharples et al., 2003). In addition, most of the studies tend to focus on learner satisfaction, rarely examining the participants’ perception of the impact on their clinical skills. Goodall et al. (2005) and Grant (2011) have argued that evaluating the efficacy of CPD on individual perceived practice outcomes is challenging due to the complexity of clinical areas both acute and the community (Cotterill-Walker, 2012; Lahti et al., 2014). The broad aim of this project
was to assess the impact of SOVA-CPD training for nurses working in both primary and secondary care. The key aims of the SOVA-CPD programme were as follows: to improve leadership skills in safeguarding adults within their area of practice and interdisciplinary working; to inform effective adoption of local and national safeguarding multi-disciplinary guidelines and improve current adult safeguarding policy and practice within participants’ employing organisations’ guidance; to achieve long-term improvements in the care and practice of safeguarding adults at risk. The programme was delivered to three different cohorts in 2012, 2013, and 2014. Each programme was delivered for one day a month over seven months, covering key areas in safeguarding such as *Safeguarding within Clinical Practice; Mental Capacity Act/Mental Health Act; Learning Disabilities; Serious Case Reviews; Legal and Ethical Aspects of Safeguarding and Communication, Leadership and Discharge Planning.* This paper reports the participants’ views on the effectiveness of the SOVA-CPD training program in terms of delivering safe and effective patient care.

**Methodology**

The participants for this study were recruited from three different cohorts of the SOVA training that had been previously delivered in 2012, 2013, and 2014 to nurses, doctors and allied health professionals. The focus for this study was on qualified nurses working in either acute or secondary care in the East of England, the focus on nursing staff was determined by the local clinical commissioning group because nurses were the largest group accessing the SOVA-CPD during that period. Approval for the study was granted by the local NHS Trust.

The data was collected between August-November 2015 via an online self-administered questionnaire, which had been developed from literature reviews and experts in the field who provided a constructive critique. This was a relevant way of assessing the validity of the questionnaire (Polit and Beck, 2006) and to critically assess if each item on the scale questionnaire was relevant to the concept being measured. A few changes were made that were mainly the rewording of questions to ensure clarity. The questionnaire comprised closed and open-ended questions and was divided into several sections covering: the purpose for undertaking the SOVA-CPD; acquisition of knowledge and skills; perceived changes in practice; a description of how they do things differently at work as a result of the training and any challenges they have experienced.
in changing practice. The final section of the questionnaire included a section about participants: age group; gender; job title; length of service; start and completion date of their SOVA-CPD course. The purpose was to provide an in-depth examination of the effectiveness and impact of CPD training for nurses working in both primary and secondary care and who had completed the study over one, two, and three years.

The advantages of using an online questionnaire were as follows: it was cheaper and quicker to administer, it created a greater social distance between the researcher and the participant, thus reducing the number of socially desirable answers and fostering the respondent’s honesty (Holbrook et al., 2003; Johnson et al., 2012; Kreuter et al., 2008) without any influence, and there was no variability of information to participants (Bryman, 2012; Bryman and Bell, 2011). The online questionnaire was also considered convenient for the respondents because they could complete it in their own time and at their own pace.

Given that online questionnaires do reduce the link between the respondent and the researcher (and are known to suffer from delays in return), a detailed covering letter was included stating the importance of the project, a summary of the research area, why the individuals were selected, and the duration for completion of the questionnaire, as well as inviting the participant to take part in the study. Participants were also informed that the participation was voluntary and their responses would be treated in strict confidence and that their identity – as well as the identity of their Trust – would not be identified in any publications. The questionnaire was administered to 70 practitioners who had completed the SOVA-CPD training during 2012, 2013 and 2014. Four reminder emails were sent at intervals of three weeks.

Of the 70 participants who were invited to complete the questionnaire, 11 participants had left their organisation and could not be located. Consequently, the total number of participants who received the questionnaires was 59, with the overall response rate considered to be an excellent 86% (51 participants responded in total). For the quantitative data that was collected, a basic descriptive statistic (percentages, rates, and frequency) was used to analyse the findings. For the qualitative responses, in relation to how participants felt they did things differently at work as a result of the course and any challenges they have experienced in changing practice, the process of data analysis
involved coding material and identifying categories, which was facilitated using the qualitative data analysis (QDA) software package NVivo 10. This approach helped to identify similarities and differences from participants qualitative responses, before focusing on the inter-relationships between different aspects of the data and finally to identify several themes from the data (Gale et al., 2013). Following the formation of themes, the findings were presented in a narrative form supported by the participants’ written data, with theoretical references as necessary. The tables below (1- 4) illustrate a summary of some key findings.

(Insert table 1-4)

**Findings: competency, leadership skills in SOVA service delivery and networking**

A key aim of the course was the expectation that participants would become *safeguarding leads* within their practice area, and consequently, the acquisition of safeguarding skills and positive practice change including those of leadership was key. When describing their experiences in relation to the SOVA-CPD, all respondents emphasised that relevance of content was an important aspect of their decision for participating in the training. The SOVA-CPD course was described as having enhanced their competency and leadership skills in service delivery by allowing the acquisition of new knowledge and skills regarding SOVA. One of the participants described how they had established an interest group within their area of work that meets once a month to share experiences of safeguarding within the workplace, while others described developing training for others, and taking on the role of ‘point of contact’ for providing learning materials and guidance on the national legislation and local policy on safeguarding. This was seen as a strategy for facilitating, influencing, and supporting change in practice. All the participants indicated that the training on safeguarding had increased their competency, awareness and confidence in managing safeguarding issues within their practice area. The participants also indicated how the training enabled them to acquire knowledge on safeguarding issues – including the Mental Capacity Act – and in turn this gave them confidence in dealing with vulnerable adults. Participants also felt they had developed self-assurance and had improved in the care they were providing to vulnerable adults within their work place; the knowledge they acquired was described as being ‘essential’ in enabling good practice.
Interestingly, some participants in this study stated that their attendance of the SOVA-CPD training had provided them with an opportunity to network and a reduced professional isolation by meeting and engaging with other practitioners within the region on areas of mutual interest while also increasing their skills and competency in safeguarding. They felt that the networking had enhanced their ability for collaboration, and that they had developed a shared understanding of the skills required in terms of working with vulnerable patients, subsequently enhancing the quality of care given to their patients. The networking and collaboration with others enabled them to identify, share, and implement good practice from other areas.

**Findings: summary of participants account of challenges encountered in practice**

Despite the above benefits, some participants described how the potential positive effects were seen to be curtailed by the inability and perceived unwillingness of managers to *allow* the learning to be implemented and cascaded. They stated that some managers were not supportive, and at times even unintentionally obstructive to implementing changes because of staffing issues and the prioritisation of organisational resources in delivering care. Although all of the staff had been supported by their Trusts when attending the CPD training, there was no clarity in terms of supporting them to implement change, and some participants stated that in some instances it was business as usual and therefore the change in practice was left at the individual level instead of transforming the organisation or unit as a whole. Consequently, some participants identified the need for a systematic follow-up after the training in order to share experiences, because some of them experienced great difficulties in implementing and managing a change in practice.

Other challenges included a lack of systems to support the implementation of evidence-based practice. Therefore, although they had gained new knowledge and skills, some participants indicated that they could not make significant changes within their practice because they didn’t have the capacity or support as to how their current way of working could be altered, to allow them to focus on being change agents and to ensure they provide the best care for their patients in line with the new knowledge. Organisational priorities and commitments were described by some participants as undermining the ability to implement change, while others described what they viewed as a *clash of priorities and cultures* within their area of work, explaining how some of their
colleagues found it difficult – due to other priorities - to accept the new guidance and protocols they had introduced following the CPD training.

**Discussion**

Consistent with the findings from other studies (Arungwa, 2014; Govranos et al., 2014; Gould et al., 2007; Ni et al., 2014; Pool et al., 2013), this study found that the primary reason for most healthcare professionals accessing CPD was to maintain evidence-based practice by updating themselves. The participants in this study overwhelmingly agreed that the SOVA-CPD had enhanced their competency in this area. They felt that this particular CPD had contributed to the improvement in the quality of their patients’ care and better management of safeguarding. This finding is similar to the work of Nsemo et al. (2013); Govranos et al. (2014) and Richards and Potgieter (2010), these studies having found that CPD had a direct impact on safe care delivery and enhanced clinician’s competencies, while the Chong et al. (2011) study found that CPD nurses in Malaysia could articulate an increase in knowledge and competency, which directly influenced an improvement in the quality of care. Although CPD in this study and others has demonstrated an increase in competency, skill development, and knowledge, other studies have found variations between younger and older nurses’ experiences of CPD. For example, while both age groups benefited from CPD, Poole et al. (2013) found that older and experienced nurses’ primary aim for CPD was to enable them to enhance their knowledge and skills in order to improve their mentoring skills, while the younger and less experienced nurses accessed CPD to enhance their clinical skills. Such differences were not noted in this present study, as indeed all participants irrespective of their age group or year of service felt that the CPD had prepared them to take on the role of safeguarding champion within their areas of practice. This was an important finding and suggests that it is important to promote and make available CPD opportunities to nurses irrespective of their level of experience and that less experienced nurses should not be denied the opportunity because of the perception that they are not ready nor experienced enough to benefit from CPD. Findings from this study indicated that similar to the well experienced nurses, the novice nurses are able to articulate and put into practice new knowledge acquired from CPD, and consequently, due to the shortage of nurses and the likelihood of retirement of an older nursing workforce, it is important for employers to ensure that newly qualified nurses are given the opportunity to access CPD in order to improve their patient care.
As the findings indicated, some of the participants had experienced challenges in introducing change within their practice area, and this difficulty has also been recorded in other studies (Yfantis, 2011; Nsemo et al., 2013 and Pool et al., 2013), the reasons identified by participants including workload pressures and change in organisational priorities. Most found that the organisational readiness and management posed the greatest challenge for them to implement change. Consequently, this suggests that it is imperative for employers to provide an environment in which staff supported for CPD can trigger and sustain change, and that the organisation supporting staff for CPD should assess its readiness for change and provide a support mechanism in order to enable practitioners to instigate and implement change. In addition, employers supporting staff for CPD should be able to understand how to adapt their management style to create an environment where the recipient of CPD could become a change agent and is able to lead the team through change whilst overcoming any resistance. As Yfantis (2011) and Pool et al. (2013) have argued, it is important for CPD to be tailored to meet the needs of the organisation, be needs driven, and to reflect contemporary practice in line with the current expectation of a particular care delivery requirement; this approach would encourage a supportive environment for the introduction and implementation of change in practice.

Given the critical essence of safeguarding of vulnerable patients in healthcare, it is important that CPD in this area is effective and can directly influence healthcare practitioners in the protection of vulnerable adults. This will ensure that practitioners are well equipped and that they have acquired the fundamentals of safeguarding as well as recognising abuse of vulnerable patients as reported by participants in this study. According to the Department of Health (2011), it is imperative for practitioners working with vulnerable patients to be aware of the processes for safeguarding in order to provide appropriate care and to protect their clients from any injury or abuse (Green, 2015). Unfortunately, abuse of vulnerable adults and children is not uncommon; indeed, Strughari’s (2011) survey demonstrated that approximately 227,000 elderly people are abused by next of kin, health and social care workers, and others within their network, while Mandelstam’s (2009) earlier work in the UK demonstrated that some participants (2.6%) had witnessed abuse first-hand, including physical, sexual, mental, and financial abuse. Consequently, as the findings
of this study have demonstrated, CPD on safeguarding is critical and has the potential to engender a positive health experience of vulnerable patients in both primary and secondary care settings.

Although a key aim of the SOVA-CPD was to strengthen participant leadership skills and for the participants to take the role of safeguarding leads within their practice environment, despite the challenges that were experienced by some participants in bringing change within their area of practice, all the participants were able to provide examples of the extended roles they had undertaken following the SOVA-CPD, which is anticipated would also enhance their career progression. This finding is in line with other studies that have demonstrated CPD’s potential to enhance the career pathway of nurses and to provide opportunities to undertake extended roles such as nurse consultants, clinical leads, team leader, or practice educator (Pool et al., 2013; Katsikitis, 2013).

The main limitation of this study was that it was based on a small sample of purposively-selected participants; however, the use of an online closed and open-ended questionnaire enabled in-depth responses from participants that covered more completely their experiences and perceptions of how the SOVA-CPD programme has influenced their practice. A further limitation of the study was the reliance on self-perception reporting by the participants instead of using an objective criteria or including a range of stake-holders such as participant employers and service users, although the findings have provided insight into the participants’ experiences of SOVA-CPD which should contribute to the discourse in this area.

**Conclusion**

This study highlighted several key benefits of the SOVA-CPD for nurses, illustrating that the perceived positive change in practice not only benefits the individual nurse but also feeds into the whole organisation and patient care in general. Unfortunately, the funding cuts that are currently being experienced across England to ongoing CPD for health and social care professionals is not only likely to create a significant risk for staff morale and patient care but will also require scrutiny of the benefits of CPD. Consequently, it would seem imperative that employers develop evaluative approaches to CPD that not only accurately gauge learning outcomes at an individual level but also at a patient and organisational level. Without such evaluative approaches it is likely that the
effectiveness and impact of CPD will be diluted, and by implication, the investment and funding for CPD will continue to deteriorate.
References


