

A Clinical Skills Unit: Addressing the need for Continued Professional Development (CPD) in Allied Health Professions

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ABSTRACT

Introduction: The Health Professions Council of South Africa (HPCSA) monitors compulsory continuing professional development (CPD) to ensure that healthcare professionals update their knowledge and skills to the benefit of their clients. One of the objectives of the Clinical Skills Unit (CSU) in the School for Allied Health Professions at the University of the Free State (UFS) was to use it for CPD as part of a responsibility towards alumni. This study investigated the needs of qualified dieticians (DT), occupational therapists (OT) and physiotherapists (PT) to assist in the provision of relevant CPD activities at the Unit.

Methods: A descriptive, comparative study was conducted. Two hundred and fifty-eight questionnaires were distributed in the Free State and Northern Cape provinces, to members of the professional groups mentioned above. To ensure reliability, 10% of the sample was re-tested after one month.

Results: One hundred and twenty-seven professionals responded to the questionnaire, with 55.6% being from the Free State. CPD activities were attended in Bloemfontein by 65.9%. Most of the CPD activities (70.6%) attended prior to the study were theoretical in nature and 85% of respondents would have preferred to observe experts and learn by doing. Differences between the groups were significant for some of the questions, for example, dieticians preferred a large group didactic approach while the other professional groups preferred to observe experts and be involved in the learning process. All the professionals preferred CPD activities to be presented by an expert in their specific field of practise.

Conclusions: Taking into consideration the views of professionals and the results of international studies, the CSU at the UFS will be able to address the CPD needs of allied health professionals in the Free State and Northern Cape.

Keywords: clinical skills unit; continued professional development; allied health professions

INTRODUCTION

The importance of educating health professionals to keep up with the communities' changing needs was advocated nearly a century ago by Abraham Flexner¹. The Alma Ata Declaration of 1978, the World Health Organisation (WHO)² also put forward the view that health services should be more equitable and appropriate to the needs of the people. This view was confirmed, for South African healthcare workers, in the Cape Town Declaration of 1995³.

One of the factors that affect the health services of a country is the human resources that are available to render these services. In a press release entitled *World Health Report*⁴, the WHO noted that health care workers, who lack the necessary training and knowledge, may be a major obstacle for health systems in the world. With the new health dispensation in South Africa, namely the imminent roll-out of the National Health Service, not only will it be important to maintain skills, but also to learn new and innovative ways of delivering quality services, with a greater focus on preventative and promotive healthcare and orientated to the needs of the community.

Continuing Professional Development (CPD) comprises post-graduate clinical education aimed at engaging the practitioner in a lifelong process of learning⁵. The goal of CPD as described by Amerih⁶ supports the view of the WHO⁴, in that it continuously improves the quality of healthcare practice, providing opportunities for professional growth and maintaining up-to-date knowledge and skills. A statement on CPD for health and social practitioners in the United Kingdom⁷, clearly states that the purpose of CPD is to enhance the quality of care that patients and clients receive from their healthcare providers.

Woillard⁸ and Philips⁹ assert that it is the responsibility of higher education institutions (HEI's) not only to ensure that undergraduate students attain the minimum standard of education, but also, that alumni maintain the required minimum standards. In some countries, CPD is managed by a separate entity, for example, the Beeches Management Centre⁷ in the United Kingdom and the Mayo

Clinic¹⁰ in the United States of America. According to Castleman,¹¹ the coordination and management of CPD activities by higher education institutions (HEIs) in South Africa vary considerably, with many institutions failing to acknowledge CPD as an integral part of their responsibility. The current scenario is that in most HEIs, CPD is decentralised to various professional groupings.

The monitoring of CPD is the responsibility of the Health Professions Council of South Africa (HPCSA)¹² and its constituent Professional Boards. In 2005, the HPCSA established an overarching CPD committee consisting of representation from all twelve Professional Boards. As a first step, the *Health Professions Amendment Bill of 2006*¹³, Section 26, stated that the Council could make rules in terms of registration, the conditions related to registration and retaining registration, the nature and providers of CPD activities. After extensive research and consultation, the CPD framework was officially implemented in January 2007¹². It is mandatory for all practising health professionals, (including dieticians, physiotherapists and occupational therapists) to be registered with the HPCSA. It is the view of the Council that CPD plays a vital role in helping healthcare professionals acquire new and updated levels of knowledge, skills and ethical values. This view is shared by the Canadian Association of Occupational Therapy¹⁴ which recognises that access to and acquisition of current relevant and evidence-based knowledge, skills and behaviours are the key to the development and use of best practices in occupational therapy.

South African health professionals are, by law compelled to accumulate 60 Continuing Education Units (CEUs) in any given two-year period. Therefore, random audits are done to establish the compliance of registered members. Non compliance can lead to suspension of registration with the Council¹³.

Three of the programmes, namely dietetics and nutrition, occupational therapy and physiotherapy in the School for Allied Health Professions (SAHP), located in the University of the Free State (UFS) in Bloemfontein, South Africa, at the time of the study have to adhere to these regulations.



The results of an international study by Amerih⁶ reported that only 25% of occupational therapy (OT) respondents indicated that CDP activities were readily available, and that therapists in developed countries were more likely to participate in CPD activities than those in developing countries. CPD is also mandatory for physiotherapists in many countries and a range of formal and informal activities exist¹⁵. A study by Gunn¹⁶ supports evidence that CPD has an effect on the clinical practises of physiotherapists based in community primary care, and that undertaking CPD improves confidence as well as competence. A study by Martin et al.¹⁷ concluded that CPD existed to ensure that scientific information was accessible to all dieticians in South Africa and that this could only happen if a system existed that was supportive of learning opportunities. The HPCSA is, however, concerned about the percentage of non-compliance among health workers registered by the various Professional Boards. For example, according to the HPCSA only 32% of Dieticians¹⁸ and 29% of Occupational Therapists¹⁹ were CPD-compliant over the last few years.

Research by Van Vuuren and Nel²⁰ on the value of a Clinical Skills Unit (CSU) led to the planning, construction and establishment of a CSU for the School for Allied Health Professions at the University of the Free State. The CSU is viewed as a facility in which students, physicians, nurses and other health professionals can learn clinical and communication skills, to a specific level of competence, prior to, and in coordination with patient contact²¹. The perceived vision and functions²² of the CSU at the School for Allied Health Professions were undergraduate clinical skills training, postgraduate clinical skills training (including CPD activities), community service, and student and staff wellness. After commissioning of the facility in 2011, strategies had to be developed to ensure that these functions were established. Dent^{23,406} asserted that "Clinical Skills Centres (CSC) must develop continuously if they are to respond to the current demands and future challenges" and continues his argument that if CSC's wanted to expand their activities, including the offering of CPD, they should:

- (i) Be recognised as an independent entity;
- (ii) engage an efficient management structure;
- (iii) secure a substantial and reliable budget;
- (iv) co-operate with academic standards committees (in this case the HPCSA and the South African Qualifications Authority [SAQA]);
- (v) maintain good relations with other key stakeholders within the Faculty;
- (vi) develop a recognised career structure that attracts and supports its teaching staff;
- (vii) value the human resources at the centre and
- (viii) remain approachable to everyone.

However, in order to utilise the full potential of a Clinical Skills Unit for CPD activities, Eraut²⁴ noted that sufficient attention was rarely given to the identification of learning needs, the prioritisation of these needs and matching the needs to learning opportunities and activities in delivering CPD activities/programme. Grant²⁵ argued that learning is more likely to lead to change when a needs assessment has been conducted and the education is linked to practice. Literature therefore supports the argument that establishing the learning needs and priorities of professionals is important before CPD is planned and offered. The investigation can be viewed as a necessary step to fully utilise the Clinical Skills Unit for CPD of allied health professionals.

PROBLEM STATEMENT

Allied health professionals in central South Africa, especially the Free State and Northern Cape provinces, do not always, for a variety of reasons, have access to a range of CPD activities. In addition, at times they are required to attend such activities, sometimes at great cost, outside the provinces, to adhere to the expectations of the HPCSA. In the opinion of the first author who has been involved in the training of allied health professions in the Free State for more than thirty years, a high percentage of CPD activities focus on knowledge provision, usually in big groups rather than skills

acquisition as well as limited provision for individual activities or the development of specific needs. In addition, very little research or exploration has been undertaken to ascertain what CPD activities allied health practitioners might like to have access to. As the University of the Free State and the CSU at the School for Allied Health Professions is currently the only Institution of Higher Education in both these vast rural provinces, it is crucial that the Institution and its entities should play a role in the provision of CPD.

STUDY METHODS

Aim of the study

The aim of the study was to investigate the CPD needs of the identified allied health professionals (occupational therapists, physiotherapists and dieticians,) in the Free State and Northern Cape provinces of South Africa. The data could then be used to develop a proposal for the offering of CPD activities within the CSU, at the School for Allied Health Professions.

Methods

The research design was of a descriptive nature²⁶. A survey was undertaken by means of a self-administered questionnaire that collected information on the views of the identified allied health professionals. Approval to conduct the study was granted by the Ethics Committee of the Faculty of Health Sciences, University of the Free State.

Study population and sampling

The HPCSA registers indicated that at the time of investigation, there were 138 occupational therapists, 169 working physiotherapists and 141 dieticians in the Free State and Northern Cape (448 in total.) All 448 of these professionals were contacted to participate in the study but only 258 practitioners could be tracked down according to the contact details on the lists. The administrative officer at the CSU continued to communicate with these practitioners to explain the purpose of the study, verify their details, their preferred manner of receiving communication and to enquire if they would also be willing to participate in a reliability test one month after all the questionnaires were returned.

Data collection

The above mentioned questionnaire was developed from the literature^{10-21,23} and the personal experience of the first author. This structured questionnaire included questions on: the background information of participants; the frequency of attending CPD activities; the places where they most frequently accessed CPD activities; topics that they wished to be covered to enable service delivery and when it was preferable for these to be scheduled. Before the questionnaires were sent out, a pilot study was conducted to ensure that the questions were unbiased and clear. The Heads of the Departments of Occupational Therapy, Physiotherapy and Nutrition and Dietetics, at the UFS were used to pilot test the questionnaire, to clarify questions and make suggestions on additional questions. The time needed to complete the questionnaire was also established. Changes made to the questionnaire included adding to some of the questions "any other comments" as well as clarifying a few of the questions.

Due to the vast geographical area of the Free State and Northern Cape provinces, a postal survey supplemented at times by, electronic mail and fax was conducted. Questionnaires sent by post included a franked envelope. The majority of participants preferred email as the means of communication. A telephone call to remind participants of outstanding questionnaires was made by the administrative officer two weeks after distribution of the questionnaire. All the participants who did not return their questionnaires were contacted again after one month.

Reliability was provided by re-testing 10% of the sample. The reliability questionnaires were sent to 13 professionals representing the three groups, one month after all the questionnaires were returned (n=127). They were selected to represent the groups proportionally.

The validity of this study is supported by the fact that CPD activities are currently compulsory for all the participants, and they should have had some previous experience of CPD activities.

Data analysis

The analysis of the data was done by the Department of Biostatistics, Faculty of Health Sciences, UFS. Descriptive statistics, namely frequencies and percentages for categorical data and medians and percentiles for continuous data, were calculated. Further statistical analysis was done by comparing the responses of the three different groups as well as the differences in the needs of the different age groups by means of 95% confidence intervals (CI) for the percentage difference.

The reliability questionnaires were compared with the questionnaires received earlier. When 20% or more of participants gave a different answer to a question it was deemed unreliable. Nine opinions to four questions were thus deemed unreliable and excluded from the analysis.

RESULTS

One hundred and twenty-seven questionnaires of a total of 258 questionnaires were received back, giving a response rate of 49% considered by the researchers as in keeping with a typical rate for mailed questionnaires²⁷. Forty four percent (44.1%) of respondents were occupational therapists (OT), 24.4% were dieticians (DT), and 31.5% physiotherapists (PT). Sixty-eight per cent (68.5%) of the participants had worked for a period of less than 10 years. The median period of working was five years, ranging from less than a year to a maximum of 44 years. The majority (71.7%) were working in the public sector. Their place of work was mainly situated in the larger urban areas of the Free State (55.6%) and Northern Cape (44.4%).

Approximately two thirds of the participants (65.9%) had attended CPD activities in Bloemfontein (the capital city in the Free State Province) in the past. Other places where activities were attended included Kimberley (18.3% of participants) and Johannesburg, Pretoria, and Cape Town (15.9% participants). Of these activities, 70.6% were mainly theoretical sessions. Almost all (97.6%) of the participants indicated they would prefer to attend

skills sessions, rather than pure theory sessions. A 95% confidence interval (95% CI) to indicate differences between the professional groups was used to analyse the differences in response of the three professional groups.

Table 1 shows the participants' view with regard to preferred learning opportunities during CPD. The results depicted in the table were fairly similar for all three professional groups, and the view was expressed that the activities should cater for both experienced and newly qualified professionals.

All the groups were positive about web-based activities 76.8% of occupational therapists indicated a need for a web page, compared to 74.2% of dieticians and 75% of physiotherapist's. A statistically significant difference was found on the following questions:

Organise an opportunity in which an expert assesses an individual's skill on request. Differences were found between DT and PT [7.0%; 49.1%] as well as OT and PT [3.5%; 40.0%]; *Record of CPD activities should be kept to ensure that a variety of topics are covered.* The results showed the same tendency between OT and DT [-49.1%; -10.7%] and *Introduce an electronic newsletter to share information.* A significant difference was found between OT and DT [-35.1%; -2.2%] and DT and PT [5.4%; 42.1%].

The results regarding specific skills that should be part of CPD activities as indicated by the participants are listed in Table 2 on page 44.

The results in Table 2 reflect the generic topics that allied health professionals want to be addressed during CPD. All the groups placed the highest priority (89.3% of OT; 74.2% of DT and 87.5% of PT) on the addressing of therapeutic intervention skills. A statistically significant difference was found between the different professions on the following questions: *Interpersonal skills such as consultation:* between DT and PT [6.0%; 44.3%], and OT and DT [-59.5%; -19.2%]; and *to educate family and care givers:* the differences were between OT and DT [-47.0%; -4.4%] and PT and OT [4.3%; 41.2%].

The majority of participants (85%) indicated that they would like to learn by doing and would prefer small workshops (89.8%) to learn their skills (see Table III). In the event of the seminar

Table I: Participants' view on what learning opportunities should be provided during CPD

Activity	Group					
	Total (n=127)		DT ^a (n=31)		OT ^a (n=56)	
	n	%	n	%	n	%
Activities for experienced as well as newly qualified professionals	113	88.9	20	80.7	54	96.4
An opportunity to observe an expert demonstrating skills	101	79.5	27	87.1	47	83.9
Activities to be advertised on a web page	96	75.6	23	74.2	43	76.8
Electronic newsletter to share information	93	73.2	28	90.3	39	69.6
Skills for practice-based needs	90	70.9	23	74.2	41	73.2
Activities of such quality that it can improve service rendering	89	70.1	25	80.7	40	71.4
An opportunity for professionals to share information	88	69.3	23	74.2	37	66.1
That a variety of topics be covered according to records	87	68.5	27	87.1	38	67.9
An opportunity to practise skills under the guidance of an expert	86	67.7	24	77.4	36	64.3
An opportunity for self-assessment of skills	63	49.5	20	64.5	24	42.9
An opportunity where an expert can assess my skills	54	42.5	17	54.8	27	48.2
Other needs ^b : practical sessions; research; provision of literature; provision of evidence of attendance; provide activities as part of work schedule of staff	7	5.5	2	6.5	4	7.1
					1	2.5

^aDT = dieticians, OT = occupational therapists, PT = physiotherapists

^bOther: open-ended questionnaire item; responses combined

Table II: Topics to be covered in CPD activities

Activity	Group							
	Total (n=127)		DT ^a (n=31)		OT ^a (n=56)		PT ^a (n=40)	
	n	n	%	n	n	%	n	%
Therapeutic interventions	108	85.0	23	74.2	50	89.3	35	87.5
Ethical aspects	67	52.8	15	48.4	31	55.4	21	52.5
Interpersonal skills such as giving advice	66	51.9	24	77.4	28	50.0	14	35.0
Preventative steps to promote health	62	48.8	17	54.5	24	42.9	21	52.5
Training family/carers	57	44.9	17	54.8	29	51.8	11	27.5
Personal development such as time management	49	38.6	17	54.8	18	32.1	14	35.0
Other activities ^b : practice-based versus evidence-based; need for most recent developments in the profession; community practice of different topic, such as rare cases; financial management; staff wellness	6	4.7	1	3.2	5	8.9	0	0

^aDT = dieticians, OT = occupational therapists, PT = physiotherapists^bOther: open-ended questionnaire item; responses combined**Table III: Participants' views on: Learning experiences and presentation of CPD activities**

Learning style and environment	Group							
	Total (n=127)		DT ^a (n=31)		OT ^a (n=56)		PT ^a (n=40)	
	n	%	n	n	%	n	n	%
Learning styles								
Learning by doing	108	85.0	23	74.2	50	89.3	35	87.5
Observe experts (skills)	94	74.0	17	54.5	43	76.8	34	85.0
Presentation of theory by experts	92	72.4	25	80.7	38	67.9	29	72.5
Observation of applying procedures on standardised patients	71	55.9	11	35.5	38	67.9	22	55.0
Discussion of case studies	70	55.1	19	61.3	29	51.5	22	55.0
Other learning styles ^b : practicals; research; electronic media, for example DVDs; provision of study material	5	3.9	0	0	4	7.1	1	2.5
Learning environment								
Small workshops	114	89.8	28	90.3	51	91.1	35	87.5
Postgraduate courses	78	61.4	19	61.3	30	53.6	29	72.5
Seminars	77	60.6	25	80.7	28	50.0	24	60.0
Discussion groups	71	55.9	18	58.1	32	57.1	21	52.5
Structured individual set-up	56	44.1	13	41.9	29	51.8	14	35.0
Formal lecturers in big groups	53	41.7	17	54.8	17	30.4	19	47.5
Web-based environment	50	39.4	16	51.6	23	41.1	11	27.5
Teleconferences	15	11.8	6	19.4	7	12.5	2	5.0
Other learning environments ^b : multi-disciplinary groups; short intensive courses; demonstrations	5	3.9	1	3.2	4	7.1	0	0

^aDT = dieticians, OT = occupational therapists, PT = physiotherapists^bOther: open-ended questionnaire item; responses combined**Table IV: Participants' view on when CPD activities should be scheduled**

When CPD activities should be presented	Group							
	Total (n=127)		DT ^a (n=31)		OT ^a (n=56)		PT ^a (n=40)	
	n	%	n	n	%	n	n	%
Week days	76	59.8	24	77.2	35	62.5	17	42.5
No specific preference	26	20.5	3	9.7	15	26.8	8	20.0
Weekends	23	18.1	3	9.7	5	8.9	15	37.5
School holidays	2	1.6	1	3.2	1	1.8	0	0

aDT = dieticians, OT = occupational therapists, PT = physiotherapists

format being used, the theory should be presented by an expert on the topic. Participants working more than 10 years indicated a preference for individual learning activities (65%), compared to professionals working less than 10 years (34.48%).

A statistically significant difference was found between the DT and PT with regard to *observing experts applying procedures on standardised patients* [-50.3%; -10.5%]. *Observing the demonstration of professional skills by experts; for example, administration of standardised assessment skills*: There were no statistical significant difference found between OT and DT [-8.6%; 23.1%]; and DT and PT [-41.3%; -1.6%].

As shown in Table IV on page 44, a slight majority (59.8%) of respondents preferred to attend CPD activities on week days, while 18.1% preferred weekends. With regard to the three different groups, 42.5% of physiotherapists indicated a preference for activities on week days compared to 62.5% of occupational therapists and 77.4% of dieticians.

DISCUSSION

Apart from the main purpose of the CSU to train undergraduate students' skills, one of the other envisaged functions was also to provide for Continued Professional Development.

Non-compliance to CPD activities by dieticians, occupational therapists and physiotherapists has been noted as a concern, and will impact on the offering of quality healthcare in South African. Literature reports that non-compliance is higher among occupational therapists in developing countries⁶, like South Africa. However, limited information is available on the reasons for the non-compliance. Some of the reasons²⁵ may be that limited attention is given to identifying practitioners learning needs, and prioritising and matching these in delivering CPD. In vast provinces such as the Free State and Northern Cape insufficient communication of CPD activities and updating their contacting details with the HPCSA may also play a role.

The results indicate that the participants have a specific view of CPD activities and suggested that specific topics for example, therapeutic interventions, are covered. In a study involving nurses and allied health professionals in the UK, participants placed emphasis on the importance of applying learning to practice. They were also of the opinion that this may be intuitive without formal measurement or documentation²⁷. It underlines the importance of the results of this study where a formal opportunity was created to establish the focus of CPD from this group.

These results underpin the importance of covering a variety of topics relevant to the service needs during CPD. With the exception of the dieticians, participants preferred the format of the learning experience to be presented in small groups, rather than large formal lectures. According to the 2008–2009 annual report of the Health Professions Council (HPC) of the United Kingdom²⁸, many professionals in the UK emphasised that formal didactic learning was not the only means to keep up-to-date. In terms of the way in which activities are presented, the results of this study correspond with the view of the NHS²⁹ that the focus should be on practical experience, and skills units that *simulate learning through practise* are becoming more commonplace and should be encouraged.

Participants with more than ten years of experience indicated a need for individually structured activities to develop or recap their skills. Literature supports an emerging difference in CPD needs and provision among specialist (ex. more experienced) and more junior staff³⁰.

All the participants were of the opinion that they wanted experts in their field of practice to present CPD activities. They would welcome the development of electronic media to communicate CPD activities, make online requests for activities and register for these activities. Also to enable the sharing of opinions and asking for advice and guidance. This concurs with the view of Dent²³ that a CSC should be approachable to those in need of additional help. The results showed that practitioners would prefer a different approach to the majority of current activities by using more practical

learning that focuses on skills. These results are similar to the view of Austin³¹ on CPD.

Most of the participants indicated that they have come to Bloemfontein for CPD in the past, so the CSU is well situated at the University of the Free State. The CSU was planned for the use of all the allied health professionals in the School of Allied Health Professions at the UFS. The unit is staffed with a manager, administrative assistants, technical assistants for set-ups, has state of the art equipment, information technology facilities, and an outdoor area where training of specific outdoor skills can take place.

In keeping with Dent's²³ view on what a CSU should offer, the CSU at the School for Allied Health Professions is well placed to address the CPD needs as expressed by the participants of this study. Dent²³ recommended that a CSU should be a separate entity. The CSU at the UFS is a separate entity and serves all the programmes within the School. Further, the unit is managed by its own complement of staff under the leadership of the Head of the School. Another recommendation²⁴ is that it should maintain good relations with other key sections within the Faculty. The Faculty of Health Sciences has formed an interest group within the faculty with representation from the skills/simulation unit of the SAHP, Schools of Medicine and Nursing to enable collaboration and sharing between the Schools.

With reference to the results reported here, the unit has the facilities and resources to (i) address the needs of "learning while practising"; staff are employed to do practical set-ups according to the presenters needs; (ii) host small workshops/seminars; the floor space of the unit has been designed to easily be altered or changed according to specific needs; (iii) allow for the opportunity to observe or learn from experts; (iv) make use of multimedia; the unit, for example, has its own computer laboratory and audio-visual equipment; and (vi) perform activities in small groups or on an individual basis.

The results of this study will not only give direction to the various professional groups responsible for CPD, but ensure that the CSU becomes a place that draws professionals to activities of quality, in order to comply with CPD. In addition, this will hopefully see a move away from pure gathering of the required CPUs points, but rather afford practitioners the time and space to learn and master new skills and knowledge.

Quality assurance measures are also compulsory for all departments and unit at the UFS and regularly monitored. The Liaison group of the Health Professions Council UK²⁸ recognised that the quality of CPD activities was in many instances more important to maintain high standards in practice, than the quantity of CPD undertaken. It is recommended that peer evaluation of the activities and the organisation, administration and management of the activities is implemented to adhere to quality assurance measures at the CSU. Furthermore, the CSU can implement and ensure quality assurance for example peer and expert evaluation of all activities, which is a priority.

Implications for practice

The CSU should consider developing a web-based environment to offer information of CPD activities, other practice-related enquiries and offer activities applicable according to indicated needs of the different professional groups. Expert presenters should be invited to present CPD activities and these presentations and demonstrations should focus on skills and these could be streamed live to give access to health professionals. CPD activities should be hosted in small workshops, seminars or discussion groups. A well equipped unit such as the CSU can bring about the opportunity for evidence based professional- and educational research, as well as inter professional research.

CONCLUSIONS

While there is evidence of non-compliance to CPD by allied health professionals in South Africa, the reasons are currently unknown especially for the practitioners in the Free State and Northern Cape



provinces. The building of the CSU at the SAHP also envisioned the provision of CPD activities, but the view of practitioners was needed to ensure that their needs were met. Results of the study showed that the CSU at the UFS has the potential to address the CPD needs of allied health professionals in the Free State and Northern Cape.

Acknowledgements

Dr. Daleen Struwig, medical writer, Faculty of Health Sciences, UFS, for assistance with technical and editorial preparation of the manuscript.

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