The Everyday Reality of Continuing Professional Development in the Lives of Rural and Regional Nurses

Submitted by

Carole Maddison BNg, MNg

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Faculty of Education
La Trobe University
Bundoora, Victoria 3086
Australia

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Summary

Continuing Professional Development (McCormack, Manley, & Titchen, 2013) has long been understood in health care professions to be an essential component of maintaining and developing knowledge and skills for the individual to meet the challenges of the practice setting. The delivery of health care services in rural and regional settings requires a different approach from metropolitan settings. Nurses working in these settings have been noted to have different requirements for practice and the development of a broad range skills and professional abilities.

In July 2010, the Australian Health Practitioner Regulatory Authority was formed and the new national Nursing and Midwifery Board of Australia was established. This has prompted increased attention on CPD and its role in ensuring nurses' competence to practise as the new national mandatory requirements for an annual minimum of twenty hours of CPD has been implemented.

Using an interpretive phenomenological approach, this study examines the experiences of CPD in the professional lives of a small group of purposively selected nurses in the context of the rural and regional health care setting in Victoria, Australia. It provides an opportunity to learn about the place of CPD in the everyday experience of clinical nurses and explore the relationship between CPD, learning and practice from their unique perspectives.

The data analysis identified the four themes of Context, Motivation, Activating and Connecting. These encompassed the nature of rural practice; access, preference and support for CPD; identification of learning outcomes; implementation of CPD learning to practice and the influence of organisational culture.

The generalised findings indicate that to enhance the impact of CPD it is recommended that there is increased use of reflection as a tool in the cycle of identification of learning needs, planning, evaluating and implementing learning from CPD. A change in the focus on CPD is recommended to develop systems for rural and regional healthcare settings that promote CPD as a continuous process of learning that is integral to and not separate from practice.

Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without the due acknowledgement in the main text of the thesis.

The thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

Permission to conduct this research was granted by the Faculty of Education Human Ethics Committee (FHEC approval Number: R003/11) and the Ballarat Health Services and St John of God Human Research Ethics Committee (HREC Reference Number: HREC/11/BHSSJOG/53).

Signature:

Name: Carole Maddison

Date: 27th September 2013

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Chapter 1: Introduction

In this study I have explored the experiences of Continuing Professional Development (CPD) in the professional lives of nurses in the context of the rural and regional health care setting in Victoria, Australia. It has provided an opportunity to discover nurses' understanding of the association between CPD, learning and practice. The study is set against a background of increasing focus on CPD and its role in ensuring nurses' competence to practise prompted by the establishment of a new national nursing regulatory authority.

Within this chapter I describe the rationale and purpose of the study, what is being explored and the place of the investigation in the broader context of learning and nursing practice. An outline of the research approach that was used is provided, along with a preliminary overview of the subsequent chapters.

1.1 Background and Context

In Australia there is a range of governance structures in health care that have either national or state and territory mandates. There is a national regulatory body, the Australian Health Practitioner Regulatory Authority (AHPRA), with individual discipline-specific boards that determine codes of conduct, competence to practice frameworks and scope of practice. In nursing this is the Nursing and Midwifery Board of Australia (NMBA). A national Department of Health and Ageing sets national health care priorities and has both fund holding and some service delivery responsibilities. Each state or territory has its own Department of Health that has fund holding, monitoring, service delivery and policy responsibilities. In the Victorian Department of Health the state is separated into eight geographical regions with the responsibility of service delivery and monitoring of health care. This study is set within the Grampians Region of Victoria and is represented in the map of Victorian health service regions in Appendix A (Department of Human Services, 2010b).

1.1.1 Continuing Professional Development

Throughout their professional life, nurses undertake many hours of education as part of their CPD, to inform and enhance their knowledge and practice. The concept of

CPD is closely aligned to that of lifelong learning (Hegney, Tuckett, Parker, & Eley, 2010) and is considered by nurse regulatory bodies and others as a necessary undertaking to ensure relevancy and currency of practice. The concept of lifelong learning encompasses learning from life and work experience and acknowledges this in addition to encouraging the individual to continue their formal education and training. It requires the development of self-motivation and metacognitive skills to be able to reflect and understand how to learn and is espoused as a means of coping with the "... massive and continuing changes in the workplace and in living itself" (Burns, 2002, p. 42). Continuing Professional Development is acknowledged as an integral part of this framework within Australia and internationally (Draper & Clark, 2007; Queensland Health, 2012; Royal College of Nursing Australia, 2012a).

The Nursing and Midwifery Board of Australia have adopted the definition of CPD from the Australian Nursing and Midwifery Council as

> ...the means, by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives. The CPD cycle involves reviewing practice, identifying learning needs, planning and participating in relevant learning activities, and reflecting on the value of those activities. (Nursing and Midwifery Board of Australia, 2010a, p. 1)

CPD has been adopted as one of the indicators of continuing competence for Australian nurses and midwives (Australian Nursing Midwifery Council, 2009) and in 2010 was reaffirmed by the newly formed Nursing and Midwifery Board of Australia (NMBA), which determined an annual requirement for twenty hours CPD for nurses and twenty hours for midwives (Nursing and Midwifery Board of Australia, 2010a). Where midwives are also registered as nurses then some of these hours can be claimed towards both nursing and midwifery requirements. This involves engagement in 'active learning' (Nursing and Midwifery Board of Australia, 2010b), which involves a range of activities including the following examples taken from the

Australian Nursing and Midwifery Council Continuing Competence Framework (2009):

- Reflecting on feedback, keeping a practice journal
- Acting as a preceptor/mentor/tutor
- Participating in accreditation, audit or quality improvement committees
- Undertaking supervised practice for skills development
- Participating in clinical audits, critical incident monitoring, case reviews and clinical meetings
- Participating in a professional reading and discussion group
- Developing skills in IT, numeracy, communications, improving own performance, problem solving and working with others
- Writing or reviewing educational materials, journal articles, books
- Active membership of professional groups and committees
- Reading professional journals or books
- Writing for publication
- Developing policy, protocols or guidelines
- Working with a mentor to improve practice
- Presenting at or attending workplace education, in-service sessions or skills workshops
- Undertaking undergraduate or postgraduate studies which are of relevance to the context of practice
- Presenting at or attending conferences, lectures, seminars or professional meetings
- Conducting or contributing to research
- Undertaking relevant online or distance education

The description of active learning also identifies the need to incorporate a process of reflection, identification of learning need, strategies and evaluation of the learning activity. The Nursing and Midwifery Board of Australia selects a random number of nurses and midwives to audit CPD activity annually.

Undergraduate skill and knowledge development is widely regarded as the beginning of learning that continues during professional life. The need for CPD as part of lifelong learning in the health care professions including nursing has been recognized internationally as a strategy to improve healthcare outcomes (DeSilets & Dickerson, 2008; Gallagher, 2007). The emphasis on responsive and evidence-based practice drives the necessity for all health care professionals to continue their learning beyond attainment of undergraduate qualifications. The impact of rapid technological change and the development and revision of nursing knowledge requires continual updating by nurses. This then allows nurses to assume the professional responsibility for the service they deliver to patients and the community (Royal College of Nursing Australia, 2012b). Continuing Professional Development in nursing is centrally concerned with reflection on practice, learning and the translation of this knowledge by the nurse in the practice context (Nursing and Midwifery Board of Australia, 2010b).

The need to undertake CPD is an implicit professional obligation for individual nurses. The implicit obligation for CPD to be a part of the professional life of nurses is now sustained by the explicit requirements of the regulatory body for twenty hours CPD to meet practice standards that are fundamental to registration. Previously the individual state and territory regulatory bodies in Australia had adopted differing requirements for nurses' involvement with CPD. The new specified mandatory requirements were a significant change for nurses in Victoria. The decision in Australia to embed the prerequisite for CPD as a regulatory requirement reflects the belief that training, education and learning influences practice.

In each health service there are training requirements for all employees to ensure compliance with regulatory and legislative standards. These usually include training for fire and emergency management, occupational health and safety and codes of conduct. Nurses and midwives have additional clinical training requirements that are established to ensure patient safety and may include topics such as basic life support and medication safety. These organisational training requirements can be included in the calculation of the twenty hours CPD, if it is relevant to the context in

which nurses or midwives practise and involves active learning (Nursing and Midwifery Board of Australia, 2010b).

At the time of the study, financial support from employers for nurses undertaking CPD varied between health services and in the amount offered. In some situations this resulted in limited financial support being available from health services for nurses to complete CPD. There are a number of government and independently funded scholarships that are focused on assisting rural and remote nurses to attend CPD and enrol in post-graduate courses. Nurses are required to individually seek out and apply for these scholarships. Usually, nurses are required to pay for the costs associated with undertaking or attending CPD themselves with an opportunity to claim these costs as part of their self-education expenditure in their taxation return each year.

In Victoria, there is an employment award entitlement for nurses in the public sector to have paid study leave to attend CPD. At the time of the study this was five days for full-time employees and two days for part time employees. New award conditions have been implemented since the completion of the study which will be outlined in the discussion in Chapter Six. The granting of leave is at the discretion of management, as this usually means replacing clinical nurses on the work roster. In rural areas there are often nursing workforce shortages which can impact on the ability of organisations to release staff to attend CPD. The granting of study leave to attend CPD is therefore not guaranteed for nurses in any setting, but may be more difficult where there are fewer opportunities to replace staff.

In recognition of the importance of lifelong learning for nurses, the Victorian Department of Health has provided funding to support subsidised Continuing Nurse and Midwife Education (CNME) programs across the state. In rural areas this is sometimes managed through regional consortia, which allow more local access to CPD at a minimal cost to participants. In the Grampians region this has become known as ‘The Highway Model’.

1.1.2 Rural practice settings

The type of health services and the delivery of these services in rural and regional areas are quite different from metropolitan areas. Not only is there a difference in the physical infrastructure of the health services but there are variances in the type and level of care that can be provided and the human health care resources available (Hegney, McCarthy, & Pearson, 1999).

In Australia, there have been predictions of workforce shortages within all areas of health care (Health Workforce Australia, 2012) that have driven considerations as to how the future workforce in health might be structured (Duckett, 2005; Karmel & Blomberg, 2009; Productivity Commission, 2005). The predicted and actual reality of the national and international nursing/midwifery workforce shortage across all practice areas continues to impact on the way health care is delivered now and will do so into the future (Department of Human Services, 2004). The projections for workforce shortage in rural and remote areas[1] have been seen as more significant than those in regional and metropolitan areas (Productivity Commission, 2005). The problem of recruitment and retention is magnified in rural and remote areas because they lack the attractions of major educational and health care infrastructure. In reality, the education, work and lifestyle opportunities may be more limited in rural areas. The healthcare workforce shortages are seen across the spectrum of general and specialist medical practitioners, nursing, midwifery and allied health professions in rural and regional areas. The need for rural general practitioners has been well publicised but the need to meet deficits in other health professions is less well known. The distribution of nurses and midwives across Australia is variable with the data identifying that the supply in rural and regional areas remains the lowest per head of population (Australian Institute of Health and

[1] The definition of rural is based on the Rural, Remote and Metropolitan Areas index (Australian Institute of Health and Welfare, 2012b). Primarily the health services included in the discussion of this paper fit within RRMA classifications R1-R3 being between populations of less than 10,000 up to 99,000. All RRMA classifications are created using 'distance factors' related to urban centres containing a population of 10,000 persons or more, plus a factor called 'personal distance'. Personal distance relates to population density and indicates the 'remoteness' or average distance of residents from one another.

Welfare, 2012a). These shortages in all disciplines have required the development of new roles and extensions to the scope of practice for nurses (Kenny, 2009).

In smaller rural health care settings the roles of nurses can be quite different from those in larger settings, often requiring them to multi-task; caring for general medical, rehabilitation and paediatric patients as well as postnatal women, within the same work area. The role of many nurses in small rural health services has become that of the "specialist generalist" (Hegney, 1996). As described by Hegney et al. (1999), these nurses operate in advanced practice roles, are often left after-hours with no on-site medical coverage and are responsible for making advanced assessments and the decision of when to call for assistance. The need for a broader range of knowledge and skills may be greater than for nurses in major centres (Hegney, et al., 1999). There have been concerted efforts in Victoria by the Department of Health to introduce new roles for rural nurses with an extended scope of practice who work in collaborative models to meet rural health needs.

These include Nurse Practitioners and the newer model of the Rural and Isolated Practice Registered Nurse (RIPRN), who use advanced practice skills that include being able to prescribe and dispense medications from an agreed formulary (Department of Health Victoria, 2009). The need for continuing education and learning opportunities to support and advance the practice, ensure sustainability and enhance the professional recognition of nurses in these new and expanded roles has been little understood or recognised amid the enthusiasm for initiating the new positions. Ensuring access to appropriate educational and training opportunities in rural areas is essential (Department of Education Science and Training, 2001; Francis, Lindsay, & Malko, 2001). Continuing Professional Development has been identified by the regulatory authority (NMBA) and the national and Victorian Departments of Health as an integral component in preparing and sustaining the workforce to meet the particular health care needs of their community.

1.2 The Problem Statement

The everyday reality of the role of CPD in the professional lives of nurses is unknown. Importantly, the effectiveness of CPD in achieving the intended outcomes as stated by the NMBA's definition has not been explored. Specifically there is little understanding of the effectiveness of CPD in meeting the intended objective of competence to practice or the influence it may have in the professional lives of nurses.

Nurse regulatory authorities, both within Australia and internationally, have for many years included requirements for CPD to assist with the maintenance and growth of competence and capability of nurses. In Australia, CPD is embedded in the national continuing competence framework, but the relationship of CPD and nurses' practice is not well understood or described (James & Francis, 2011). This need for analysis of the relationship of CPD with practice has also been reiterated in the international literature (Draper & Clark, 2007; Hegney, et al., 2010; Webster-Wright, 2009). Discussion about the need, advantages and disadvantages of making CPD mandatory in Australia has been occurring since the 1990's with commentary from the Royal College of Nursing Australia (Hamilton, 1996) and the Nurses Board of Victoria in 2006. This discussion continues and calls for further clarification of the utility and value of mandatory requirements for CPD (James & Francis, 2011). The regulation and mandatory nature for twenty hours of CPD is a recent situation in Australia, which may influence attitudes and approaches of nurses in engagement with CPD.

The expanded scope of practice of rural nurses results in the heightened importance of CPD in assisting them to maintain competence to practice and develop the professional qualities and attributes required (Hegney, et al., 2010). The use, access and support for CPD in rural and regional areas are critical factors in the experience of nurses from these settings. This results in an additional overlay to the discussions about the influence of CPD in the professional lives of these nurses.

The critical evaluation of assumptions about CPD and the experience of how professionals learn in their practice setting is lacking (Webster-Wright, 2009). Given the national approach to mandatory CPD requirements has been introduced since July 2010, it is timely for this study to reflect on how these standards might influence the experience of the role of CPD in the professional lives of 'on the floor' clinical nurses in rural and regional areas.

The rationale for the study was established through my observation that as Australia has moved towards mandatory requirements for CPD as part of the registration process for nurses and midwives, there is little understanding of the relationship of CPD activity, its effectiveness and how it influences nurses' professional lives. My position as the Director of Nursing and Midwifery Education of a large regional health service that includes responsibility for the coordination of the regional Continuing Nurse & Midwife Education (CNME) program provides an opportunity to observe nursing practice and education.

1.3 The Aim of the Study

The aim of this study is to explore nurses' experience and understanding of the relationship between CPD and areas of their professional lives and practice with particular attention to the rural and regional setting. The primary intended outcome from the study is to provide a foundational understanding of the role of CPD in nurses' professional lives which can be used by policy makers, educators, employers and nurses to better tailor CPD to increase its effectiveness in improving competence to practice and professional development of nurses in regional and rural settings. The study will entail critically reviewing some of the assumptions and expectations of CPD by focusing on the personal perspectives of individual nurses. It will include an exploration of:

- How and why nurses engage in CPD
- What CPD offers to nurses
- The types of CPD used
- Factors that may enable or hinder CPD
- The relationship of CPD to learning and practice

- The impact of the rural and regional healthcare context.

These aspects will be explored to reach the study aim by use of individual semi-structured discussions with clinical nurses in the Grampians Region of Victoria, Australia.

This study provides an opportunity to learn of the experiences of nurses in rural and regional contexts which may also provide insights that are of value to nurses in many other contexts. It is inherently understood that CPD will be influential in ensuring competence to practice and that it will provide nurses with the understanding and skills to enhance patient care (Draper & Clark, 2007; International Council of Nurses, 2006; James & Francis, 2011). Having previously been seen as a professional responsibility of nurses, there is an underlying tension that exists now that CPD has become a mandated requirement for nurses to demonstrate continuing competence.

There is considerable effort and cost associated with provision and access to CPD (Draper & Clark, 2007). Nurses need to maintain their clinical knowledge to remain up to date with contemporary practice once they have graduated. The challenge in rural and regional areas is to access these educational opportunities in a timely and cost effective way (Department of Education Science and Training, 2001; Hegney, et al., 2010). This study will assist the nursing profession to establish some understanding of how the investment of time and effort in CPD may influence and enhance clinical practice (Furze & Pearcey, 1999; James & Francis, 2011).

The outcomes expected of CPD as described by the Nursing and Midwifery Board of Australia include enhancing understanding, building nurses' personal and professional capabilities and providing opportunities for practice development. The findings from this study will provide a basis for consideration of issues that may augment the development of praxis in the nursing profession that in turn may enhance patient care and outcomes.

1.4 Introduction to Theoretical Framework and Methodology

In this study I have used theory and theoretical frameworks as outlined by Miles and Huberman (1994, p17) who contend that theory has a critical role in qualitative research to orient the researcher to the topic and research approach with “some rudimentary conceptual framework". This conceptual framework is made from the theories and experiences the researcher brings to and draws upon in envisaging the study from the very beginning. It has influenced how I think about the problem, investigate the literature, enter the field, go about recording observations, conducting interviews and writing up research. It has a role in framing and conducting almost every aspect of the study. There is an understanding of the domain of enquiry and familiarity with a range of literature that may be relevant to the general area of investigation (Gherardi & Turner, 2002).

In this investigation there are associations with areas of research and literature that provide a conceptual framework. These include lifelong learning (Knowles, 1973; Walters, Borg, Mayo, & Foley, 2004), situated learning and communities of practice (Wenger, 2012) and practice development (McCormack, et al., 2009). They have informed my understanding of the milieu in which CPD and nursing practice exists so that I am attentive to the possible experiences of the participant nurses. This literature and research will be explored in detail in Chapter Two.

This study is interpretive and qualitative in nature, aimed at the discovery and exploration of the everyday experiences of individual clinical nurses. I have utilised the theoretical orientation of constructivism in this study by adopting the perspective of interpretive or hermeneutic phenomenology. The study is not seeking findings that can be generalized across all nurses and contexts, rather valuing the diversity and uniqueness of each experience in the context for each nurse. By engaging in dialogue with nurses who work in clinical practice, I have provided an opportunity for their voices to be heard and to describe their everyday experiences of CPD. It was therefore important that I did not pre-empt the process of discovery by establishing a narrow focus of enquiry, based on my own preconceptions. This approach may not have allowed me to be open and inquiring of participants’ particular experience. Observations made in the literature and my personal

experience suggested the exploration of the assumptions and process of learning with CPD activities, its application to practice and influence on the professional lives of the participant nurses. The qualitative nature of the study does not encourage the development of pre-conceived concrete research questions. Instead, there were three open ended areas of enquiry which underpinned my study.

- What might the nurses tell me about how and why they go about their CPD activity?
- What kind of outcomes from their CPD activity can the nurses describe to me?
- What types of enablers and barriers to CPD might nurses tell me about?

Ten nurses in clinical practice from a range of different backgrounds and organisations across the Victorian Department of Health, Grampians region were included in the study following their provision of background information of their experiences of CPD in their professional lives and practice. The Grampians region covers an area of 47,980 square kilometres. Individual semi-structured discussions were undertaken in each nurse's local environment. The research design is further detailed in Chapter Three.

1.5 Thesis Overview

This thesis comprises six chapters. In the first chapter I have provided an introduction to the study by describing the research problem and the purpose with a background to CPD and rural and regional nursing practice. It touched on the place of CPD with lifelong learning, the nature of nursing clinical practice and the underlying unstated expectation that practice is influenced by CPD activity. The significance and justification for the study and research questions were then identified with a brief overview of the study design.

In Chapter Two I have reviewed the literature that relates to the relationship of CPD to clinical practice. These are explored through groupings such as an overview of CPD and learning, rural nursing clinical practice, change in the health care setting and the way nursing practice is developed.

Within Chapter Three I have examined the methodology of this qualitative study design exploring the rationale for choice of an interpretive hermeneutic phenomenological approach. The ethical considerations included in the study are followed by a description and justification for the use of the method and techniques to ensure the experiences of nurses were appropriately identified and heard.

In Chapter Four I have given details of the demographics of the participants and provided an insight to their individual experiences of CPD in their professional life and practice within their context. In the following Chapter Five the findings and broad themes identified from the data analysis are presented. Particular attention has been given to ensure the voices and meanings of participants are captured by way of inclusion of a range of exemplars extracted from discussion transcripts.

Finally, in Chapter Six I have provided a more detailed discussion of the study findings in relationship to the existing literature and stated aims of CPD by the NMBA. I have outlined the considerations from the study findings and potential applications for nursing and healthcare with particular reference to rural and regional centres. Based on the findings of this study, this last chapter offers a series of recommendations for consideration.

1.6 Conclusion

Within this study I explore the reality of clinical nurses' experience of CPD in their professional lives and practice in their rural or regional workplace. Continuing Professional Development is a pivotal component in the drive to ensure continuing competence in nursing practice but there is little or no understanding of its relationship and ability to actually achieve the desired outcomes. In this first chapter, I have outlined the research problem together with the aims of the study and the research approach chosen. The following chapter presents background literature associated with the development of this study.

Chapter 2: Literature Review

2.1 Introduction

In this chapter I have presented the relevant literature relating to Continuing Professional Development (CPD), its place in nursing internationally, in the Australian setting and its relevance to the learning and practice of nurses. An initial review of the literature was undertaken to orient me to the research context. I identified that there were no studies that particularly explored the way in which CPD was incorporated into the everyday professional lives of clinical nurses. To ensure consistency with the phenomenological approach to the study, a more complete exploration of the literature was undertaken after completion of the data collection process. This made certain that I had focussed on the voices and experiences of the nurses and was not unduly influenced by the findings of others. In this literature review I have grouped the discussion around the topics of CPD, learning, the rural setting and change in the health care setting.

2.2 Literature

An understanding of CPD in the nursing profession is confounded by the many terms used that relate to the education of nurses after gaining their professional qualifications. There is extensive literature that uses terms such as Continuous Professional Development (CPD), Continuous Professional Education (CPE), Continuing Education (CE), Continuous Professional Learning (CPL) or lifelong learning, but there is little consensus about the definitions of these terms (Gallagher, 2007; Hegney, et al., 2010). The lack of clarity is acknowledged by Gallagher (2007) who suggests in her conceptual analysis of continuing education that the understanding of what is meant by these terms in the nursing profession is variable and confusing, often resulting in the substitution of associated terms. She advises that our understanding of these terms is undergoing progressive change through time and the context from which the topic is viewed. The essence of confusion appears to relate to the type of learning activities that are encompassed by each of these terms. Continuing Education, CPE and in some literature CPD seem to relate to formalised education courses and programs. While CPL and lifelong learning are

inclusive of other learning approaches as well as the courses and programs (Gopee, 2005). It is clear that there is a good deal of literature that explores professional development in nursing, (Bahn, 2007; Furze & Pearcey, 1999; Gould, Drey, & Berridge, 2007), although relatively little that relates to the Australian or the rural Australian experience (Hegney, et al., 2010).

In this study, the description of CPD is grounded by that of the Nursing and Midwifery Board of Australia (NMBA) which adopted the definition of CPD from the Australian Nursing and Midwifery Council (Nursing and Midwifery Board of Australia, 2010a). As previously presented in Chapter One, it is described by the NMBA as part of the annual process required of each nurse to confirm their competence to practise. This definition clearly identifies the cyclical nature of review of professional practice and the use of a variety of learning strategies to meet identified learning needs. These learning strategies that are labelled as 'active learning' by the NMBA not only include structured education programs but explicitly name other activities such as journal reading, clinical review and mentoring of other nurses. This appears to differentiate the understanding of CPD in the contemporary Australian setting from that described in other contexts in the literature which largely focus on structured education courses and programs. The description also incorporates the dimension of time over the professional life of the nurse and resonates with many of the concepts of lifelong learning. These shared concepts include the development of both personal and professional qualities through incorporating a range of learning activities other than only structured educational programs.

To better appreciate how CPD and lifelong learning may provide a theoretical framework for nurses, it requires that there is an understanding of how these concepts may correlate. Lifelong learning is described as being inclusive learning undertaken in formal education settings and also in unstructured, informal situations (Walters, et al., 2004). It has been identified by the Organisation for Economic Co-operation and Development as an important strategy in enabling populations and individuals to reach their potential from preschool to adulthood (Organisation for Economic Co-operation and Development, 2012). Lifelong learning is a recurrent theme within the nursing/midwifery workforce and has close associations with adult

learning and self-directed learning (Burns, 2002; Knowles, 1973). Lifelong learning in nursing is described by McCormack (2006) as a continuous process of updating that enables the individual to meet the changing needs of their practice and underpins both formal post-graduate courses and other CPD activity (McCormack, 2006). The relationship of CPD with lifelong learning has also been examined by Gopee (2001) by exploring the perceptions of nurses towards lifelong learning in the United Kingdom. He suggests that lifelong learning is an overarching concept and that CPD is a strategy within this broader goal. Ryan (2003) holds an alternative but aligned view that CPD exists along a continuum of lifelong learning and that the type of CPD sought is a product of the motivation of the individual nurse and the organisational needs. In the discussion of CPD by Ryan and Gopee, the types of learning activity discussed were structured courses or programs.

In the Australian setting, lifelong learning has been included in the discourse of the profession, often in regard to nursing education, maintenance of competence to practise and CPD. The 'National review of nursing education 2002: Our duty of care' document (Heath, 2002) provided recommendations that clearly identified lifelong learning as a concept that should underpin the professional development of the nursing workforce. This was reiterated by the National Nursing and Nursing Education Taskforce that was commissioned to address the recommendations made in the report. The recent Australian literature that discusses nursing CPD has chosen to either use lifelong learning and CPD interchangeably or in the case of Francis and James (2011) to refer to CPD as a concept that incorporates lifelong learning. Hegney et al. (2010) acknowledge the nuances in meanings of the many terms used and chose not to differentiate between the terms of lifelong learning and CPD, instead opting to use the term Continuing Professional Education in their study of access and support for CPE for Queensland nurses. The Royal College of Nursing Australia (now known as the Australian College of Nursing) has for many years embraced the concept of lifelong learning with the establishment of their lifelong learning program (3LP) that offers a credentialing facility for education providers and a voluntary point based accrual system for nurses. The understanding of CPD as part of lifelong

learning is reinforced in their recent background information and position statement on CPD (Royal College of Nursing Australia, 2012b).

Few studies investigate CPD from the perspective of the nurse. Gould, Drey and Berridge (2007) highlight that previous studies investigating the provision of learning to nurses had been undertaken mainly from the perspectives of managers and education providers, omitting exploration of nurses' experiences of CPD. Hegney et al. (2010) also reiterate the need to focus on the learner in the process of learning from CPD. Additionally, Hegney et al. (2010) identify the need for education providers to foster nurses' critical evaluation of the educational material and evidence that is presented.

The place of reflection in the processes required for engaging in CPD are noted by the NMBA (2010b) in the cycle of CPD using the terms 'reviewing practice' and 'reflecting on the value of those [CPD] activities'. This is underpinned by the International Council of Nurses recommendations for ensuring competence to practice through a process of reflection on practice, to identify learning needs (International Council of Nurses, 2006) and is embedded in the Australian national competency standards for the Registered Nurse in the domain of 'critical thinking and analysis' (Australian Nursing Midwifery Council, 2006). Schön (2009) describes reflective practice as the capacity to reflect on action and reflect during action in order to engage in a process of continuous learning. He suggests this is a defining characteristic of a profession. Little exploration of how reflection is used by nurses in the CPD process is evident in the literature, although a recent publication from Howatson-Jones (2012) begins to explore the way nurses' learn and the place of reflection in this process. It builds on earlier work where she identifies ways to enhance reflective processes in the attainment of lifelong learning and meeting the UK regulatory requirements for CPD (Howatson-Jones, 2003). The place of reflection in the learning process and its application to professional development is explored at length in the work of Moon (2006), who has developed a map of learning that provides descriptions of the stages, approaches and best representations of learning. The approaches to learning are described as being surface learning and deep learning and are based on studies of students' approaches to learning. Surface

learning is described as being the approach used by the learner to recall facts in order to meet short term needs while deep learning is concerned with developing a more complete understanding of concepts. The place of reflection in these processes is linked to the use of critical thinking skills and is primarily associated with deep learning.

Nurses' learning and professional growth can be an outcome of the interaction and guidance from nursing and interdisciplinary peers in the practice setting. The interrelationship between CPD and this kind of experiential learning for nursing is not specifically focussed upon in the literature. However, a related study of the nurses' experiences of CPD in the UK, Gould et al. (2007) reported a call for a return to more 'work-based learning' with an emphasis on clinical training rather than a plethora of courses. This identification that no one style of CPD suits all nurses, led to their suggestion that there should be a mix of CPD strategies utilised. Davis and Hase (2001) describe workplace learning as learning that equips the learner to manage in the complex reality of their life and in relation to their organisational systems and environment (Hase & Kenyon, 2001). They suggest it can be in the form of intentional and focused workplace learning, but may also occur in the milieu of the everyday working life. Such incidental learning is thought to most readily occur when the individual undertakes reflexive processes within their activities. They propose that the development of this reflective attitude enables the ongoing learning process to continue even without a formalised plan or structure. The use of reflection in practice is recommended for nurses in their processes of identifying and completing CPD activities (Australian Nursing Midwifery Council, 2009).

The place of experience in the learning of adults is outlined in the work of Kolb (1984) with his model describing learning styles and the Experiential Learning Theory. Lave and Wenger (1991) further expand on some of Kolb's theories and describe situated learning as a social theory and model of learning that occurs in the context of a community of practice, advocating that knowledge is created from the interaction of the learner and others within a social setting. Developed in the context of apprenticeship-based learning, Lave and Wenger (Lave & Wenger, 1991) suggests that the components of social learning theory that include practice,

community and identity come together in the context of a Community of Practice (CoP). Communities of Practice are described by Wenger (2012, p. 1) as "... groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly." There are three main elements which Wenger describes as being necessary to define a Community of Practice as opposed to any other type of community. These CoP have a *domain* of interest in which knowledge and expertise are developed and shared by members and there is a *community* where the relationships that exist enable members to learn from each other. Lastly, members are involved in *practice* and collectively develop a range of strategies and resources that enable them to address recurring situations. Whilst the concept of CoP has great appeal for embedding learning in the practice setting for nurses, Wenger's model has been largely used in the business or construction setting with some utilisation in education. More recent applications in the health care clinical setting are emerging in the literature and have some relevance for the nursing clinical perspective.

Andrew, Tolson and Ferguson (2008) examine the place of CoP in nursing within the context of higher education and its interaction with nurses in the practice setting to develop a professional and educational network. They highlight some of the deficiencies of Wegner's model and the mismatch with the nature of nursing practice, stating that CoP may be a simplistic and unrealistic solution to a more complex situation of explaining how nurses learn in the practice setting. Le May (2009) suggests that CoP can be an ideal mechanism for bringing people together to develop best practice, implement new knowledge and adapt old knowledge to practice, but he also countenances caution. He acknowledges the potential for the development of social, professional and patient capital through the use of CoP, but he suggests the lack of quantifiable evidence of effectiveness on patient outcomes leaves the model vulnerable in the health care world of fiscal scrutiny.

Gobbi (2009) in writing of how nurses learn in the workplace community suggests that while many aspects of Lave and Wenger's (1991) model of situated learning can be applied to nurses in CoP, they do not expand the understanding of how other health professionals, patients and carers might influence the development of nursing

practice. Gobbi describes the driver for learning in the practice setting as the need to find the best outcome for the patient. She asks if this clinical questioning in the practice setting would constitute a temporary CoP or whether it is actually more likely to be a pragmatic process of communal learning from questioning. Gobbi differentiates between CoP and teams, which are prescribed by the organisation and are given goals external to their group and CoP, which form around practice and are guided by those within the group. This differentiation is helpful when clarifying potential roles for CoP, but does leave some unanswered questions about making the most from such structures and if indeed there can be informal CoP.

Boud and Middleton (2003) also suggest that the concepts of Wenger are less helpful when describing the informal learning which is often invisible and not valued in an organisation. The place of informal CoP in the professional lives of nurses is not evident in the literature, which largely relates to highly structured and intentional mechanisms. In Australia and internationally, there are good examples of these kinds of CoP in healthcare professional specialities where they collaborate, communicate and co-construct new knowledge in their domain. In Australia and particularly rural Victoria, evidence of this practice is not apparent in the current literature.

Whilst not based in the healthcare environment, Knapper (2001) and Kirby, Knapper, Carty & Gadula (2003) describe the existence of a different orientation to learning in the workplace as opposed to learning in the classroom. They suggest that work-based learning is often required to equip the worker with procedural knowledge that is balanced by the need for production, while classroom learning is more de-contextualised, and individual in nature. The study by Kirby et al. (2003) revealed key factors that affected workplace learning including good supervision where managers encouraged independent learning, creativity, workload and choice. In these situations independence reflected the ability of workers to organise their work including the necessary learning. These studies provide a perspective of how the organisational climate may influence learning.

The influence and role of organisational culture in the process of learning and change is relevant to the discussion about CPD. Deal and Kennedy (2000) suggest that the culture of an organisation is shaped by its adoption of incremental and fundamental changes, reorganising its priorities and values. Shared values build a strong and effective organisational culture and it is imperative that these values reflect any changes that occur. When organisational culture is strong they suggest this can be a significant barrier to change. This is reiterated by Manley, Sanders, Cardiff and Webster (2011) and also McCormack, Manley and Titchen (2013) who describe the accepted norms of a strong culture in the workplace mean that they are rarely challenged unless the workplace is examined from a detached perspective. Manley, Solomon and Jackson, writing about effective workplace culture in McCormack et al. (2013) identify that an understanding of the power of workplace culture to influence good and poor care can enable the growth and development of attributes of effective workplace cultures that deliver patient-centred care. In healthcare, the relationship between performance, organisational culture and culture change has been identified as being an untested assumption by some researchers (Scott, Mannion, Davies, & Marshall, 2003). Garside (1998), relates models of organisational development and change management theory to the pursuit of quality improvement in health care, concluding that there are three essential elements to successful change. These include ensuring change is driven by a shared vision; there is an organisational culture receptive to change and there is a focus on processes for the implementation of the change. Garside states (1998, p. 12) “Change does not happen because someone has a vision, it happens when there is a vision and the change is managed in a receptive culture”.

Outside of healthcare, there is a range of literature that touches on organisational change and learning. Learning for change is an approach that has been used for the Asia Development Bank, identifying the place of the learning organisation in adaptation to and innovation for change in order to increase effectiveness and functionality (Serrat, 2009). Originally derived from the works of Schön (1973) and Argyris and Schön (1978) and more latterly Senge (1990), learning for change explores the relationship of an organisation’s culture in relation to learning and its

ability to adapt to change. Learning organisations are described as having the elements required to reflect and identify areas of inquiry that arise from their environment, provide ongoing learning opportunities, use learning to reach their goals and embrace the creative tensions as a positive force. In the education setting, Fullan (2008) builds on the understandings of change and organisations by focussing on the people involved in change when he describes six secrets to change: love your employees; connect peers with purpose; capacity building prevails; learning is the work; transparency rules and systems learn. Fullan (2008) contends it is often difficult to grasp the entirety of the information that can assist in the change management process.

In further exploring the nurse's experience of CPD it has been suggested that an understanding of motivation may provide insight to the outcomes of CPD or CPE (Barriball & While, 1996). Barriball and While propose that without learner motivation to engage in CPE, it is unlikely that improvements in patient care, changes in knowledge or personal and professional growth will occur. Writing in an Australian context, Hegney et al. (2010) highlighted the role of motivation in engagement with CPE and its potential for effectiveness in outcomes. In a review of motivational theory that underpins engagement with CPD for health professionals, Ryan (2003) emphasizes that inherently, the motivation and initiation of self-directed CPD involves the individual who may be promoted and encouraged by the health service. However, a large element of the decision making around the undertaking of self-directed CPD rests with the nurse.

As adult learners, intrinsic rather than extrinsic motivations are suggested by Burns (2002) to best promote engagement in lifelong learning. This is informed by the early work of Vallerand et al. (1992, p. 1007) whose study of motivation in education, described intrinsic motivation as doing an activity for itself because it provides satisfaction in participation and has strong links to the individual needs for competence and self-determination. They suggest the behaviour which provides satisfaction of these needs will be repeated frequently (Vallerand, et al., 1992). Extrinsic motivation relates to a wide variety of behaviours which are engaged in as a means to an end. The attainment of the reward, whether monetary or other types, is

seen as the goal rather than the challenge of achievement. A third construct of motivation has been described by Vallerand et al. (1992, p. 1007) as amotivation, where individuals fail to see the associations between outcomes and their own actions. Such individuals are neither intrinsically or extrinsically motivated but have feelings of incompetence and expectations of uncontrollability, seeing their behaviours as determined by others (Vallerand, et al., 1992, p. 1007). Their study was focussed in a structured education setting in France, which may pose limitations on the application to the healthcare setting and CPD. It does however; provide some clarification of the motivational forces for those who do not choose to willingly engage in education.

Furze and Pearcey (1999) in their literature review of CPE in the UK identified that the motivational and enabling factors which surround nurses engaging in CPE activities may be varied but largely focused on increasing competence and the professionalization of nursing. Bahn (2007) identified the motivations of different levels of nurses in undertaking CPD in her study in the United Kingdom. She found that the nurses who did not have higher education qualifications were prompted to up skill in order to not be left behind and to provide enhanced patient care. Gould et al. (2007) reviewed nurses' engagement with CPD across three National Health Services trusts in the UK by way of survey, finding that personal motivation to access CPD was either enhanced or dampened by the actions of managers. In their study, nurses were clear that CPD was important in maintaining patient safety, improving service provision and promoting career and personal progression. The opportunity to access CPD was also seen to promote the perception of their individual value and was a motivating factor for their retention in the workforce.

External motivation for undertaking CPD may be applied by the requirements of employing organisations and nurse regulatory authorities. A number of studies noted that requirements or expectations of employers were not always well matched with the CPD/CPE aspirations of the nurse (Bahn, 2007; Munro, 2008). This may be a result of organisations determining education needs to meet service delivery requirements or inconsistent person dependent management strategies. Nursing and midwifery regulatory authorities throughout the various states and territories of

Australia have for many years required nurses to adhere to the principles of lifelong learning (Australian Nursing Midwifery Council, 2009) with participation in CPD linked to competence to practise (Queensland Nursing Council, 2001).

The effectiveness of making CPD mandatory and its relationship with enhancing professional practice has been questioned in Australia and internationally (Smith, 2004). Prior to the introduction of mandatory CPD in Australia in 2010, the Australian Nursing Federation, the previous Nurses Board of Victoria and other international studies have argued against it, stating concerns that the mandatory requirement is opposed to the principles of adult learning and that benefits to patient outcomes are untested (Australian Nursing Federation (Victoria), 2006; Eustace, 2001; James & Francis, 2011). On the other hand there was acknowledgement that there were a number of potential benefits of mandatory CPD for the profession of nursing and the public (James & Francis, 2011). The tension that is created between the regulated requirements and the desire to enrich one's professional practice by way of lifelong learning and CPD is often unstated but potentially influential on practice in the workplace. Most of the literature that explores motivation and CPD involves participants who have been active in pursing their CPD. There may well be different perspectives to be investigated with the cohort who do not actively engage in CPD or CPE. Furze and Pearcy (1999) suggest capturing the experiences of these nurses can be challenging and suggest that around 25 to 35% of members of a profession are 'laggards' who have fixed ideas, deteriorated skills and do not regularly engage in CPE and that making CPE mandatory is designed to focus on these 'laggards'. Barriball and While (1996) also noted that older nurses tended to be less likely to attend CPE regularly in their study in the UK.

Ensuring competence to practise is a fundamental principle clearly articulated by the International Council of Nurses (ICN) to ensure public safety. The role of professional development in achieving competence to practise is clearly articulated by the ICN (2006) and the Australian definition of CPD (Australian Nursing Midwifery Council, 2009). CPD is increasingly being utilised by regulatory authorities of the nursing profession as an indicator of competence to practise that is embedded in codes of conduct and in some cases as an integral part of the requirements for registration

(Furze & Pearcey, 1999; Gallagher, 2007; Nursing and Midwifery Board of Australia, 2010a).

Investigation to date has found limited evidence of how effective CPE or CPD is in enhancing patient care and outcomes. Some studies have explored the most effective delivery of CPD on medical clinical practice (Davis, et al., 1999). They have shown that physician performance and practice change was enhanced by the delivery of Continuing Medical Education (CME) by interactive formats instead of didactic delivery approaches. A more recent systematic review by the Cochrane Collaboration (Forsetlund, et al., 2009) of eighty one studies looking at the effect of education on medical clinical practice and health outcomes found that educational meetings did provide small improvements in professional practice and patient outcomes irrespective of whether they were delivered as stand alone or combined with other interventions. Where the sessions were mixed didactic and interactive with larger numbers, this showed most benefit but the improvement was less marked when clinical outcomes were more complex.

The desire to establish the evidence and enable greater understanding of the impact of CPD on patient outcomes has become increasingly evident in the literature. There are numerous calls to explore the relationship of lifelong learning, CE and CPD to the practice of health care professionals and ultimately the effect on patient care (Draper & Clark, 2007; Furze & Pearcey, 1999; Hegney, et al., 2010; James & Francis, 2011). The need for empirical evidence to establish the effectiveness of CE in practice has been made by Draper and Clark (2007) who assert that an approach is required that enables a multidimensional perspective, including a range of stakeholders, particularly capturing the narratives of the nurses involved in continuing education. DeSilets and Dickerson (2008) call for ways of exploring the issue of improving health care outcomes through lifelong learning. They suggest a range of initiatives that are relevant to consider for nursing CE that include the development of structured evaluation processes of continuing education utilising new ways of measuring outcomes. They recommended the new measurement criteria should include patient outcomes, the transfer of learning to practice and the move away from lecture based education formats. In Australia, Hegney et al. (2010)

contend that the discussion of the effectiveness of CPE requires three areas to be explored; the place of the learner in the process of CPE, the critical evaluation of the evidence being presented and the impact on improved patient care of the CPE activity.

A common element that is notable within most of the literature is the reference to Continuing Education (CE), or Continuing Professional Education (CPE) that is occurring outside of the practice environment utilising structured education formats. This is not the only approach to CPD that is espoused by the Nursing and Midwifery Board of Australia who advocate a range of learning activities should be included. Over the past ten years a body of work that describes the nature and processes of Practice Development (PD) in nursing has grown. Manley and McCormack (2003; Manley, et al., 2011) based in the UK, have identified the role of PD as linking professional development with the practice of nursing in delivery of patient care. Practice Development acknowledges the complexities of the workplace practice environment, the influences of assumed and acknowledged beliefs and values. They suggest there is a flow on effect to the nurturing of improved care practices and that this differs from solely improving nurses' knowledge base. Manley and McCormack (2003) further differentiate between technical and emancipatory PD. They describe technical PD as a change in processes due to the acquisition of new knowledge, while the terminology of emancipatory PD relates to a deliberate intention to affect the development and empowerment of staff and drive for cultural change (Manley & McCormack, 2003; Manley, et al., 2011; McCormack, et al., 2013). Key concepts underpinning PD include workplace culture, person-centredness, facilitation, practice context, evidence, values and approaches to active learning (McCormack, et al., 2009). The discourse around PD appears to advocate enabling learning with a goal for sustainable change and has associations with the role of CPD and practice change. Webster-Wright (2009) also suggests that we need to rethink the understanding of the role of CPD in professional practice to explore and support the understanding of how professionals learn and relate this to practice as part of a new discourse about Continuous Professional Learning (CPL).

The rural setting for health care has particular characteristics that impact on workforce attributes, the scope of practice required and the demands for education and training to appropriately equip nurses to deliver the required patient care (Pearson, 2008). This is observed internationally as well as in Australia and a significant body of work has been focused on rural nursing. It is useful to gain an understanding of the issues in rural nursing between different contexts. Bushy (2002) compares literature on rural nursing from Canada, Australia and the USA, noting that whilst direct comparisons are not always possible because of different health service delivery models, ways of measuring the burden of disease and socio-demographic differences, there are definite similarities of experience between each country. These similarities include the expanded scope of practice, recruitment and retention of staff, the connectedness of nurses and rural communities and the need for educational preparation for practice in rural areas. There is now an increasing inventory of rural nursing information that includes the Australian as well as the North American perspectives. The publication of the third edition of a book on rural nursing (Winters & Lee, 2010) has captured contemporary views of many of the issues Bushy noted and also includes an Australian perspective on the resilience of rural communities. The understanding of nursing in the rural setting in Australia over the past decade has been highlighted in a systematic review of the literature from 1996 to 2008 by Mills, Birks and Hegney (2010).

Drawing on the Australian literature, the workforce mix and scope of practice for nursing in rural areas is quite different from metropolitan areas. Hegney et al. (1999) reviewed the effect of the size of health service on the scope of rural nursing practice for Registered Nurses in a national audit of nursing activities in 1997. They identified by observation, questionnaire and interviews that the roles of nurses in smaller rural health care settings can be quite different from those in larger settings. Often the smaller health services had fewer Registered Nurses in the skill mix, relying on either Enrolled Nurses or Assistants in Nursing. This observation is supported by more recent data from a Department of Human Services study in Victoria (2004, p. 28) which identified Enrolled Nurses comprise a significantly higher proportion of the nursing workforce in non-metropolitan hospitals. This difference in health care

workforce makeup and scope of practice is to a large degree a result of workforce shortages in rural areas seen across the spectrum of general and specialist medical practitioners, nursing, midwifery and allied health (Kenny, 2009).

The resulting development of enhanced rural Registered and Enrolled nurse roles has required new processes and structures to ensure their safe implementation, requiring substantial forward planning by stakeholders. In reviewing the changing roles of Enrolled nurses in rural hospitals in Victoria there are reported significant challenges, misunderstandings and varied work satisfaction in extending their scope of practice (Hoodless & Bourke, 2009; Nankervis, Kenny, & Bish, 2008). From each of these studies it is clear that a planned change management process is required which is supported by access to affordable education to underpin the Enrolled nurses' new practices. The change in roles and scope of practice for rural nurses and midwives demand an educational underpinning for the nurses involved. This not only requires formal institutional based education as identified by these authors, but also demands clinically based support that encompasses less formalised learning opportunities in the workplace. The extension of scope of practice also requires the development of understanding and support from the other health care workers with whom they interact. The role of CPD is not identified by either author as a potential avenue that can enhance understanding, implementation and sustainability of the new Enrolled nurses' scope of practice.

The educational and training needs to equip nurses to practice in the rural environment where such diversity of practice exists is acknowledged (Francis, et al., 2001; Kenny & Duckett, 2003). Kenny et al. (2003) promote preparing nurses at undergraduate level in rural university programs to ensure that graduating nurses have a sound theoretical and practical preparation for rural practice. Unstated by Kenny and Duckett (2003) is the need of new graduates from these programs to access appropriate consolidation and developmental opportunities through CPD that are relevant to their practice context. The role of CPD and practice-based learning in assisting this consolidation and development for newly graduating and existing nurses in the rural workforce is a significant and largely omitted consideration in the literature. Francis et al. (2001) in an issues paper on 'Action on Nursing in Rural and

Remote Areas' for the National Rural Health Alliance advocate amongst other initiatives to support nurses, that post-graduate study should be designed to prepare nurses for remote and rural practice. Whilst increasing numbers of viable opportunities now exist in rural areas for online and distance education to improve access to post-graduate qualifications, there remains significant cost and time barriers for nurses who wish to undertake these studies. Most nurses currently working in rural areas still do not have these post-graduate qualifications, although new initiatives are being adopted within Victoria to meet the particular needs of rural nurses (Department of Health Victoria, 2009).

The reality of CPE for Queensland nurses was explored by Hegney et al. (2010) in their study of access to and support for CPE between 2004 to 2007. They noted that access to CPE opportunities remains problematic especially in rural areas. They identified a number of key factors that affect uptake of education opportunities including intrinsic and extrinsic motivation, distance and financial and leave support to access CPD (Hegney, et al., 2010, p. 148). The cost variances in undertaking CPE were noted to be influenced by the context in which nurses practise. Accessibility and affordability have been identified as barriers to undertaking CPE where nurses work and reside in rural areas (Department of Education Science and Training, 2001; Francis, et al., 2001; Hegney, et al., 2010; Penz, et al., 2007). Francis and Mills (2011) also highlighted the need for rural nurses to be able to access CPD to support the extensions to scope of practice and provide career development in an effort to sustain the rural nursing and midwifery workforce.

2.3 Conclusion

In this chapter I have provided an overview of the literature that gives the background to CPD in nursing within the rural and regional Australian setting. Drawing on literature outside of healthcare and from the international perspective, I have included a review of the influencing factors of motivation, organisational attributes and change. I have provided underpinning information about the definition of CPD in the international and Australian nursing contexts, the place it takes in learning and professional development for nurses and the current limited understanding of its ability to influence clinical practice. I have also touched on the

nature of nursing in rural communities and the additional overlay this can place on the experiences of CPD for nurses in the rural Australian context. In the following Chapter Three, I will outline the research approaches used in this study in order to expand understanding of nurses' experiences and begin to address some of the noted gaps in the literature.

Chapter 3: Methodology

3.1 Introduction

This chapter presents a detailed description of the qualitative study design and an explanation of the personal perspective which has guided my use of constructivism and in particular hermeneutic phenomenology as the methodological approach. I have identified the numerous ways of ensuring the ethical conduct of this qualitative study and explored the guiding principles from which these strategies were developed. This qualitative study has used the criteria of credibility, transferability, dependability and confirmability to ensure reliability and validity in the study design (Guba, 1981; Guba & Lincoln, 1982). The ways in which these criteria are incorporated are explained. The use of semi-structured individual discussions as the principal research method is introduced and justified as the most effective way of collecting data on the individual nurses' experiences of CPD in their workplace. The identification of participants and the choice of geographical region in which to undertake the study and the selection process are discussed. The limitations of this approach are identified. In the final section of this chapter, the data coding processes, data analysis strategies and data presentation approaches are described.

3.2 Theoretical framework and approaches

The personal perspective from which I have chosen to approach this study is a product of my own experiences as a nurse, educator and manager having worked in health care for many years within rural, regional and remote Australia and New Zealand. I have been challenged to examine my own beliefs about ways of knowing particularly during experiences with indigenous peoples. It has become clear to me that there is no one way of knowing about something and that there are multiple personal and individual perspectives based on social and historical experiences that will influence understanding and meaning. This aligns closely with constructivism which sees reality as being socially constructed and refers to learning as the construction of new meanings or knowledge by the learner (Piaget, 1954).

3.2.1 The healthcare setting

There are different ways of knowing, but some such as the scientific paradigm have become firmly entrenched in particular settings as being 'superior' from others (Kalantzis & Cope, 2008). Within the health professions many identify that knowledge is objective and that reality is able to be manipulated and tested to find the 'real truth'. This understanding of ontology and epistemology is based largely on the principles of the scientific or empirical traditions, where knowledge is gained by systematic observation and scientific experimentation. The resulting outcome has been the move within the clinical setting to emphasize and value evidence-based practice. This has provided a basis for the contention that knowledge can only be gained by research endeavours, ignoring the reality of learning by other means such as in the work environment. There are, however, limitations of addressing questions in the human realm within the requirements of the empirical methods (Guba & Lincoln, 1982; Laverty, 2003).

Nursing has been influenced by positivistic approaches in gaining initial clinical theoretical knowledge. In their educational preparation and the reality of the practice setting, nurses have also been exposed to other ways of thinking and learning, challenging them to examine the way they perceive and apply knowledge. The nursing profession has been influenced by naturalistic paradigms in the development of ways of discovering, describing and finding meaning in the focus of inquiries. These approaches acknowledge the situated context in which understanding is found. The resultant qualitative methodologies that have been used in nursing research have been influential in enriching the understanding of practice. The appropriateness of using constructivist and interpretive paradigms in nursing practice is supported by the profession's links with the human sciences, as nurses work with patients, families and others in the health care team.

This study of rural and regional nurses' experiences of CPD in their professional lives has been located within the overarching paradigm of constructivism. I have set out to value the individual nurses' experiences and understandings from each of their different perspectives which will assist in gaining an insight to the context of rural nursing practice and the relationship with CPD activities. This is important because

there is little understood about how nurses view or experience the linkages between CPD and practice change to improve care and patient outcomes (Gallagher, 2007; Hegney, et al., 2010).

3.2.2 Constructivism

Constructivist research seeks to give meaning to reality, enabling participants to make sense of their experience and acknowledging the varied ways human experience can influence the process (Appleton & King, 2002). It allows researchers to explore in detail the maze of interactions of human experience and how these may influence the various constructions of reality, looking for congruency in meaning but being alert to and equally valuing alternative explanations. Constructivism is based on five principles; reality and its elements, causality, unique contexts resulting in absence of generalization, the relationship between the researcher and the phenomena under study and the impact of values on the inquiry process (Appleton & King, 2002; Guba & Lincoln, 1982; Lincoln & Guba, 1985).

The constructivist view is that there are multiple, intangible realities that exist providing differing explanations of reality. It is possible to have opposing views expressed within a study given the differing experiences and power balances in each situation, providing a composite picture of different viewpoints. As a constructivist researcher, I may try and find a consensual view but I have also acknowledged and equally value those views that are divergent or conflicting, seeking the contexts and influences that may shape them. I have closely recorded and detailed the multiple realities expressed by participants and myself in order to establish the trustworthiness of the process. The concept of causality is seen as misleading and simplistic by constructivist researchers who perceive that the assembly of meaning does not occur in a lineal fashion but results from what is happening in complex social situations (Lincoln & Guba, 1985). In fact the same 'cause' may result in different constructions or meanings. As there are unique contexts in each person's situation, there is little validity in making sweeping generalizations. It is the uniqueness of these settings being studied that is particularly valued (Appleton & King, 2002). In a constructivist paradigm the study findings are very much a product of the interaction of the researcher and participant. Throughout the data collection

process there is a reciprocal interactive dialogue which influences each other, providing a mutual shaping of understanding. During the data gathering in constructivist research there is a hermeneutic data analysis process when the researcher can seek out similar or differing perspectives about discrepancies that may arise (Conroy, 2003; Koch, 1996; VanManen, 1990). Whilst other paradigms may value the detachment of the researcher, constructivism acknowledges that the values and pre knowledge of the researcher and other stakeholders will in some way influence the choice of research topic, the theoretical paradigms and methodology chosen (Appleton & King, 2002).

3.2.3 Phenomenology

Hermeneutic or interpretive phenomenology fits within a constructivist paradigm and aligns with my belief that the individual experience of nurses will help me gain an understanding about the role and influence of CPD in their professional lives and practice. It acknowledges that there are multiple situated realities in contexts, including my own as researcher, that will give meaning to the phenomenon (Young, 2008). Phenomenology is a philosophy or approach to the study of human existence that is based on the belief that reality is founded on the individual perception of objects or events. The individuality of the experience is the essence of this approach (Crotty, 1996, p. 13) and clearly places this study within a constructivist paradigm.

There are different branches of phenomenology that are quite diverse in their assumptions. Heideggerian phenomenology is also known as hermeneutic or interpretive phenomenology (Heidegger, 1962). Heidegger held a view of people and the world being related inextricably in cultural, social and historical contexts. He proposed that human existence is always interpretive and understanding is dependent on interpretation influenced by the individual's background or historicality (Laverty, 2003). It is important therefore to explore all possible interpretive influences to gain understanding.

Phenomenology becomes hermeneutical when it moves from being descriptive to being interpretive. Hermeneutics relates to interpretation of texts and was used by Heidegger as a way of moving questioningly between the parts and the whole of the

experience (Koch, 1996). As a student of Heidegger, Gadamer (1977, 2004) further developed the practical application of this type of phenomenology and its interpretation using the hermeneutic circle. He saw interpretive methods as useful in increasing levels of understanding, but robustly emphasized that these were never totally objective or value free. Gadamer did not support the notion of being able to bracket one's beliefs, given that understanding is inextricably entwined with the knower's historical, cultural and social backgrounds (Koch, 1996). The use of the hermeneutic circle process has been expanded upon to incorporate the concept of a hermeneutic spiral that is a continuous process of reflection that leads to deeper meanings and understandings of the lived experience of the phenomena under study (Conroy, 2003).

Some of the key factors in hermeneutic phenomenology rely on the dialogue between the researcher and those who are participants in the process. This requires a conversation between parties so the development of understanding can occur. This dialogue needs to be recorded as accurately as can be so that the written word text of the transcription can be used as part of the processes of gaining understanding. Koch (1995, p. 835) states;

> Hermeneutics invites participants into an ongoing conversation, but does not provide a set methodology. Understanding occurs through a fusion of horizons, which is dialectic between the pre-understandings of the research process, the interpretive framework and the sources of information.

It is important to recognise my pre-understanding and incorporate it in the developing understanding of the phenomenon of CPD in nurses' professional lives. My pre-understanding is sourced from a range of learning experiences, texts, interactions and observations. Given my current situation and involvement in nursing education and practice, I cannot be devoid of insights to this area of study. My beginning understanding and experiences of CPD and nursing practice form the basis for commencing the study and provided a valuable foundation for developing rapport and understanding with participants. I am aligned with the Heideggerian hermeneutic approach to phenomenology which acknowledges that I cannot enter

the research process and suspend or bracket my various beliefs in order to study the topic.

The use of hermeneutic phenomenology as the approach to the in-depth discussions allows me to explore the unique CPD experiences of regional and rural nurses, providing a depth and richness of information that gives insight to this research topic. The information provided by participant nurses is considered from within their contextual situation. The context of nurses' work can exert significant influence on their experiences. In rural areas, the nature and scope of practice, the access to educational opportunities and ability to implement learning in the workplace are all factors that differ for the individual nurse. It is acknowledged that these and other factors will affect the experience of each nurse in the study. The overarching constructivist paradigm allows the research question to be explored with consistent processes. It is supported by the congruent use of a hermeneutic phenomenological approach to the individual in-depth discussions, data analysis and reporting.

3.3 Ethical considerations

The ethical conduct of this study was considered throughout the research process from early planning and identification of the research problem, designing the study to the writing of the findings at the conclusion. Ethics approval was provided from the La Trobe University Faculty of Education Human Ethics Committee (FHEC: R003/11) and the Ballarat Health Services and St John of God Human Research Ethics Committee (HREC/11/8/BHSSJOG/53) before commencement of recruitment and data collection. Approval from these committees was required as a doctoral candidate undertaking research across multiple health services in the Victorian Department of Health, Grampians Region. As the study related to the experiences of clinical nurses in the health services, I established a meeting with the Grampians Region Executive Nurse Network to present the study and gain their support. Following the meeting I received letters of support or approval from nine of the twelve health services which were included with my multisite ethics application to Ballarat Health Services and St John of God Human Research Ethics Committee (BHS & SJOG HREC).

The basis for all research is to ensure that the interests of those participating in a study are not harmed as a result of research being done. The Belmont report developed a set of principles for biomedical and behavioural research involving people in the United States. The three fundamental principles of; respect for persons, beneficence (do no harm) and justice underpin all ethical processes in research today (Mertens, 2010, pp. 16-18; National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). A description of how each of these principles have been addressed and included in this study is outlined in the following sections.

3.3.1 Respect for persons

Demonstration of respect for persons was achieved by the provision of information about the study to potential participants, recognizing that a person has the right to informed consent and autonomy in decision making. Information pamphlets and posters were distributed in work areas to encourage nurses' voluntary contact to express interest in the study. Their responses to this invitation were made to me by telephone and email. This established a relationship that enabled the gathering of background information on their experiences of CPD in their professional life and practice. Subsequently, a written information sheet was emailed to them providing the study outline, their requirements and any risks or benefits if they were to participate. This was provided before confirmation of inclusion in the study and the individual face-to-face discussion. In this way any questions and further explanation could be provided before continuing on to be considered for inclusion or before providing written consent at the beginning of our discussion.

3.3.2 Beneficence

Beneficence requires that no physical or psycho social harm is caused to participants in the course of the research study. The risks and benefits of the study were clearly outlined to participants and opportunity for further information provided before their signing the formal consent. Measures to ensure confidentiality of discussions included the participant choice of the timing and location of discussions in an area where they were comfortable and secure. Pseudonyms have been used to maintain anonymity of participants in any publicly shared information. In the presentation of

reports, identifying descriptions of participants or their organisation have been replaced and noted by the use of editorial bracketing (e.g. “There is always a great deal of enthusiasm to participate in [name of organisation]’s workshops on tracheostomy care”). All data has been kept on a password protected computer and in locked storage in my office. Discussion audio recordings were transcribed by a third person and their guarantee of confidentiality was provided by completion of a confidentiality agreement prior to their involvement in the study.

3.3.3 Justice

Ensuring justice requires that the research processes are not exploitative, are fair and reasonable and provide some benefit to those who participate (Mertens, 2010, p. 12). It was unlikely that any harm or direct benefit would be encountered from participating in the study. However, as some of these nurses may not have considered the role of CPD in their professional lives, participating in the study may have required them to become more reflective of this question. This may be a secondary benefit of this study.

I have avoided potential power imbalances which could be construed as exploitative by deliberately choosing to conduct the study in a different region from where I live and work. The self-selecting nature of participation in the study also ensures there is no direct coercion from me as the researcher. Acknowledgement of and thanks for the time provided by participants has been conveyed by written correspondence and the nominal gift of a university pen, avoiding any direct inducement or exploitation.

3.4 Methods and techniques

The study design involves semi-structured in-depth discussions with ten nurses who are working in direct clinical care in rural or regional health services in the Victorian Department of Health, Grampians Region. The study is based within the constructivist perspective and incorporates interpretive phenomenological techniques to allow me to access the information rich experiences of the participant nurses. These techniques have allowed me to explore in detail the maze of interactions of nurses’ experiences and how these may influence their various constructions of reality, looking for similarity in meaning but being alert to and

equally valuing alternative explanations (Appleton & King, 2002). The experiences are varied and influenced by factors such as relationships, practice context and the individual nurse's use of reflective approaches and awareness of their own learning needs as they relate to practice. The nurses' experiences are situated in unique organisational and management environments and provide a variety of distinctive insights that alongside my own reflections provide a beginning understanding of CPD and its associations with their professional lives and practice.

Purposive selection was used to assist the identification of information-rich examples of nurses' experiences that could provide the broadest range of understanding and meanings for exploration in the study (Mertens, 2010). Participants were aware that inclusion in the study would be made on this basis. More detailed description of this process is outlined later in the chapter.

3.4.1 Identifying Participants

The study has focused on Registered and Enrolled Nurses working in publicly funded health services that provide acute clinical care. Many rural health services are focused on residential aged care and I wished to include health services that also delivered acute clinical care to explore the experiences of nurses with a diverse range of skills. I chose the Grampians region as the location of the study, it being one of five rural regions recognized by the Victorian Department of Health. It has a geographic footprint of approximately 24% of the State with twelve different sized publicly funded health services caring for 5% of the state's population (Department of Human Services, 2010a, 2010b). Geographically, the Grampians region has provided relatively easy access for the conduct of in-depth discussions and is an area where I was unknown, thus avoiding potential power imbalances and enhancing the chance of more candid responses. Participants were required to identify as primarily working in direct clinical practice as they are embedded in the reality of delivering care and nursing practice.

Whilst the Grampians region is relatively easy access for me to undertake discussions, it also provided the additional challenges of being unknown. I believed that a degree of professional courtesy was required to enter the Grampians region

and seek access to discuss with nurses in clinical practice what could be perceived as a sensitive issue for nursing management. I was aware that senior nursing management could act as professional and organisational gatekeepers. This is an important protective role but can also be used to unnecessarily impede access to potential study participants. This was the foundation for my subsequent decision to meet with senior nursing personnel of the Grampians Region Executive Nurse Network (GRENN) and also served to enhance the likelihood of engaging health services in strategies to identify potential participants (Lee, 2005). Promotion of the study commenced with emailed information sent prior to the presentation to the GRENN where I was able to personally meet and discuss the study with these members, seeking their support. The twelve organizations were a mix of size and geographical spread across the Grampians Region (see Appendix A and Table 2). Nine letters of support or approval for the study were forwarded to me for inclusion with the multi-site health service HREC application. Of those that did not engage, two did not respond to the request and one commented that nurses in that organisation would not be interested.

The opportunity to introduce the study to the Senior Nursing Management in this way also provided me with strategies and contacts for reaching potential participants once I had ethics clearance from the BHS & SJOG HREC to proceed. Each Director of Nursing from the nine participating organizations was asked to identify a key contact who would be able guide me on the most appropriate approach to reach nurses who were in direct clinical practice in their organization. A mixed approach to finding potential participants included utilizing posters, pamphlets and email information to address local variances in use of electronic and personal communication strategies. In later discussions with participants it appears that each of these approaches was used with an additional strategy of the delivery of a pamphlet to the mail box of each nurse in one level C hospital. These key contacts were also used to follow up after four weeks if no participants from their organisation had made contact. This follow up was judiciously used, recognizing the fine balance between the workloads of the contacts and my need to find participants. All were graciously accommodating and some requested further pamphlets or responded by ensuring that key areas and staff

were aware of the study. Once the participant cohort was finalized, email thanks were sent to each contact.

Responses from potential participants were made over a six week period when each respondent was asked about their background, area of practice and other aspects that could guide selection. It was explained that this was to ensure I could select a range of experiences from clinical nurses with different practice settings and backgrounds and that inclusion in the study would be made on this basis. This background information was included with data for analysis and provided me some early understanding of the nurse's experiences and the context in which they were situated.

The process of purposive selection was utilized to provide an opportunity to explore the most diverse experiences of CPD for these clinical nurses (Mertens, 2010). The background information provided by nurses enabled me to select participants with a range of attributes and experiences. I did not want for example, to attract only nurses from one particular sized health service, clinical background or years of nursing experience. I expressly sought out a variety of experiences and backgrounds. Once I had identified sufficient eligible participants that provided the range of attributes and experiences required for the study, no further participants were included (Liamputtong & Ezzy, 2005).

Of the twelve initial respondents, ten of these were invited and agreed to participate in individual in-depth discussions to explore their experiences of CPD in their professional lives and clinical practice. The two respondents who were not selected were either not in direct clinical practice or failed to respond to follow up contact via email or telephone. The ten participants worked in six different sized health services in the Grampians Department of Health Region (Table 1). There were multiple participants from two health services but each was in different areas and roles.

Table 1 Participant Nurse Demographic Information

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Dana	SRHS	RN	Community Health	24	32
Graham	SRHS	EN	Aged care	16	40
Stephanie	Major B	RN	Breast care	11	40
Julie	C	RN	Transfusion Nurse / Associate Nurse Manager Day Procedure Unit	27	28
Kathy	Major B	RN	Clinical Support Nurse	26	40
Harold	C	RN	Acute ward / Emergency	15	40
Denise	C	RN	Emergency / Acute ward	12	32
Scilla	Major B	RN	Perioperative / Clinical Educator Perioperative	11	37
Janet	C	RN/ RM	Acute ward / Midwifery	3 & 18	20
Joylene	C	RN	Infection control / Staff immunisation / Associate Nurse Manager Aged care	36	40

RN = Registered Nurse; EN = Enrolled Nurse; RM = Registered Midwife

Major B = Base Hospital and Regional health service

B = Regional health service

C = Rural health service

SRHS = Small Rural Health Service

Two of the ten participants were male, reflecting a slightly higher inclusion rate than the general make up of the Australian employed nursing workforce which sits at 9.6% (Australian Institute of Health and Welfare, 2011). One participant was an Enrolled Nurse with medication endorsement. National data identifies that 24% of employed nurses are Enrolled Nurses (Australian Institute of Health and Welfare, 2011). Given the small number of participants and the qualitative nature of this

study, recruitment did not intentionally set out to achieve a statistically representative sample.

3.4.2 Data Gathering

Within this study, data was gathered from a range of sources to provide a growing understanding of nurses' experience of CPD in their professional lives and practice. This approach ensures congruence within the study and enables me to attribute the sources of understanding accordingly (Koch, 1995). Sources included my personal perspectives identified in the reflexive researcher journal and the field notes, discussion transcripts, background information and the initial reviewed literature.

Within this qualitative study there has been an integration of data collection and analysis occurring simultaneously as a means of gaining the fullest understanding. This iterative approach provides "... an inductive method for building theory and interpretations from the perspectives of the people being studied" (Ezzy, 2002, p. 61). The entwining of data collection and analysis enabled me to build and explore interpretations and understanding as I progressed through each research stage.

Semi-structured, face-to-face discussions with participants were chosen as the most beneficial approach to enable nurses to feel comfortable to share their experiences and explore some of the issues in a safe and convenient environment for audio recording. Locations for discussions included coffee shops or meeting rooms and personal offices in the participant's workplace setting. The intention of discussion was to build on the foundation relationship established at first contact and then move on to explore their experience of CPD. This entailed three trips to the Grampians Region over a period of weeks between October and November 2011. The collection of the background information and invitations to participate in the study generally preceded the discussions by 1-5 weeks. This period of time provided an opportunity to reflect on my own expectations in relation to each nurse's information and my past experiences. It also allowed me to research some basic information about the community and health service in which they were working so I was more informed before our meeting.

Participants were forwarded information sheets and consent forms once they had been included in the study. This provided an opportunity to familiarize themselves with the intent of the study and the extent of their involvement. Before the discussion with participants commenced we reviewed the information and I provided sufficient time to answer further questions. Consent forms enabling me to audio record the discussion and reassuring that they could withdraw from the study without prejudice were signed at the first meeting. Audio recording enabled me to interact and respond freely during the discussion and ensure a true capturing of participant nurses' information. Each discussion varied between thirty five to fifty five minutes duration.

The discussion guide was used to ensure that there was some consistency within and between discussions in the general topics covered without the restriction of set questions and closing the opportunities for new and unexpected perspectives that may arise (Liamputtong & Ezzy, 2005). I was very aware of the need to capture the experiences and voice of the nurses rather than pre-empting this with a range of set questions. The discussion guide enabled me to prompt the participant to explore areas in their discussion that had not immediately come to mind. In some discussions the prompts were little used and needed, while other nurses were more reserved in their discussion or reflections and required me to prompt them to consider other areas. In all circumstances where I was unsure of the participant's experience and meaning, then I would reiterate a brief description of their discussion and ask for the participant to verify if my synopsis of their experience or meaning was accurate. Where previous participants had identified a different aspect of their experience, I would enquire about this with the next participants if it was not spontaneously included. This was done in order to gather as much information as possible about the phenomena of CPD in nurses' professional lives and the potential influencing factors. Following departure from the location of each discussion I set aside time to reflect on and document the context, key information and my recollection and perceptions of the participant's discussion forming my researcher field notes.

My reflexive journal has been maintained through all stages of the project. It forms a significant source of data on my personal thoughts as it was initiated in the planning stages of the research project, identifying decisions made about the topic and my perspectives, theoretical framework and research design. This information has been utilized in the data collection and analysis process which has been an iterative and ongoing process after each discussion. It provides part of an audit trail which clearly indentifies the details, responses and impressions gained around data collection.

In order to capture the voices of participants about their personal experiences, audio recordings were transcribed verbatim. Discussion transcripts were verified with the audio recordings by me before returning them to participants by their preferred method as had been indicated at time of discussion. I also provided a one to two page document outlining the key discussion topics that I had identified from these transcripts and our discussions. Participant nurses were invited to make additional comments or to correct my understandings if required. Nurses were contacted by phone if no response was received. Minor additional information or corrections were provided by the nurses.

3.4.3 Data Analysis

The simultaneous collection and analysis of data provides enhanced opportunities to build understanding from the perspectives of the nurses who participated in the study (Ezzy, 2002). This approach was used to ensure that opportunities for investigation were followed up as the cues were presented during discussions and the collation of background information for purposive sampling.

Hermeneutic phenomenology requires the researcher and participant to be involved in a co-construction of data. The participant nurse and I were involved in exploring the experience of CPD in their professional life during discussion in 'real time' and in the subsequent transcript text. In this course of action we acknowledged the pre-understanding each of us bring to the process. In the ideal situation numerous conversations with each participant would have been preferred. In the reality of the rural context of the study I was required to use telephone and email contact to fulfil the need for further communication.

The approach to data analysis in this study has included the following elements; immersion, understanding, synthesis and theme development, illustration of the phenomena and integration and critique of findings (Ajjawa & Higgs, 2007; Conroy, 2003). This process requires the researcher to be open and thoughtful at all stages of the research moving between all data sources.

I utilised the suggestions of Miles and Huberman (1994) to implement a processes of data reduction, data display, conclusion drawing and verification in the analysis of the qualitative data. Whilst data analysis occurred throughout the research process, a more intense time was spent reviewing the audio recordings and transcriptions once these were available alongside the background information and my reflexive journal and field notes. This enabled me to become immersed in the discussion and pick up nuances of meaning from audio files that were not apparent in the written transcript. During this process using the strategies of Miles and Huberman (1994), I noted words or phrases that conveyed a particular topic of discussion or meaning. I was able to write about these topics on a separate summary page as my first level of analysis which was forwarded along with the discussion transcripts to each participant for their comments or corrections.

Whilst the use of whole text gives a richness of data, large blocks of text are difficult to compare and contrast for analysis. The use of participants' verbatim transcripts to initially identify their main areas of discussion enabled me to identify a beginning understanding of their experience. I have used a three level system of reviewing data as described by Bazeley (2009) of *category*, *concept* and *theme*. *Category* is used as the descriptive level of data; *concept* is a more abstract grouping and *theme* an integrated relational idea from the data. DeSantis and Ugarriza (2000) suggest the term *theme* has been poorly defined and left open to interpretation in nursing qualitative research, resulting in confusion of both researchers and readers. In this study I have adopted their understanding of *theme* which was based on literature review, interdisciplinary concepts of the term and the foundations of three qualitative methodologies.

A *theme* is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a *theme* captures and unifies the nature or basis of the experience into a meaningful whole (DeSantis & Ugarriza, 2000, p. 362). This is congruent with the phenomenological approach used in this study and the clarification of the term *theme* provides rigour to the research process.

The decisions about which data chunks to code are analytic choices that were made by me as researcher, being consciously aware of the processes this involves and the potential for researcher bias. To offset this potential I utilised a trusted colleague who independently reviewed the discussion transcripts to identify *categories* and make suggestions that I could consider. As I awaited each participant's response to the transcripts and first level data analysis, I again went back to the data sources and identified and coded the data into *categories* to allow easier identification of the topics we had discussed.

To assist in this process I developed a thematic matrix for collating data and to begin to explore linked or unique *categories* as recommended by Miles and Huberman (1994). This allowed me to explore common and divergent ideas to ensure the various perspectives of the experience of CPD could be established, compared and contrasted. Each participant was allocated an individual page which included their background information, the context of discussion, extracts from researcher field notes and journal, researcher forward assumptions and any additional information sourced from discussion transcripts that had not been identified during the first level of analysis.

Alongside these *categories*, I documented direct quotes that provided a record of each nurse's voice about this topic. As the pages developed for each participant I was able to go back to data sources to cross reference and follow up comments made by other participants to identify any shared or differing experiences. Having completed the page for each individual participant I was then able to transfer this information to a collating spreadsheet that enabled me to group the *categories* into *concepts* on the side axis and by participant across the top axis.

These *concepts* in turn were able to be woven together to form into *themes* to provide the fabric of my foundational understanding of CPD and its place in the lives of rural and regional nurses. The understanding and discovery of meaning has occurred through a the coming together of information from various sources as previously described (Koch, 1995).

3.4.3 Data Presentation

The presentation of the data is included in two chapters. Chapter Four contains each of the nurse participants' background, context of practice and individual perspectives of CPD in their professional lives. This enables an insight to the thick description (Guba, 1981, p. 83) that emerged during the discussions with each nurse. In Chapter Five I have presented the thematic analysis of the study findings to bring together the experiences, capture the voices of the nurses by way of direct quotes and present the emergent *themes*.

As part of the nurse participants' description, I have provided the identification of the health service as a description as outlined in Table 1. Similarly, individual nurses are identified by a pseudonym that I allocated in order to provide a degree of identity protection. The use of direct quotes in the data presentation is intended to ensure that the voices of nurses are heard and their experiences are accurately captured. In terms of data presentation, all quotations are shown in smaller font and are followed by the participant's allocated pseudonym. To enhance the readability of the verbatim transcript excerpts, I have removed repeated words, vocalisations indicating agreement or repeated and incomplete phrases used by participants when they were seeking the best expression of ideas. If an interpolation is used to join together pieces of transcribed text to enhance the flow, it is indicated in bracketed text [for example]. Grammatical errors have been retained to ensure the authenticity of the participant's meaning is captured.

3.5 Rigour and Trustworthiness

In using non positivistic paradigms for research, the descriptions of legitimation (issues of rigour) and representation (whose voice is being heard) are of central importance to provide clarity, credibility and ensure congruence with the study aims

(Koch, 1996, p. 178). Within a hermeneutical phenomenological study, the multiple stages of interpretation that allow the emergence of patterns, the documentation of how they have been sourced from data as well as the interpretive process utilised, are all critical in demonstrating rigour (Koch, 1996, p. 178). The use of the different data sources; literature review, in-depth discussion, field notes and researcher journal, is a way of verifying and expanding my understanding in a form of data triangulation to add to the rigour of the study.

In this qualitative study the terms credibility, transferability, dependability and confirmability replace the terms of truth value, applicability, consistency and neutrality used in rationalist works to demonstrate rigour. These differences arise from the epistemological and ontological differences in paradigms (Guba, 1981, p. 80; Guba & Lincoln, 1982). In structuring the design of this study I have included processes that address the areas that build trustworthiness and rigour throughout. These approaches are outlined in the following overview and at times meet more than one of these requirements for building trustworthiness.

3.5.1 Credibility

Building credibility of the study requires acknowledgment that the researcher is seeking a holistic approach to understanding the phenomena under inquiry, taking in the many influences and differences that may be involved. I have clearly identified my values and place as the researcher by reflecting on my prior background and understanding and documenting these by way of a researcher journal. This journal also provides an audit trail of my philosophical and methodological reflections, decisions, responses and strategies utilised as part of the research process.

I established my relationships with potential participants initially by way of engagement in the recruitment process and these were further developed by email, telephone and personal contact. This stepped approach to building a relationship between me as the researcher and the clinical nurse participant occurred over a period of time and was developed within the context of their own situation as I travelled to discussions with them in their local setting.

To build the credibility of the project I have used the verbatim transcribed text from audio recordings of discussions with participants when member checking the discussion transcriptions. This transcript is additional to my reflexive journal entries that record non verbal and contextual information to help build the thick and rich description (Guba, 1981, p. 86) that provide a wealth of data for analysis.

3.5.2 Transferability

The aim of research in line with the constructivist paradigm is not to generate grand theory or generalizations to be applied over a broad range of situations (Guba & Lincoln, 1982, p. 238). In this paradigm, there is an understanding that all human behavioural phenomena are context bound. Transferability seeks interpretations of meaning that can be useful in understanding the phenomena in similar situations. This can be established by providing the reader as much information to be able to discern if there are understandings of the phenomena that can be applied in other contexts other than that described. The use of detailed, in-depth description of the individual participant, contextual reality and researcher responses allow the judgement of 'fittingness' with other contexts (Guba, 1981, p. 81). In using purposive sampling to select discussion participants I intentionally sought out participants with differing experiences that were able to inform the inquiry with new contexts, meanings and perspectives, providing another way of seeking transferability.

3.5.3 Dependability

The stability of information and meaning in the study is a product of the participants' meaning placed on the phenomena at the time it is explored. The context and understanding of participants will not remain unchanged over time as further experiences and different contexts will alter their perceptions. Within this study, I have clearly documented the interpretations of meaning as they emerge with each participant that has created an audit trail that can be analysed by others.

3.5.4 Confirmability

A clear description of the place of the researcher and the participant when using the hermeneutical phenomenological approach in this study has clearly identified my pre-understanding and values in regards to the phenomenon. My objectivity as a

researcher is not required as I am instrumental in creating interpretation and meaning. Developing researcher reflexivity ensures that I can identify where these pre-understandings interact with participant experiences. Journaling again provides a recorded context for these observations and can acknowledge where a fusion of horizons occurs, linking the researcher preconceptions, literature and data from the study (Koch, 1996). It is important that the utilisation of interpretative processes is well described and in this study revolves around the hermeneutical spiral process which allows the building of understanding as an ongoing and interpretive process over time (Conroy, 2003).

3.6 Conclusion

Within this chapter I have explained the rationale behind my choices of an interpretive phenomenological approach based within a constructivist perspective to gain the rich data of the experiences with CPD of individual clinical nurses and the site of the study. I have incorporated ethical considerations, rigour and trustworthiness in the development and conducting of the study which are described along with detailed information about the techniques and methods utilised to achieve these objectives.

The following Chapter 4 will allow the reader to step into the reality of the nurses' experience of CPD in their professional lives by the presentation of their individual accounts. This builds a picture of their world to allow a foundation for reviewing the thematic analysis of data presented in Chapter 5.

Chapter 4: Presentation of Data

4.1 Introduction

In this chapter I have presented the findings from the initial data analysis of the ten nurse's individual semi-structured discussions, the researcher journal and background information provided by participants.

I have provided a description of the participants that presents a contextual background to their experiences. This is followed by a presentation of the data by way of recounting each nurse's experience of CPD in the form of the key discussion areas from each of our interactions. It enables a personal insight into the professional lives of rural and regional nurses and the influence of CPD in assisting them to maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required. Finally a summary of this chapter and focus for the following chapter is provided.

4.2 Participant profiles & stories

Each participant nurse was required to be involved in direct clinical practice and engage in CPD. A number of participant nurses not only worked clinically but often had other roles of responsibility and autonomy. Information relevant to each of the participant nurses is presented by an extract from Table 1 provided in the earlier methodology chapter, to enable recall of this orienting information. A legend of abbreviations used is provided below.

RN = Registered Nurse; EN = Enrolled Nurse; RM = Registered Midwife

Major B = Base Hospital and Regional health service

B = Regional health service

C = Rural health service

SRHS = Small Rural Health Service

Table 1 (p 41), extract

In order to clearly delineate my own perspectives from those of the participant nurses, my forward assumptions were identified in the researcher journal before each meeting. These assumptions are included in each profile to enable clarity between my expectations and the participant's voices. Each participant's profile presents the key discussion areas that emerged in a factual manner so that they can be viewed collectively and individually to present the emergent themes as the next stage of analysis.

During each semi-structured discussion I utilised the Discussion Guide (Appendix B) to ensure I had provided the opportunity for each nurse to comment on the anticipated areas of discussion without the rigidity of set questions, allowing the flexibility of the discussions to roam freely and not inhibit new topics to be included.

4.2.1 Dana

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs/ wk worked
Dana	SRHS	RN	Community Health	24	32

Table 1 (p 41), extract

Dana began her nursing career as an Enrolled Nurse and undertook further tertiary study to become a Registered Nurse. This required significant planning to juggle travel to attend classes three hours drive from home, caring for a young family and working part time. She has been employed for eight years in a Small Rural Health Service (SRHS). Her community health role requires her to work independently without direct supervision of her practice as part of a small team of mainly nurses with a team leader who is an allied health assistant. Prior to our meeting Dana had provided written feedback indicating that she had experienced a range of experiences of CPD in her professional life.

Forward assumptions:

I went into the meeting conscious that my assumptions, informed from my own experience, were that community health roles are more autonomous and therefore more able to decide on how to develop their own practice.

Discussion overview:

In the opening discussion of background and experience, Dana indicated that she had difficulty in accessing programs that were close to where she was living in rural Victoria to upgrade her qualifications to a Registered Nurse. This had required determination and professional commitment, time and resources to succeed. I asked Dana about how she now goes about deciding which CPD to complete, the support she has to access this and how she applies the learning into her professional life.

Dana described a broad scope of practice in Community Health that was seen by her as providing the benefits of increased professional interest and variety. She explained that the breadth and complexity of community health practice in rural areas is driven by the limited access to other more specialised health resources, programs and health professionals. She described how the breadth and diversity of this practice brings with it additional needs for CPD to ensure her practice aligns with best practice principles in a multitude of areas. Working in a SRHS, Dana very clearly identified that there was a greater affinity and similarity with CPD offered in a remote rather than a metropolitan context. The lack of supportive infrastructure that exists in her role is much more aligned to the experiences of health care in the remote areas of Australia.

She indicated that her decisions about CPD were self-determined, provided there was relevance to her work situation and were identified and discussed with her manager at annual performance review. Some CPD was prescribed by her employer but she saw this as being relevant and welcome. Dana's process of deciding the type and topic of CPD to engage with was either opportunistic or reactive to needs as they become apparent to her. As part of maintaining a constant flow of information in her professional life, she subscribes to a number of professional bodies and

receives regular email and printed matter from them and other sources. Reading these and other information from journals combined with attendance at workshops, courses, online education and the completion of mandatory training required by the organisation constitute her involvement in CPD. I enquired how she documents her CPD activity and she outlined that some of this is recorded by her employer but she keeps a personal record for her own reference. There is an expectation by her manager of feedback from any courses or workshops attended to be provided to the organisation.

Dana indicated that financial support from her organisation for CPD was very limited and that over the years she had noted a change to CPD being much more self-funded. She commented that this can be restrictive, particularly as programs can be very expensive and there is the additional time, costs of travel and accommodation that are often increased because of her geographic location. Dana had sought and received a scholarship from the Royal College of Nursing Australia to attend the chronic disease in remote health course. Her organisation gave paid study leave for part of the time.

Discussion also focussed on particular experiences of CPD that Dana felt were memorable and influential for her, touching on the range of modalities for delivery. I moved discussion to explore Dana's perspectives of CPD over the years, its influence in nurses' lives and the attitudes and approaches to CPD that she has experienced. Dana commented that there is an increased focus on education in her current work environment but that in her experience a number of her colleagues commented that some CPD lacked practical application, being too conceptual and 'airy fairy'. She also stated that on some occasions she had experienced staff that have been in an organisation for a long period of time and were not accepting of new information, preferring to rely on traditional, long held methods as the only way to work. Dana suggested that in the past nurses held the view that learning was only required for the early part of your nursing career, that you did not learn any more after a certain time and then it was time for retirement. She went on to say that in a previous smaller workplace where access and support for CPD attendance was not provided,

there was more likelihood of seeing resistance to using CPD as part of developing and updating practice.

Dana identified that the influence of organisational culture and values was a key factor in how CPD is incorporated into the everyday lives of nurses. The influence of CPD in practice was seen by Dana to be limited by a number of other factors including the lack of time to work out how to implement new learning/skills. She commented that the small health facility gives limited opportunity to practice skills, so the skill and confidence to implement practice change is reduced. Dana made a final comment noting that some General Practitioners were reluctant to alter clinical practice, believing they alone understood a particular area of clinical practice.

The personal experience of CPD in Dana's professional life was recounted as a positive influence. At the end of our discussion she described her self-motivation to strive for constant improvement and was enthused by the changing roles of nurses and the opportunities in rural practice this could provide, although this was tempered by limitations of the work environment. Where there were decisions on CPD that could lead to a changed career direction, she noted this required her to address broader social, family and lifestyle considerations.

4.2.2 Graham

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Graham	SRHS	EN	Aged care	16	40

Table 1 (p 41), extract

Graham's pathway into a nursing career was preceded by thirteen years as a Personal Care Attendant in an aged care setting. Five years ago he completed studies to become an Enrolled Nurse and he now has attained endorsement for medication administration. He works as team leader on his shift with other Enrolled Nurses or Personal Care Attendants and one overseeing Registered Nurse for all teams on the shift in the residential aged care facility. Graham very clearly expressed that he will

be looking to leave the town and nursing in the next two years when his child has completed schooling.

Forward assumptions:

The assumptions that I took into the meeting with Graham were that an Enrolled Nurse may be less able to identify the need and place of CPD in their professional lives being constrained by their task focused roles. Upon further reflection, I recognized that my assumptions were influenced by the historically skills based approach to Enrolled Nurse education within the Vocational Education and Training sector in Victoria.

Discussion overview:

I initiated discussion to explore Graham's background in his nursing career and then progressed to ask him about his experiences of CPD in his professional life. He described his initial enthusiasm when mandatory twenty hours CPD was introduced by the Nursing and Midwifery Board of Australia and how he had established a logbook so that he could keep a record of his activity, expecting an active auditing system. He currently keeps certificates of CPD completion in a folder but has been surprised there has been no request for information from the regulatory authority.

Graham described how he decides on the type of CPD to attend predominantly in an opportunistic manner as information is posted on notice boards. He noted that these decisions were left to the nurse to make as long as it was relevant to the work setting. Access to CPD was enhanced as his organisation usually paid for up to five days of study leave and the associated costs for the registration of workshops. Often these educational opportunities were available at minimal cost as they are offered by the subsidised regionally based continuing nurse education program.

The discussion largely focused on Graham's experience of the upgrading of Enrolled Nurses' qualifications to enable them to administer medication and expand their practice. Encouraged and fully supported by the organisation, Graham chose to take on this education. These new roles for medication endorsed Enrolled Nurses required management to establish new practices and structures that enabled this to

happen. Graham's motivation to engage in this education was about moving on and enhancing his opportunities as an Enrolled Nurse. He saw no need to extend into other available education such as IV medication administration or ECG taking because he was not in a position to use these skills in his current work setting.

Looking more generally at the influence of CPD on his practice, Graham could see that his medication endorsement enabled his new role as a team leader, overseeing the other Enrolled Nurses and Personal Care attendants and the structural changes to reporting. Graham identified that management had established a structure into which the new practice of medication administration by Enrolled Nurses could fit. He described other training done with diversion activities for dementia patients and how he was enabled by management to put in place a program for residents making 'home brew ', citing the therapeutic benefits this provided.

In closing remarks, Graham stated that whilst appearing a bit negative about CPD, he believed it was a good thing to keep up to date with new practice and that he would easily meet the twenty hour requirement. As we concluded our meeting he pondered on what consequences there might be for nurses who did not actively engage in CPD.

4.2.3 Stephanie

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Stephanie	Major B	RN	Breast care	11	40

Table 1 (p 41), extract

Stephanie described how she had worked in a variety of public and private healthcare organisations within small and large units and mainly with an oncology focus. Her present role as a breast care nurse was based in a large regional centre in a community setting, working with another Registered Nurse. Stephanie is currently employed by the major level B health service, reporting to senior nursing executive there as well as to the McGrath Foundation that provides the funding for the

position. Primarily it is a community health role with some limited reach into the local private acute health agencies. Stephanie's experience in both the public and private sector provides an interesting differentiation with the role of CPD in her professional life in each of these sectors. She provided detailed background information by email before our meeting that indicated she had had a range of experiences of how CPD had influenced her professional life and practice.

Forward assumptions:

Based on my own understanding of the breast care role, I identified my assumption that Stephanie would have an autonomous community role. I believed she would have an opportunity and an obligation for utilising CPD in her professional life to modify her own practice. I understood that this role may also require some delivery of practice content to others and contribute to their CPD.

Discussion overview:

Preliminary chatting about Stephanie's work environment led into the more focussed discussion about Stephanie's approach to CPD, how she organises it and its influences on her professional life and practice. Stephanie commented that the McGrath Foundation supported professional development and generously provided funding to allow attendance for even interstate conferences. The organisation expected that new learning would be implemented by her on return. In a recent situation Stephanie commented that she had not necessarily learned anything new but was able to develop contact networks and locate resources that could assist her in practice. Such CPD opportunities also gave her information that she could share with other colleagues.

I followed up with an enquiry about influences that may have either allowed or hindered practice change. Stephanie explained that in her current role with only the two Registered Nurses it was easy to change things; just a matter of discussing with management who were very supportive of any change. This moved on to a more detailed explanation of her employment arrangements and how that impacts on her

ability to influence practice. She explained that her role was community based, working to align practice across health sectors.

Stephanie commented that the openness to new ideas varied between departments in the public and private sector. She had mixed experiences of being able to apply learning in the practice setting in the private sector organisations. She noted that in a private oncology unit where she had previously worked they were quite proactive with instigating new learning in practice with a clearly understood process of approval to implement practice change. In another place, she commented they were very resistant to even small changes. Upon enquiring about factors that could have caused this difficulty, she commented that where staff has been there a long time, they rely on familiar methods. She reiterated that in her current position management was supportive of CPD attendance in relation to Breast Care topics and this was often incorporated in her working hours. Stephanie recognized that her role as Breast Care Nurse gave credibility to her suggestions for practice change and development.

In deciding the types of CPD to access, Stephanie suggested that it is usually opportunistic, associated with when she might see the flyer and think that she is probably needing to know more in that particular subject area. She stated she does not have a process of identifying her needs and seeking out particular CPD opportunities to meet them. I also asked if she took the time to reflect on the usefulness of CPD in her professional life and practice after she had completed activities. Stephanie explained that in recent times she had commenced doing this a little more. Making time to reflect and document after CPD was something that Stephanie had been finding quite difficult to achieve in her work and private life.

As our discussion had largely talked about attending conferences and workshops, I enquired about other types of CPD that Stephanie accessed. Certainly attending workshops from the subsidised continuing nurse education program was readily available along with other short sessions at the large regional hospital. Additionally, Stephanie reads journals and newsletters from professional groups and is prompted to seek out these resources to support her practice. There was little experience of

online learning. Stephanie did not perceive that she was at all disadvantaged in accessing CPD in working from a regional centre. She was willing to also travel to Melbourne to access opportunities and had utilised videoconferencing to link up with education and other nurses from across the region.

In closing comments Stephanie noted that she had experienced some nurses who became quite upset with the amount of effort involved to achieve the mandatory twenty hours CPD. Stephanie noted that in her experience, those nurses who were in a position for a long time could become resistant to change. Stephanie went on to suggest that these nurses were less willing to go to CPD and they are probably thinking that new ideas will bring more work. She suggested that when you can sit down and tell them what is happening they are able to accept it most times.

Finally, Stephanie reiterated that in her current position the culture of the organisation valued critical enquiry and practice change. This sits well with her personal need to be well informed and to have credible information behind her practice.

4.2.4 Julie

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Julie	C	RN	Transfusion/ Assoc Nurse Manager Day Procedure Unit	27	28

Table 1 (p 41), extract

Julie has past experience in a diverse range of areas in larger health facilities including paediatrics, oncology and perioperative nursing. Currently she works across two roles as an Associate Nurse Manager of the Day Stay Unit in a large community health centre and the majority of her hours as the Transfusion Nurse. This role requires her to advise and audit practice in both the community health and acute settings of the organisation.

Forward assumptions:

I had a supposition going into our discussions that Julie may have differing experiences of the influence and place of CPD in each of her roles. I also expected that her Transfusion nurse role would require her to be actively involved in the provision of CPD to others which may influence her reflection on the place of CPD for nurses' professional lives.

Discussion overview:

Prior to our meeting Julie had provided very positive comments on the role of CPD in her experiences. Her grounding as a hospital trained nurse has been supplemented over the years with a number of courses. Over the years these have equipped her to work in particular specialised areas such as oncology, breastfeeding counsellor and more recently as a transfusion nurse. Most of these courses followed appointment to positions in the speciality but in taking the initiative to attend CPD on blood products and transfusions this prompted Julie to lobby for the development of a transfusion nurse role in her organisation. This association of CPD to career development had not previously occurred to Julie until our discussion.

Julie explained that CPD is encouraged and discussed in performance review each year, linking CPD to the professional goals set with her manager. She is supported financially and also with time to attend, stating there is not much left to claim on tax at the end of the year as her organisation has paid for her attendance. The types of CPD she utilises include clinical and non clinical workshops and online learning for both mandatory training determined by her organisation and for professional interest, choosing those that are most appropriate for her practice. Just prior to the commencement of mandatory twenty hours CPD, she became aware of the broad range of activities such as reading journals and researching information that can be included.

I asked Julie about how she reflects on her CPD and if she then decides she needs to implement some different practice, how does she go about this. Julie does not have a structured process of reflecting on every CPD activity, rather selecting those that

she considers are more important and relevant to her and using an organisation wide system to log her CPD so that she can easily provide evidence for audit purposes. Julie outlined a process to implement learning to practice that included the gathering of evidence and supporting documentation to take to key personnel and then present this to them with her planned changes. This has worked well for her and she believes she sets clear, achievable goals for herself. Whilst some things take longer to implement than expected, Julie considers one of the keys is that the goals she and the organisation establish are achievable in the first place. Some of the barriers to applying learning from CPD to the practice setting were identified as the lack of IT skills to access information and communications and also the nurses' perception of busyness in the clinical setting that does not allow them the time.

Julie sees great value in staying current in her practice, particularly when she is dealing with students. She explained that she cannot rest on her 'laurels' with the information she provides to them, as practice is changing all the time.

As I was bringing the discussion to a close, I asked Julie if there was anything she thought was really important that I should know of her experiences. She identified that some nurses were concerned and 'frightened' about the number of hours required for CPD, but this had not concerned her. Julie had more than adequate CPD to meet the twenty hours requirement. The concern of others related to the experience of some nurses in the organisation who had been audited on their CPD from the NMBA. Unfortunately they had not kept good records and consequently felt it was a 'huge deal'.

Julie also commented that being a SRHS with a couple of General Practitioners and a visiting surgeon meant that sometimes there is not the opportunity to review and learn of new ideas. She believed it required nurses to actively seek out information and resources themselves instead of having it more readily available as you would see in a larger health service. She also commented that she had seen resistance from long staying staff to new ideas that were shared by nurses just finishing their perioperative certificate. She commented that the older staff were very resistant at times saying 'oh we have always done it that way.'

As I summarised our discussions, Julie agreed when I commented that her Transfusion Nurse role was quite independent practice that required her to influence the practice of others as well as ensure she was up to date.

4.2.5 Kathy

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Kathy	Major B	RN	Clinical Support Nurse	26	40

Table 1 (p 41), extract

The extensive background of community nursing for Kathy provides a contrast to her recent move back into the acute sector of the large Major B regional health service. Kathy had been in her current role as a Clinical Support Nurse working with new graduate nurses in the acute sector for three months and has described this transition as being a steep learning curve. She is required to work alongside the new graduate nurses in clinical areas to assist and guide them in clinical practice in all areas of the acute service.

Forward assumptions:

My major assumption going in to the discussions with Kathy was that the move back into the acute areas of nursing and taking on the clinical support and education role may have required her to be actively seeking out CPD opportunities. I also thought it may have prompted her to reflect on how CPD fits with her life as a nurse.

Discussion overview:

The written background information that Kathy provided before our meeting indicated a familiarity with themes around practice, CPD and quality and risk strategies in health care. She documented a range of experiences of how CPD had influenced her and the practice of colleagues.

My opening question of the discussion focussed on gaining a clear understanding of Kathy's current role and responsibilities as a clinical support nurse and an overview

of her previous nursing experience. Kathy stated she had not stayed in places very long and also commented that she had in the past needed to be driven to go out and find CPD that related to the core business of her practice so that she could ensure she was practising safely and at the highest level she could. Kathy has sought out specific courses to prepare her for practice in particular clinical areas, but this has not always resulted in being successful in her applications for positions that would use this knowledge.

Kathy noted that in her past community nursing role there was a lot of travel required to attend workshops and that she was also required to fund and were undertaken in her own time. She clearly identified that she does not regularly read journals but will go to the library or seek information from the online Clinicians Health Channel. In her present role in a major regional hospital she has easy access during normal working hours to education offered daily during shift change over time for nursing staff. These education sessions are focused on identified key learning needs for nurses in the organisation and are able to be included as part of CPD. She commented that this offered immediate information that she was able to apply and pass on to the graduate nurses in the clinical setting.

I enquired about how she was able to take the learning from CPD into her professional life, with particular reference to new information that was not currently reflected in the organisation. Kathy explained that she gathers supporting evidence for the recommendation and talks first with her manager, nurse managers and then uses the hospital process for updating or developing policies. She acknowledged she needed some CPD on how to write policies as this was not an area of activity in which she had previously been involved. In her past experience, Kathy reflected that as an outsider, or someone who was relatively new to the team there was no professional respect given to the opinions she offered from some team members. She thought this was because she was an unknown quantity and that whilst good conversations were had; there was no implementation of her information. This she found very challenging and she commented that it would have been detrimental to her health and well being if she was working full time in this type of setting.

A lengthy discussion ensued around the use of Information Communication Technology (ICT), the difficulty as an older nurse in coming to terms with this and the challenges she had encountered in using online learning and maintaining motivation for education programs delivered in this format. Kathy noted that for a significant number of her colleagues living in the Grampians region, IT access was variable and unreliable, making this less useful in supporting their access to CPD outside of work hours. Kathy recounted the overwhelming nature of some of the new technical information she has needed to become familiar with and how useful the online resources from equipment manufacturers has been to access after work hours.

As Kathy was the fifth nurse I had met with, I asked her thoughts around some of the key points others had mentioned. The cost factor of accessing workshops was a shared concern for Kathy. She had applied and been successful in getting a scholarship from the Royal College of Nursing Australia to support her to undertake a course interstate. Whilst this did not offset all costs incurred, she felt it was a significant contribution that enabled her to embark on this education. Kathy spoke readily about the costs of workshops held in Melbourne which were not attainable for her because of her financial situation. Kathy commented that she always looked for CPD that met her criteria for quality, cost and accessibility. On a more positive note she was enthusiastic about the availability and low cost for some locally held and organised workshops.

Lastly I returned to her comments about the inability to implement learning from CPD impacting on her wellbeing. She expanded to explain that she believed change is made with some difficulty in health services and that sometimes she has had to accept that change will not happen and make the best of the circumstances.

4.2.6 Harold

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Harold	C	RN	Acute ward / Emergency	15	40

Table 1 (p 41), extract

Harold gained his initial qualifications in the Philippines fifteen years ago. He has since worked in Saudi Arabia in areas of dialysis, emergency, private nursing and middle management. He immigrated to Australia on a sponsorship visa and commenced working full time at the level C health service eighteen months ago. Harold is alternating between the acute ward and the emergency department where he is one of a small team who often work on their own.

Forward assumptions:

Harold was made aware of the study and encouraged to participate by the educator in his organisation. I was therefore unsure if the motivation to take part may be more than an interest in the topic but a need to be seen as a willing and valuable worker for his health service. Given that Harold will need to secure work after his visa sponsorship expires, I entered discussions being mindful that his responses and perspectives on CPD in his professional life may have been coloured by this requirement. I also assumed that his different cultural and professional preparation for nursing may provide alternative perceptions around the topic.

Discussion overview:

Harold began the discussion explaining his background experience. When I enquired how he approached the decision making processes of accessing CPD from the SRHS, he identified that there were organisation determined mandatory training requirements for all staff and that there was also a list of education opportunities made available that he can apply to attend. He noted that the nurse manager may ask him to attend a program to update himself and for the benefit of the unit. Harold commented on the need to assess the suitability of CPD to his practice context. He

had attended an education program run by the Council for Remote Area Nurses Australia which was more applicable and relevant to his situation than programs run in major metropolitan settings. He noted this was based on the skill differences required and lack of infrastructure in practising in the small health service as opposed to a major centre. Harold reflected that after this workshop he considered there was little need to change the way things were done within the organisation, rather it was a matter of honing his skills and updating skills he would need to use for unfamiliar situations.

The types of CPD that Harold completed recently included online education which he identified had some limitations in application to practice. He noted that he sought out journals when he needed information about particular clinical situations and used Google as his most common source of online information. In following up on other nurses' comments, he felt cost was not much of a problem in attending CPD as the hospital would usually pay or else he would claim it on his taxation. Access to study leave was not an issue and the organisation was sponsoring him to go to an emergency advanced nursing course.

As part of this discussion, Harold commented that there were notable differences in the health systems and the scope of practice for nurses between Saudi Arabia and Australia. In Saudi he was used to a much more restrictive system for practice and a reliance on medical staff because of the language barrier with patients. He saw CPD as influencing his personal practice which in turn benefited the organisation.

I asked if he saw any association between CPD activities and changing practice. He suggested that in his experience there can be a gap if the hospital policies and procedures do not permit what is being learned in CPD. He noted that Enrolled Nurses who had gained intravenous medication administration endorsement were not permitted by the hospital to use this in their practice.

In bringing the discussion to a close, he was able to articulate very clearly his view of the place of CPD in professional life as being more than a regulatory requirement. He explained that CPD helped him cope with change and was a part of his personal and professional growth.

4.2.7 Denise

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Denise	C	RN	Emergency / Acute ward	12	32

Table 1 (p 41), extract

Denise commenced working as a dental nurse and then completed Enrolled Nurse education which articulated directly to become a Registered Nurse. Her background included District Nursing and the emergency department of a Major level B health service in another region. Denise works principally in the emergency department of a Level C health service as part of a small team and rotates and helps out in the acute ward when required. She is the sole nurse for most of her time in the emergency department.

Forward assumptions:

As there was no time to establish contact, receive information or build rapport before entering our discussions, my assumptions were that this encounter may be less fruitful due to the lack of preparation by both parties. My reflection included thoughts of lack of commitment to the study by the participant and possible coercion from others that may influence any information provided about experiences of CPD in Denise's professional life.

Discussion overview:

After establishing Denise's professional background and history that brought her to her current role, she explained how she worked across both emergency and the acute ward and the difficulties this can pose. In describing the decision making process around what to do for her CPD, Denise relayed to me the challenges of working in a small health service with an emergency department without permanent medical or allied health staff for support. This was the reason for commencing a post-graduate emergency nursing course. She chose a program that was available online so that she had more flexibility in completing her studies with

videoconferencing links to her lecturers in South Australia. Despite this program being designed for nurses working in large trauma centres, Denise found it provided new ideas and development of her skills. This had been the main focus of her CPD activity over the past eighteen months and she was considering continuing on to get a Master's qualification. Denise had also completed a few workshops focused on managing trauma in a rural setting.

In describing how CPD had influenced her professional life Denise stated that she had returned and changed her practice. She had found it very frustrating to influence and change practice more generally due to issues of skill mix and staffing of the emergency department where she is often the only staff available. I enquired about factors that may influence the readiness or willingness for change and she suggested that there were too many people who had been in the organisation for too long who she considered were in their comfort zone and did not want to 'do the education' and take on new ways of practising.

Denise does not keep an ongoing record of her CPD or spend time intentionally reflecting on the influence that CPD may have in her professional life. She completes some online programs which give her a certificate of completion that she can print out should she require it for auditing purposes, but considers the time spent on her post-graduate studies more than adequately fulfils the mandatory twenty hour CPD requirements. In discussing the support for CPD, Denise acknowledged that the organisation has provided financial support for her post-graduate studies, but has struggled to provide clinical mentors required for her course to assist her. Denise commented that she believed there should be more acknowledgement and support to maintain and up skill health professionals in rural areas, suggesting rural communities are disadvantaged through poor access to the best care.

After the audio recording of our discussion completed, Denise gave me a tour of the emergency department and commented that there was an unwillingness to change policy in the organisation, even in light of the research and established practices in neighbouring health agencies.

4.2.8 Scilla

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Scilla	Major B	RN	Perioperative / Clinical Educator Perioperative	11	37

Table 1 (p 41), extract

Scilla has worked her eleven years in Perioperative nursing in the same Major B level health service. Recently, she has taken on the role of Clinical Educator for the Perioperative area working most of her hours each week in this role and retaining one shift each fortnight to work clinically. She sees this mix of roles as complimentary and allows her to work with students and graduates over the week and some weekend shifts. Scilla works in a team of ten other educators and has nearly completed a Post-graduate Diploma in Education which she started when considering leaving nursing.

Forward assumptions:

In light of Scilla's education studies, I approached the discussions with the belief that she may have a more extensive understanding of the place CPD could have in the professional lives of nurses. I assumed that this would also transfer to her personal experiences but I was also concerned that her recounting of experiences of CPD from the clinical setting may be overshadowed by her education knowledge.

Discussion overview:

My initial question to Scilla concerned how she went about her own CPD. Her experience as a new nurse was that she was very unclear about how to go about developing professionally, there was no clear guidance provided and she had to watch other nurses to see the best course of action. Once she identified appropriate professional bodies to join and understood how to apply for study leave Scilla now considers this provides good CPD opportunities. She believes her current position of clinical educator provides an opportunity to be a role model to the novice nurses and

provide that guidance. On the other hand, she commented that there was a mismatch between the availability of study leave and the ability to take it. Her experience in the perioperative department of accessing study leave was restricted by the lack of staff to replace her so that she could attend CPD. In her clinical role in theatre it was also impossible to access the daily education program offered to all other staff as there was no shift change-over time when theatre staff could be released.

Scilla has developed a proactive approach to identifying her knowledge deficits that inform her choices for CPD. In her current education position she is able to review her learning needs as part of the performance review process and she has been able to attend education within her clinical education hours, unrestricted by the need to be replaced as she was as a clinical nurse in theatre. In her previous clinical position experience, it was definitely the nurse's responsibility to take on the CPD to address these learning needs.

I approached the subject of the cost of CPD as it was raised by other participants and Scilla agreed that some things are cost prohibitive and that the opportunity to apply for funding from the organisation was not well understood by her and appeared inconsistent in its application. Cost could be a determining factor in the decision making process around CPD. The opportunity to claim CPD costs on taxation was seen as a positive assistance.

In reviewing the impact of CPD in her professional life, Scilla reflected on the challenges of the practical application of learning in the workplace. Despite sometimes feeling that the new information is 'bigger than you' and that she cannot achieve change, Scilla commented that her education position provided new insights and influence in effecting change. Some of this may have been that she just did not know about the steps to take as a clinical nurse. I asked Scilla if she saw this was a result of the perspective of her education position or if clinical nurses are not recognised in the organisation as being able to influence practice decisions. She went on to explain how frustrated she became in her clinical role at being unable to influence practice, commenting that management were not interested. Scilla

detailed how she goes about influencing practice in her present role. She uses an inclusive approach that requires taking the opportunity to spend time, build confidence and empower nurses to strive for high standards as part of the change process. Scilla also commented that the culture of the work environment can have an impact, stating that "when people feel empowered, then change is easy to effect, because they feel included" (p6). She suggested that whilst the health service has a good focus on education as part of their identity, each department can become insular, having their own culture separate from that of the organisation.

Continuing the discussion about her personal experiences with CPD, Scilla highlighted that in her education role she spent an enormous amount of time reading journals and researching to assist her post-graduate students. This alongside the workplace discussions and meetings with the education team contribute and more than satisfy her CPD mandatory requirements. Scilla has observed that the move to mandatory requirements has brought CPD to forefront of people's thinking and she believes this has been a positive thing. Scilla keeps a log of her CPD, but commented she could probably spend more time reflecting and evaluating her CPD activity and its impact on her practice. After my question about her experience of other nurse's behaviour around CPD she noted that the introduction of mandatory requirements has heightened awareness of CPD among a large number of nurses. She continued, explaining that she believes there is a small group who do not spend time reflecting on their CPD activity and relating it to their practice, but she is unsure how to influence this cohort.

4.2.9 Janet

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Janet	C	RN/ RM	Acute ward / Midwifery	3 & 18	20

Table 1 (p 41), extract

At the time of our meeting, Janet had only been living and working in a rural area and in Australia for about twelve months, having moved from Auckland, New Zealand (NZ) with her family. Janet had registered in NZ as a comprehensive nurse who can work in either general or obstetric nursing. She completed her midwifery course in the United Kingdom and has since been a midwife, returning to work in general nursing for about three years as a strategic decision to enhance her employability, particularly in rural Australian settings Australia. Janet's background provided different perspectives of the experience with CPD in her professional life which included New Zealand / Australia, large health service/ small health service, city/rural and nursing/ midwifery aspects. At the time of our meeting Janet was employed as a Registered Nurse and Registered Midwife, in a Level C health service to care for both general nursing patients and any midwifery patients who may present. She is one of eight midwives on staff who are usually rostered to cover each shift. Additionally, Janet has each week travelled to work in a supported midwifery role in the large Level B regional health service to update and maintain her midwifery skills and practice. Janet expressed a range of experiences with CPD in her contact prior to our meeting which were different from other participants.

Forward assumptions:

My expectations and assumptions of the meeting with Janet included a concern that the midwifery approach may cloud the other experiences for the study. Midwives are often considered to be more independent thinking and focused on the care of women and the family in their practice as they strive to ensure a normal, healthy process of pregnancy and childbirth. I was thus mindful that I could learn of a

different range of experiences from Janet than some of the other participants and I entered into our discussions being mindful of these things.

Discussion overview:

We commenced our discussion in review of Janet's background and experience and then I asked about her experiences of working in the current general nursing setting. She recounted a number of situations that had challenged her in regards to the elderly patients and medication prescribing, suggesting that she had experienced poor prescribing practices by General Practitioners which seemed to be accepted in the rural setting. This compounded her needs to learn about the different medications prescribed for the elderly clientele in her care.

I enquired about how Janet experiences CPD in her professional life, touching on how she chooses and goes about organising CPD activities. She commented that there is often an overlap with the mandatory twenty hours for nursing and the additional twenty hours of midwifery requirements for mandatory CPD, citing that some of the activities or sessions she attends are relevant to both. Her motivation for pursuing nursing focused CPD has been that she is unfamiliar with the Australian health system and that she wanted to ensure she would meet regulatory requirements if she was ever audited. Janet explained she self-identifies the kind of CPD she needs to undertake to meet her learning needs and this was reinforced during performance review. She recounted an experience where she had identified wishing to attend a particular workshop in her performance review with her manager, but was denied her application for leave to attend. This lack of consistency caused Janet much frustration. Difficulties in accessing funds to support attendance were identified, although she acknowledged that some of the subsidised workshops in the regional continuing nurse education program were very reasonably priced.

Janet described how she goes about using the information she has learned and the processes around her CPD. While she is aware of the need to keep a log of her attendances and completion of CPD which she does by storing certificates of completion in a folder, she was quite open that she does not spend time documenting her reflections of the CPD activity and its place in her practice.

Janet went on to say that there is little opportunity in the staff meetings to feedback on CPD activity and she was not really aware of a process to bring about change in the practice setting, apart from talking to a senior nurse or manager for guidance. She also commented that being employed part time gave her little opportunity to pursue the implementation of new ideas in the workplace. As a relative newcomer to the organisation and with experience in other settings, Janet stated that when she has suggested a new practice she found little acceptance, with nurses stating that it had been tried before. She believes that this is a defeatist attitude and that nurses should try again.

As Janet was a Registered Midwife and a Registered Nurse I explored some of her experiences of CPD in midwifery. She commented that most CPD in midwifery is offered outside the rural area and accessing funding and release from work made this very difficult, giving a range of examples where her applications had been denied. She believes the situation was more difficult because of the dual management structure in her situation, one for nursing and one for midwifery in regards to providing approvals.

Janet spoke enthusiastically about being able to access the supported midwifery practice model run out of the major regional health service as part of her CPD. This has provided her with an opportunity to work in different areas of midwifery to maintain her clinical skills with a mentor to assist her learning until she was independent in her practice. She now tries to work in the maternity services in this larger facility at least one shift per fortnight.

In regards to the approach to CPD and her experience in New Zealand and Australia Janet commented that it was quite different, describing the New Zealand system of funding and study leave for CPD based on years of practice. Janet believed the New Zealand process around CPD provided clear guidelines and encouraged permanent staff to stay on in an organisation. This was supported by an organisational professional development program that mirrored the requirements of the regulatory body.

Janet noted that in her present situation she found it difficult to make the time to read journals at home and that lack of affordable internet access was a significant barrier to e-learning. Whilst she enjoys the clinical content of the inexpensive regional sponsored continuing nurse education workshops, she sees equal value in networking with other small health services to learn of their activities. Janet commented that this can provide a reference point to look at new ways of practising and seems to be more readily accepted than her early use of references to practices in New Zealand. Closing comments from Janet related to the development of a culture of celebrating achievement and a willingness to listen and hear of what others have learned.

4.2.10 Joylene

Background:

Participant	Health service description	Registration Type	Area of practice	Yrs in nursing / midwifery	Hrs / wk worked
Joylene	C	RN	Infection control / Staff immunisation / Associate Nurse Manager Aged care	36	40

Table 1 (p 41), extract

Joylene has worked in the same level C health service for the previous eighteen years in a variety of roles. Currently she holds the positions of Associate Nurse Manager in aged care and also Infection Control and Staff Immunisation Nurse. Previously she has worked in Perioperative nursing in a large metropolitan hospital and also in the current level C health service.

Forward assumptions:

As the last participant of the study, I approached the meeting being mindful that this could potentially affect my approaches and attitudes. Having stayed in the same hospital for many years I also considered that Joylene may have different ideas about the place of CPD in her professional life, given comments from earlier participants. Joylene had contacted me via email to express her interest in the study,

reflecting that she was enthusiastic to share her varied experiences with CPD and its place in her professional life.

Discussion overview:

I commenced the discussion by exploring Joylene's background as well as her current roles and responsibilities. I asked how she goes about using CPD in her professional life and she commented that given her different roles, she receives many emails notifying her of upcoming education and conferences. Decisions about attendance are taken collaboratively with her manager but mainly paying the costs herself. She uses her allocation of study leave as well as annual leave to support her attendance at programs. Joylene acknowledged that there was a limited budget for education in the organisation and they could not fund everything she wanted. She did comment that in her experience it was frustrating when there were education opportunities provided for others and they would not attend.

I enquired about Joylene's experiences of accessing CPD in rural areas. She highlighted that the necessity to travel for CPD, particularly for specialised topics required not only money but additional time away from work. In many cases, nurses in rural areas have multiple roles so this also increases the requirement to access CPD to keep up to date. In specialist areas such as perioperative nursing Joylene thought it will be very difficult to get twenty hours CPD unless nurses are willing to travel. Joylene also noted that in her experience a few staff are not really keen on education and unless they were spoon fed with programs run in work hours on-site, they would not be interested.

Joylene used e-learning to complete a number of theoretical mandatory training requirements like basic life support, drug calculations and others. Her range of types of CPD accessed included journal reading, organising and attending regional workshops. Following up on comments from earlier participants I asked how she went about journal reading and she commented that journal reading tended to be in response to clinical situations when she was seeking information, as she did not have the time to read all the journals that come to her. She was aware that many nurses

found the subsidised regional continuing nurse education program workshops affordable and accessible although they did not cater for her clinical speciality.

In regards to the documentation of CPD, Joylene identified that there was an internal organisational system that allowed her to send in certificates of completion for CPD and this would be recorded on a central data base that can printed out. She suggested that the requirement for twenty hours CPD annually had not really hit home to many nurses as no one had yet been audited by the new regulatory authority.

In discussion of the types of processes she uses to reflect and apply CPD in her professional life and practice, Joylene was able to provide examples where she had taken the initiative to alert management of new technology to reduce injury and infection in the clinical setting. She had worked collaboratively with them to identify cost factors, run a trial program and evaluate the product before implementing it throughout the organisation. I questioned how she went about effecting new behaviours and if this was a different approach. Where there needed to be a change in practice, she had sought and then presented the evidence for discussion and recommendations before it was agreed by the appropriate committee and had final approval by the Board. Implementation required education of where to find the new policy, what was the new content, supplemented by 'walk arounds' to assist and check out how new practice was being used in the clinical setting. She felt these were generally successful strategies. In responding to Joylene's earlier comments about barriers to implementing learning, I came back to the topic to enquire about any particular enabling factors that were useful. Management were identified as a very positive influence if they understood the benefit and importance of the changes but they could also provide the biggest barrier if they did not share this perspective. The use of a successful implementation of different practice by other sites in the region was seen by her as a helpful approach where others may have identified the best approaches to take. Joylene warned that there was a need to review the supporting evidence and assess its applicability to the local context before accepting such new approaches.

Joylene agreed that her role provided her with a position of influence on practice as she was responsible for writing and updating policy for the organisation around infection control. Following the theme of her ability to influence practice in her role, Joylene noted that strategic management processes had seen the approval of all her suggestions for change. In the past as a clinical nurse, Joylene felt she did not have the understanding to change or influence practice in the same way. She went on to identify that in a clinical situation there is a 'chain of command' that is in play when you identify practice you wish to alter. The ideas are passed to the manager and then the nurse can get back to the clinical care. Frustration can occur when staff do not see that their suggestions have been acted upon. Nurses' expectation of the time frames for changing practice may not align with the reality. Joylene suggested clinical nurses may not appreciate that there are processes of review that take time and are overlaid by financial considerations. She also suggested that some clinical staff lack knowledge on the process of how to get things changed.

Joylene commented that resistance to implementing learning in the practice setting was often from clinical nurses who believed the change will increase workloads and not provide any gains. She commented that some nurses may be threatened by new practice, not being aware of how much health care is changing. I queried if this was particularly an issue of rural areas. She suggested that a lack of access to education may be a factor of rurality and the reluctance of staff to move around other hospitals to see how things are done differently. In her experience, some nurses who have been in the one hospital since leaving school are pretty set in their ways, while others who have moved around extensively are more open to change. She thought that these more mobile nurses might be more likely to initiate change. As a newcomer to an organisation, she observed that there was a need to give time to become familiar with local practices and build relationships with staff before suggesting new practice. Existing staff were more likely to be negative in their responses if too many comparisons were made with the previous organisations. Joylene commented relationships and building trust are important in enabling change in practice. As we had come to a natural low in conversation we brought our meeting to a close after inviting Joylene to add anything further.

4.3 Conclusion

The purpose of this chapter has been to describe the attributes of the participants in the study and provide an insight into their experiences of CPD in their professional lives guided by the identified research considerations established in Chapter One. Participants were from a variety of backgrounds and practice settings, with positions that were based principally in clinical practice or which had added responsibilities and expectations that enabled them to exert influence in the practice setting. A broad range of experiences of CPD in their professional lives were described by the ten nurses. A thematic analysis of this data will be presented in the following chapter to identify the common, divergent and individual experiences that will enable the foundational understanding of the role of CPD for nurse's professional lives.

Chapter 5: Thematic Analysis of Data

5.1 Introduction

In the previous chapter I presented the vignettes of the ten nurse's individual semi-structured discussions that have enabled an insight of the nurses' professional context and experience of CPD. In this interpretive phenomenological study I have used thematic analysis as a means of approaching and exploring the data to gain understanding (VanManen, 1990). This provides an opportunity to identify the common and individual experiences that provide a beginning understanding of the role of CPD for these nurses' in their professional lives. In the final chapter, a detailed discussion will be undertaken to further explore and compare these findings with the existing literature and identify their application to the healthcare setting.

As previously described in the chapter on methodology, this data has been analysed and presented in *themes* to make explicit the meanings stated and inferred from the words, behaviours and events described by the nurses. The *themes* are a unifying and abstract description of the meanings expressed in the data that arise from the direct text and concrete examples of *categories* and *concepts* which underpin them. Four themes emerged from the data; Context, Motivation, Activating and Connecting.

5.2 Context

Context refers to the environmental influences that were described as affecting nurses' experiences of CPD. Context is an integral component of the experience of CPD in the professional lives of nurses in the study. Nurses related the rural or regional context of their professional lives with issues of access and support, choice and availability of CPD, as well as attitudes to CPD, learning and practice change.

The particular nature of rural nursing practice was highlighted by all the Registered Nurses in the rural health care settings. Nurses who worked in smaller rural health services identified that they are often required to have concurrent, multiple roles in their health service. This results from the limited access to allied health, medical and nursing workforce in rural communities. They stated that the deficits in the rural

health workforce require that nurses take on some aspects of clinical care and an increased range of clinical responsibilities that would not normally be expected in their scope of practice. Rurality and isolation were seen to influence the nature of nursing practice to produce the "specialist generalist" who was able to meet the variety of needs in the practice setting (Hegney, 1996). The necessity to extend the breadth of their scope of practice and take on additional clinical responsibilities influenced the range and type of CPD required. This was associated with increased financial and leave requirements to meet this need. Some nurses described needing to have more in-depth knowledge to extend their scope of practice. Others noted that their multiple clinical roles and responsibilities also increased the amount of CPD required to equip them for practice.

This experience of multiple roles, the diversity and extended scope of practice was not shared by the nurses in the larger regional health service. Nurses working in regional health service had more delineated clinical roles and responsibilities. They identified that this is a product of the increased clinical presentations, the availability of the extended health care workforce and a larger pool of nurses with a variety of skills.

Exemplars:

Four nurses described a range of experiences that highlighted the nature of their rural practice. Their examples included managing acute trauma presentations alongside health promotion activities and mixing together caring for elderly and midwifery patients within the same shift in the same clinical area. A further two nurses commented that the diversity of practice had increased the amount and the differing content of CPD required. Rurality corresponded to increased costs and time away from work and home to engage in CPD activities.

> There's only so much money in the education bucket and it makes it really hard, especially when you've got multiple hats, because you need the education for each area that you work in. So I mean I've got three days study that I'm allowed to have per year but that's not going to cover anything for working at the nursing home, getting education for there, plus infection control. **Joylene**

> It's been particularly in community health because you could be doing anything from education on breast care to prostate cancer to nutrition in the kinder. You need to know so much. There are always things that you can go to that would be helpful. **Dana**

While Graham the Enrolled Nurse did not specifically refer to rurality in discussions, the context and nature of his practice in the residential aged care setting was distinctive amongst the participants. I noted that along with many other Enrolled Nurses in rural areas, he had extended his scope of practice to include medication administration. The requirement to extend the scope of practice to meet the requirements for service delivery was also highlighted by the participant Midwife as well as two others who were Registered Nurses practising in the emergency department of a rural health service.

In the smaller rural health services, three nurses held the view that their practice was more aligned to that of nurses in remote rather than regional or metropolitan contexts due to the lack of allied health and medical workforce support. The CPD offered in large metropolitan settings was less directly applicable to their rural practice settings. Dana, Denise and Harold found that the programs run with the Council for Remote Area Nurses Australia (CRANA plus) better matched their CPD needs. These comments on affiliation with remote practice were not reflected in discussions with nurses who were based in, or close to the larger regional health service where there was easier access to the extended health workforce and facilities.

> I went up to Alice Springs to their chronic disease in remote health course because the one I went to in Melbourne was so focused on "you will have a multi-disciplinary team that you can call on." **Dana**

> When you compare it to a bigger hospital you've got back ups, you've got other nurses working with you in emergency, you've got doctors there immediately. But here you have to struggle finding help, to get orders, to get help. So it's really difficult for us at first but when you have these updates, which give you the idea what you really have to do and where your coverage is... [and] is it in your scope of practice? Yeah it's really helped a lot. **Harold**

Four nurses noted that they found the delivery of CPD within their region meant that they could easily contextualise their learning. The opportunity to discuss and

question strategies that had worked effectively in one health service informed others of potential approaches to meet their identified clinical needs in similar settings.

5.2.1 Theme Summary

In exploring the influence and impact of the context in which nurses practice it was noted that:

- The nature of rural nursing practice for some nurses in the study required multiple clinical roles, an increased breadth in scope of practice and in some situations an extended scope of practice.
- In smaller health services rural practice can require additional CPD to support extended scope of practice and multiple roles.
- Rural practice can require additional financial and leave support for CPD attendance and engagement.
- CPD programs must be relevant to the context of practice as noted particularly by nurses in rural health services.

5.2.2 Issues for further consideration

a. The increased and differing requirements between practice settings indicate that the rural and regional context impacts on the nurses' experience of CPD. This study found clinicians and health services focus CPD on ensuring nurses are appropriately equipped for practice in these settings. With these findings in mind, how can CPD be developed to meet the particular and differing practice requirements of rural and regional nurses?

5.3 Motivation

This theme identifies a range of reasons for engaging in CPD, which were commonly acknowledged. Through engagement with CPD, nurses in the sample focused on its ability to sustain and guide the development of their understanding, confidence and competence in practice. The descriptions of its utilisation and the motivation to engage with CPD indicated that the overarching rationale and role of CPD was to support and provide a sound framework for their practice.

5.3.1 Establishing competence & capability

A common reason for undertaking CPD emanated from nurses' need to practice safely at the highest standard and be working from best practice guidelines. The importance of keeping up to date with current practice was emphasised by all nurses in the study with some commenting that this was particularly important in rural settings where access to contemporary thinking around practice required them to take the initiative to seek information. Other drivers for CPD included the requirement for security of knowledge to maintain and improve practice and to ensure they could be confident that they were doing the best they could. This was expressed by eight of the nurses from across a range of different sized health services.

Exemplars:

Denise used CPD in the form of completing post-graduate studies in emergency nursing to assist her to feel prepared, building not only competence but capability to be ready to respond appropriately to whatever she might encounter in the practice setting. In so doing she was provided with the security she desired.

> I found not having doctors on-site and not having a lot of support team ... you don't have the technicians, the specialists, your experienced A & E doctors here. You're working with GP's ... I found I was very confronted...with what was coming in the door and with the amount of responsibility that was on my shoulders. So that's why I decided to do the post grad in emergency last year. I needed to do it. I needed that security blanket for my own personal feelings. I'm the sort of person that likes to know exactly the ins and outs of everything...I don't like doing things by the seat of my pants. I like to know how everything goes before I do it so that's why I thought the ED course was important to me. **Denise**

Kathy also provided similar perspectives.

> So I wanted to make sure that I was practicing in a safe efficient manner and that I was following best practice guidelines. That's not just because of policies but because things change and when you're not connected to an acute setting and you're not getting really up to date information at a relevant time. I felt that it was important that I went out and sourced the information for myself so that I was practicing at the highest level I could. **Kathy**

This requirement to ensure they were current with contemporary best practice demonstrates that these nurses had taken the professional responsibility for the delivery of quality care seriously. They were motivated to use their engagement in CPD to be assured they had not missed out on crucial information because they were in a rural or regional area.

5.3.2 Guiding practice

Three nurses identified the importance of ensuring their knowledge was current because they had responsibility or a perceived professional duty for guiding and enhancing the practice of students or novice nurses. These experienced nurses noted that this was a specific motivation for their own CPD and was part of the professional responsibility to preceptor and mentor beginning practitioners as part of their everyday nursing roles.

Exemplars:

Actively pursuing CPD was described by Julie and Scilla as a core component in meeting this felt responsibility and aspiration to be a role model for other nurses.

> Because we have students coming through and you have to teach them, you have to know what you're talking about to tell them. So that pushes you to stay up to date. So having the student presence probably is a good thing and it's kind of a dynamic area. You can't just rest on your laurels. You have to be pretty much on the ball. **Julie**

> So now I take it quite seriously, trying to be a model to those more junior people. **Scilla**

Four of the nurses in this study were not only supervising and guiding practice with others but were also educators. Their desire to learn and teach was a motivation to engage in CPD so they could meet the obligation for their personal competence and capability as well as ensuring that they would stand professional scrutiny and guide the nurses who were within their responsibility. The particular composition of the study group has provided an opportunity to focus attention on the importance of using CPD to support the provision of professional and clinical guidance to students and novice nurses.

5.3.3 Professional Advancement

Four of the nurses who wished to advance their career or saw an opportunity to move into different areas of nursing utilised CPD to provide the skills and required knowledge. Three of the Registered Nurses had undertaken or were about to embark on tertiary level post-graduate studies as a more structured part of their CPD. Their decisions were based on their need to progress their professional knowledge, to enhance their confidence, extend their scope of practice or prepare for new roles. CPD was used by them to provide to assist their professional advancement.

Exemplars:

In place of formal post-graduate study that provided qualifications, one nurse had chosen instead to opt for a range of shorter courses and programs to support her career development and practice. In one instance, the attendance at CPD had provided the impetus for the lobbying and subsequent development of a new specialised practice role of Transfusion Nurse in the organisation.

> I went to a study day on transfusions; they were talking about these transfusion nurses and what hospitals needed to do to meet their Equip standards. That appealed to me, so I pursued that at that time... we had to put together [a case]. We didn't have a transfusion nurse so we put it forward to management saying why we needed it and how it would be paid for and they agreed. So I really started it. **Julie**

> I thought I could just change jobs because I really want to use what I've learnt. I want to be able develop...I'm at the time where I want to focus on one thing and get to be really good at it. **Kathy**

Kathy spoke of completing a post-graduate program to equip her in the area of diabetes education with a view to gaining a position in this area and utilise her new found skills and abilities and excel in that area.

5.3.4 Meeting organisational imperatives

During the discussions with nurses in the study the focus was largely on the use of self-initiated CPD, although there were also organisational requirements that influenced their engagement. Three of the nurses talked about circumstances where management had requested, directed or strongly encouraged their participation in

CPD. As there was alignment with organisational need and personal professional aims, this approach to CPD was perceived positively.

Exemplars:

Dana, Harold and Graham all reported experiences where management had played an active role in their participation with certain CPD activities. Graham, the Enrolled Nurse working in residential aged care for the past twelve years, had been encouraged, guided and supported by management to take up study to become medication endorsed as part of an organisational development of skills and systems for service delivery. Graham also wanted to make sure he was not 'left behind' as many newly qualified Enrolled Nurses were automatically endorsed to administer medications. In completing the medication endorsement program he was then able to take on the new roles that management had created, utilising these new skills.

> ... I've become [medication] endorsed [and] we've got sixty beds in our unit ... It was terrible because we only had one RN pushing all the pills for sixty. So they've come up with the idea of a team leader who would be an EN, so I got one of those roles. **Graham**

Each of these nurses considered this management approach as a positive initiative, that the organisation was either interested in them or in the advancement of delivery of service and practice. Whilst the initial motivation for these nurses to engage in this organisationally determined CPD could be determined as being extrinsically driven, each nurse responded by engaging with the initiative. It was taken on as personally valued CPD, seeing value to their practice and the benefit to the organisation. It was also interpreted by them that the organisation had valued their personal contribution by requesting their involvement.

5.3.5 Meeting professional requirements

The introduction of mandatory twenty hours CPD by the Nursing and Midwifery Board of Australia (NMBA) was acknowledged by all participants but was not identified as a primary motivation for engaging in their professional development. CPD activity was already a part of their professional lives, so the introduction of mandatory requirements was not an acknowledged reason for engagement in CPD.

It was noted to have raised awareness of CPD in the profession and increase the thinking about it.

Exemplars:

The four nurses who held roles that required them to provide CPD education and training to other nurses noted that there were less positive responses to mandatory CPD expressed to them which did not always reflect their personal views. This was demonstrated when Stephanie reported that the introduction of mandatory requirements was perceived negatively by some nurses who had worked in the same health service for long periods of time. In Julie's experience, some of her colleagues had expressed concern about the amount of CPD hours required which she believed related to their lack of understanding of what could be included as part of their twenty hours. Underlying all the nurses' discussions was an awareness of the fact that they could be audited on their CPD activity, introducing an element of fear.

> I just think after the AHPRA announcement people were frightened about not achieving it [the mandatory 20 hours CPD]. I never thought that. I just thought as I actually look back at the reading I've done, the structure of courses, that there was plenty. So I thought it was never a concern. I know a couple of people from the hospital were audited and they made it out to be a huge deal because they hadn't kept good records. **Julie**

> Some of the nurses that I have worked with especially in my last role, they got quite upset with the amount of CPD that they had to do and I didn't think it's that hard myself... It's sometimes those people who have been in the position a very long time and they get resistant to change. **Stephanie**

> I think that personal involvement [knowledge] of someone who's been audited it does bring to you again "oh it is real and they do choose ordinary people". It just made you a bit more cognizant that I do need to document everything as I go along and do it, which is not a bad thing at all. **Scilla**

Harold commented that CPD was more than just a requirement for registration.

> We should always think CPD or continuing education not only because we need to come up with certain units for our registration, but every profession is continuous learning. Life changes every day and we need to cope with the changes. So continuing education probably helps us cope with changes. It teaches us how to cope with changes and what the changes are and how we deal with it. So I think we really we need to think we have to do continuing education, not because we are

required to do that, but because it's for us to learn and for us to grow and for us to develop. **Harold**

This statement reflected the perspective of CPD held by many of the participants, that engaging in CPD offered them more than the basics of meeting the requirements of the regulatory authority.

5.3.6 Theme Summary

The driving factors that motivated nurses in this study to engage in CPD activity have identified that:

- In the study, nurses describe a variety of reasons why they engage in CPD which broadly involve a desire to ensure confidence, competence and capability in their practice and that they are keeping up to date with best practice.
- A number of nurses perceived the learning from CPD was a crucial component in enabling them to be prepared to guide students and novice nurses and be a role model.
- Nurses saw the learning from CPD as assisting them in preparing for new scope of practice, honing skills and enhancing practice to enter a new practice area or for professional advancement.
- Mandatory requirements raised the profile of CPD but were not a primary motivation for this group of nurses.
- Some nurses in the study reported a lack of engagement with CPD by other nurses who had been employed for long periods in the same place and role.
- Where organisations requested or encouraged attendance at CPD, participant nurses considered this positively.

5.3.7 Issues for further consideration

a. The sample identified a general belief that CPD has a function which supports professional growth, professional opportunities and competence in practice. What can be learnt from the reported failure of CPD to engage the entire nursing profession as is indicated by this data?

5.4 Activating

Activating describes the processes of identifying need, planning and undertaking of CPD by nurses to instigate and maintain the CPD cycle described by the regulatory authority. This CPD cycle is a key element in the continuous process of maintaining competence to practise as determined by the NMBA (Australian Nursing Midwifery Council, 2009; Nursing and Midwifery Board of Australia, 2010b). There are identified steps in the process of meeting this registration standard including identification of learning needs, planning and undertaking CPD and reflecting on the effectiveness of the CPD on clinical competence (Australian Nursing Midwifery Council, 2009; Nursing and Midwifery Board of Australia, 2010a). All of these steps were not included by the study nurses in describing how they went about engaging with CPD.

5.4.1 Reviewing practice, identifying learning needs and planning for CPD

The nurses described differing processes used in deciding on their CPD activity. These included the use of a structured approach of identifying learning needs incorporated in Professional Development Review (PDR), the opportunistic approach to deciding on CPD without a structured review of learning needs and a less formalised approach of clinical questioning that occurred frequently in the clinical setting. Continuing Professional Development that was of a longer duration or needed time away from work or family, required consideration and planning for the leave and financial commitments.

Exemplars:

Four nurses in the study identified that there was a review and discussion of their learning needs when participating in Professional Development Review (PDR) with supervisors. None of these four nurses discussed how they would identify the type of CPD required to meet these learning needs in this process. Regular PDR did not happen for all nurses in this cohort. The other six nurses did not use any structured process in their identification of learning needs.

Finding the appropriate CPD activities was often described by the nurses as ad hoc or opportunistic, even when they had identified their learning needs. None of the

nurses mentioned strategically planning and seeking CPD opportunities to meet the identified learning needs unless it related to post-graduate programs or longer programs. Finding CPD often occurred in response to information about courses and workshops that reached them by way of leaflets, posters or emailed information. Instead, if nurses saw CPD opportunities that could be relevant, this was flagged by them as something to follow up.

A continuous process of responding to clinical questions as they arose in clinical practice was driving the choice of CPD for some of the nurses in this study. They sought more immediately available information from journals, guidelines or internet sources of information rather than other CPD opportunities such as attendance at workshops or study days as there was an immediate requirement. This information was then readily taken back to the clinical setting, informing the clinical practice decisions. Only Denise had considered this was part of her CPD.

> I've been working for eleven years now. It's always been just I've seen the flyer that looks good [and] I'll go and do that. I tend to pick areas that I am low in knowledge or I know I'm weak in. Generally it's just by chance but occasionally I'll have it in the back of my head that I need to look out for that and when it comes along I'll do it. **Stephanie**

> I'm pretty focused, like I'll self-evaluate on a regular basis and probably way too hard on myself. If I'm struggling with x,y,z drug then I'll go and research it myself. Or if I'm looking at an ECG and I'll think, oh what's that again and I'll go do something off my own bat. **Denise**

Where nurses were requested, suggested or arranged to attend CPD by their organisation, there was reduced call for them to reflect on their learning needs and limited requirement for making plans for their CPD engagement.

The three nurses who undertook longer courses or post-graduate study took time to strategically identify the most appropriate program and plan for it. An example of this kind of strategic planning was discussed by Janet who is both a Registered Nurse and Registered Midwife. She works in a rural health service where there are only one hundred births per year meaning that she cares for only a few birthing women on her shifts. Midwifery remains a small and important part of her practice. Janet had joined a regional program to enhance her midwifery skills by spending time in the

large regional health service in addition to her usual work. This required her to plan her shifts in her home organisation to accommodate the program requirements. Similarly, Denise and Dana spoke of the increased planning requirements to identify the most appropriate course in chronic disease management and post-graduate studies in emergency nursing.

The Australian Nursing and Midwifery Council describe the need for reviewing learning needs and then intentionally planning CPD to address these needs to ensure clinical competence. In this study, the self-reflection on learning needs and the intentional planning to meet them was missing for many of the nurses, despite the ANMC advice.

5.4.2 Access and support for CPD

Issues were raised by all nurses around the financial commitment, release from work and travelling requirements to attend CPD. These factors functioned either as enablers or barriers to access and were constant discussion points in my meetings with them. They noted that management support for them to engage in CPD varied considerably. This variability was reflected within the personal experiences of six nurses and the degree of support varied across the whole study group. The consideration of the applicability, cost and opportunity to attend were influential factors in nurses' engagement with CPD. Travel and increased time away from work and family to attend CPD were noted particularly by the nurses in the smaller rural health services. The cost for arranging registration, travel and accommodation for CPD programs which were offered more distantly was influential in the decision making process for them.

Exemplars:

Nurses noted they were often required to travel up to one hundred kilometres to attend the subsidised rural workshops and there was a lack of public transport alternatives in rural areas.

> I suppose access is probably the hardest thing because staff do need to travel. Some people are willing to travel, other's not so much. I went to Sydney for an antibiotics stewardship study day. So it does make it really hard for people to get to the important issues and get the information directly that way. **Joylene**

Nurses in this study were not always aware of their entitlements for study leave or financial support for their professional development. All noted the lack of visible organisational guidelines and policies in regards to CPD. Four nurses found there was a lack of guidance on how to apply through the work system and were at times confused about the rationale behind decision making for the granting of this support. Scilla, who was working in theatre, noted it was more difficult as a junior nurse because she lacked confidence to seek out the information.

> Well certainly some things are prohibitive to go to and so you just don't go. There was some funding available but none of us really knew what the funding was, we just sort of knew you could apply and perhaps you could get it or perhaps you would get half. So it would have been nice to know exactly what financial support was available to you from the organization. **Scilla**

Inability to release and replace staff for attendance at CPD workshops or programs was noted by nurses in some rural health services and was also an issue in the theatre setting in the regional health service. Other nurses in the major regional health service did not see this as a consideration as they had CPD available locally. Where the roles of nurses did not involve the provision of direct clinical care to patients as part of the rostered staffing for an area, there was more flexibility in being able to attend education during normal working hours without clinical impact.

> But in theatre as a clinical nurse, there's a bit of a mismatch between the availability of study leave and the opportunity to actually take it. So I'll apply for things, sometimes it will get knocked back because of availability of staffing, those sorts of things. **Scilla**

> Personally in [name of large regional centre] I think it's brilliant actually. When I was in my last position, the drug companies were excellent at inviting us to things in Melbourne and we could leave work early to go down to Melbourne for those things. It's not that far, it's quite easy to get to. Some people argue differently up here, but I find it easy to get to Melbourne. I attend things down there; otherwise the Grampians in the cancer service runs things from that Highway Model. Really there's a lot of education opportunity and video conferencing as well so. I think it's really well supported in this area. **Stephanie**

The financial implications of CPD were relieved by the opportunity to attend subsidised regional education workshops at no direct or minimal cost for the nurse. The inconsistency in the granting of leave and financial support by organisations was particularly noticeable for programs offered outside of the region or if they were not part of the subsidised 'Highway Model' program. Nurses could not provide a reason for this, but it may relate to the increased costs for these other types of CPD, requiring organisations to consider each request on an individual basis. The effect of being denied the opportunity to attend served to dampen the enthusiasm for CPD as it added yet another barrier. One nurse expressed frustration that financial support was offered to nurses who were not really interested in attending CPD when there were others who would benefit greatly from the support and were eager to go.

> I realized that the hospitals only have a certain budget for education and they say that the same people can't use all the budget for their education. I suppose the frustrating part of that is, even when there are things available and you try and encourage people to go, they just don't want to go. So you think, "Well why keep that money for them when they've got to be pushed or forced to go?" When you've got people who want to do the education; when you've got people who have to pay out huge money to be able to go, it just seems a little bit unfair. I mean there are people I've teed up education sessions for them in local towns like in [name of two neighbouring towns] and because it's not local, as in here, they don't want to go, or if it's in Melbourne, they definitely won't go. **Joylene**

> I think the thing that surprised me the most even though I had clearly identified in my professional review what I felt I needed to do, I then got knocked back by my manager when I tried to go and do them... Well I'm entitled to two days [study leave] because I am part time and the most challenging thing is that I have never been told that there has been a sum of money that I can put towards my study days so then it has been at the discretion of my manager, what they are willing to pay for. **Janet**

Dana and Kathy who had both worked or were currently working in small rural community health services, sought scholarships to assist them to attend longer courses and programs that were distant from them. They had not relied upon their employer to financially support their CPD. Their successful applications for rural and remote scholarships to the Royal College of Nursing, not only provided them a means of attending, it also afforded them positive feedback in their endeavours to extend their professional development. This was evidenced in the positive manner in

which these scholarships were included in our discussion. Denise and Harold were in a different situation as they were supported by their employer who applied for scholarships on their behalf to assist them to complete post-graduate study relevant to their area of practice. This scholarship process is generally predicated on the service delivery needs of a rural or regional health service and funded by the Department of Health. Apart from a very limited amount of organisationally supported CPD, a number of nurses perceived that CPD was now more of a responsibility of the individual nurse to identify, arrange and fund rather than an organisational responsibility. This has been a change over the years noted by Dana and Joylene and may contribute to feelings of frustration and confusion if this has not been explained by organisations.

5.4.3 Choices and available options for CPD

There were a range of different types of CPD used by the nurses and some were preferred or used more frequently. The different modalities of delivery provided different types of learning opportunities and in some contexts, enhanced access. These included face-to-face opportunities, video conferencing, journal reading, online learning programs and online sources of information.

There was a great reliance on attending workshops, courses and programs that allowed personal interaction with colleagues and CPD presenters. They were used by all participants and dominated the early part of each discussion about CPD in their professional lives. The preference for this kind of delivery of CPD was inferred by its frequency of inclusion and its dominance in the discussion with each participant. Not all CPD requires release from work and the use of reading journals and professional publications as part of CPD were described by six of the nine Registered Nurses (RNs). Information Communication Technology (ICT) provides access to information about available CPD programs and admission to online learning modules and journals. This allows opportunities for out of work engagement in CPD activity at the discretion and timing of the nurse. Many nurses commented on completing online learning programs amongst their range of CPD.

Where nurses practiced in speciality clinical roles such as infection control, immunisation, transfusion, perioperative education and midwifery, there was little opportunity of accessing CPD locally to meet these needs. This was of particular concern for nurses when they were located distant from major centres. Some speciality practice areas did provide internet based education and networking opportunities but largely this difficulty in access related to study days, workshops and seminars.

Exemplars:

Harold particularly noted he uses journals and professional publications to help answer clinical questions. Very few of the Registered Nurses read journals routinely, instead seeking out information from them when prompted by a clinical need. Janet, Kathy and Dana noted that it is difficult to make the time to read all the journals and that this was required outside of working hours in personal or family time. This selective approach to journal reading reflects a needs driven engagement in CPD.

> If you've got an issue going you certainly access the journals as you need them. I cannot read all the journals as they keep on coming in, because I just don't have the time to do it. But if an issue arises, then I will go searching through the journals and I'll catch up with them then as I require the information. **Joylene**

> I subscribe to the journals. My challenge with the journals is when I get home ... the last thing I want to do is read about work when I have been at work. So my biggest challenge is reading the journals. But when I do read them, I often find really interesting things that excite me so I'll go back to work and say that I read that. **Janet**

The type of information accessed by nurses online included e-learning programs from a range of providers. Kathy, now working as clinical support nurse in the large regional health service, acknowledged the huge array of information available on the internet can be confusing and contradictory, making her wary of what she accesses. Information Communication Technology has increasingly been incorporated as part of post-graduate courses to develop the blended learning approach and allow distant students access to tertiary level study. Denise noted that the majority of learning activity in her post-graduate course run from South Australia was provided in an online environment interspersed with video conferencing and campus visits.

Harold noted the limited utility of online learning in its relationship to practice due to the solely theoretical nature of the content. He suggested that the application of theory to practical skills ought to be complementary.

> But it's also different when you're just asked questions there on line, then you don't practice it. Like hand washing, like all the questions you have all the answers there but when you are with your patients you don't sometimes practice some of the things that you've learnt from the book or learnt from online. **Harold**

Two nurses commented that they were disappointed in the assumptions from employers and education providers that internet coverage and access to computers is available in rural areas. They remarked that internet coverage was unreliable and often very expensive in rural areas. Despite working in the major regional health service Kathy lived over thirty minutes from this regional centre and found difficulty in securing internet coverage. Janet noted that the time to undertake CPD activities outside work hours is also assumed by employers and the reality of doing so in a busy family life can be unrealistic.

> I have been given lots of websites to do online learning and I keep meaning to find the time to do it. I probably wish there was, I had more down time to do it at work. So the idea of doing it at home is good, but the reality is quite different when you've got other commitments. **Janet**

> The other thing that I found was when we first moved to Australia we didn't have an internet connection. That annoyed me [because I] felt there was a presumption that I had a broadband scheme at home that allowed me unlimited access, that was available to me at a reasonable cost, and I didn't. It was a USB that was really expensive. So I felt annoyed that there was not that time to do it at work. There was that expectation to do it at home. No one ever bothered to say "is this achievable for you at home?" **Janet**

The use of internet based information and the access to professional networks enabled by ICT were noted by Scilla and Joylene to be useful in keeping them informed of current issues in their speciality areas of nursing.

5.4.4 Theme Summary

The exploration of the way nurses in this study engaged with CPD activity noted that:

- In this sample, the processes to identify learning need varied with most nurses not using a structured approach. Some noted they were prompted by clinical presentations.
- Throughout this sample, opportunistic approaches to CPD engagement were mainly used.
- When nurses did identify learning needs, these nurses did not then strategically plan CPD engagement. Instead, these nurses largely relied on opportunistic approaches to finding and engaging with CPD activities.
- Those considering post-graduate courses or longer programs that were distant from home considered options more strategically.
- Value for money, time away from home and appropriateness were factors in deciding on CPD. These factors most often influenced the decisions of nurses in rural or more isolated settings where their effect was more noticeable.
- ICT access was seen to be limited, not available and expensive in some rural areas, making CPD offered from this modality outside of work hours unattainable for some nurses.
- Nurses in this sample primarily understood CPD as attendance at face-to-face programs, until they were prompted about other modalities for CPD.
- Clinical questioning and subsequent information seeking was considered as part of CPD by only one nurse, suggesting a limited perception of what can be included in CPD.

5.4.5 Issues for further consideration

The data gives reason to reflect on some key considerations for further discussion.

a. The emphasis on face-to-face programs in these nurses' choice of CPD activities and the lack of understanding of practice-based learning as part of CPD differs from that identified by the NMBA description. How does this affect the experience of CPD for nurses in rural and regional areas?

b. The variability of health services' capacity to provide financial support and opportunities for leave to attend CPD activity impacted on nurse access to CPD. Does this variability and uncertainty influence nurses' approaches to and uptake of CPD?

5.5 Connecting

The theme of Connecting relates to the way in which nurses in this study perceived and established the relationship between CPD, learning and practice. The influences upon this relationship included the use of reflection, identification of learning as an outcome of CPD and the factors affecting implementation of learning.

The identification of the learning and other outcomes from CPD activity and the impact it may have on practice was not always a part of the way nurses in this group have engaged with CPD. All nurses frequently spoke about the benefit to their knowledge from their CPD activity but rarely talked of learning. They had used CPD mainly as increasing their knowledge but had not related it or applied it in the practice setting except where clinical questioning and problem solving was occurring. Only one of those who described this clinically based process identified it as CPD.

5.5.1 Reflection as part of the process of CPD

Some nurses demonstrated little ability to clearly describe what kind of outcomes from CPD they had experienced. There was a lack of reflection undertaken by all nurses in various aspects of the CPD cycle. Whilst many nurses had not been routinely considering how to use the learning from their CPD in their professional lives, most commented about why they had not. These involved a lack of time, opportunity and motivation and a focus on the collection of evidence of CPD activity to satisfy auditing. This attention to quantifying their activity to demonstrate compliance with regulatory requirements took priority over the need for documenting reflection on CPD's usefulness and effectiveness in practice. They had not understood that the auditing would also include their reflection on their learning needs and CPD usefulness. Others were selective in how they spent time documenting their reflection and some did not use any structured reflection of CPD.

Exemplars:

Denise and Scilla both noted that their postgraduate studies more than accounted for their mandatory twenty hours and therefore they had not documented any other record of CPD. This was seen by them as the extent of their reflection required. Although reflection on their learning may have occurred as they worked in the clinical setting, this was not discussed. Stephanie commented that she had started reflecting on her CPD but making time to do so was difficult. Janet also commented that despite the best intentions she never gets around to writing up her reflections.

> But I've only just started that recently where I started up my own little file at home and I can summarize what I learnt and don't think about it anymore. If we're audited you are supposed to have a bit more reflection than in the past. I think because often you go to things and put it in the back of your head and then don't think about it so I think it is a positive change. Then I have to find the time to actually sit down and do it. **Stephanie**

> I always mean to do it as I go to the days, but the reality is I tend to get to the end of the year and sit back and go "ah". **Janet**

> When I first heard about it, I thought righto this is something that's going to be, so I went on the website and I made up a book. You know what I've done and where I've trained and all that and sat it in my little file at work and that's the last I ever looked at it because every form of training that you do you get a certificate so, stating your learning points. **Graham**

Scilla described her response to the introduction of mandatory CPD hours, her use of reflection and documentation of CPD activity.

> I think that probably that [mandatory CPD hours] all came in as I was developing my own interest in how I could and should be professionally involved. So for me it was certainly part of the picture. Oh yes I should be documenting it, I am documenting and I am quite pleased with what I am seeing. Or perhaps I should be doing a bit more here or there on that point. I get the impression from people that it has impacted positively. It's just in peoples' minds more I think. **Scilla**

Only Dana had systematically reflected on her CPD activity and documented an evaluation of its usefulness, noting also that she provided feedback to her organisation with recommendations.

> Yes we report for education and we've got someone who's responsible for education and we report all of that. We have to list what the content was, what the expectations were and any recommendations and I keep a copy of that. **Dana**

Prompted by our discussion, nurses were able to comment on some of their learning experiences and began to identify how their CPD activity fostered learning.

5.5.2 Learning as an outcome of CPD

Despite rarely speaking of learning in association with their CPD activity, nurses described a mix of different ways they were learning from CPD. These processes of learning included theoretical learning from online and face-to-face programs, the development of new and the refinement of existing skills and also learning from situations in their clinical practice setting. The learning from the clinical practice setting was mentioned as part of CPD by only one nurse, although others readily reported identifying a clinical situation that had prompted them to seek further information and initiated their learning.

Exemplars:

Harold saw CPD learning as a way of honing skills already held as well as gaining new skills. In discussing his recent attendance at a workshop he described the type of learning he had experienced.

> Not that I haven't experienced it before but it is also sort of trying to polish what you've learnt before and what you've experienced before. There are parts that you haven't experienced before and then you could effectively put it into actions while you encounter these types of situation. **Harold**

Some of the online learning options and more didactic presentations in workshops and programs were described in a way that appeared there was a separation of the CPD from the reality of practice. Nurses had 'done' or 'gone to' CPD and had not made the connection with their learning outcomes and the relationship to their practice setting.

The use of journals and internet based resources to answer questions about clinical practice was a process that the nurse initiated and was specific to identified needs.

> [I use journals] especially when I want to know something about a case and I don't know that. I do read journals but also the internet because it's more accessible. **Harold**

This kind of approach brings CPD learning to the practice setting of individual nurses and is a process of learning that is inherently embedded in nurses' practice.

5.5.3 Implementation of learning

I observed that many of the nurses did not have a structured process of identifying learning outcomes from CPD, and yet they were still able to discuss how they used CPD learning in practice once I had prompted them. This may indicate that they were using other less structured processes that enabled them to move knowledge gained from CPD into practice, although none could explain how this occurred. It appeared that they had identified specific elements from their CPD that were applicable to their practice setting and set about implementing this knowledge. There was a mix of comments that identified nurses using their learning in their own practice, in the broader practice of the department/organisation or an intermingling of both. They described a variety of approaches to bring the learning from CPD to the clinical setting by using established organisational processes, the development of personal strategies to influence organisation wide practice and a willingness to incorporate new knowledge into their personal practice.

Exemplars:

Successful examples of using CPD in practice included the experience of the transfusion nurse Julie who was able to implement new practices using a planned process. Joylene had used a systematic approach to sharing her new knowledge as an infection control nurse.

> I've just been to a conference and there are always new technologies and methods of working smarter or equipment reducing needle-stick injuries and infections. I bring them back. I show the ward nurse. I show the deputy director, we discuss the cost factor and if it's something that really could make a difference. We'll do a trial and if it's effective we implement it, hopefully. **Joylene**

Organisation wide determined changes in nursing practice were described by Graham the Enrolled Nurse in aged care and Kathy working as clinical support nurse

in the major regional health service. In these situations the pre-determined practice change was supported by CPD, thus ensuring implementation of learning was not only possible but expected.

> Yesterday I went to 'tissue tears' which is module four of the wound program that's developing in the health service that I work with. And that was very informative and also alerted me to the fact that there should be a poster or a brochure on all wards to tell staff this is the tissue tear regime and how to best rectify it. So that's already going to be implemented and I looked for it today in the ward. **Kathy**

Enrolled Nurse Graham was enabled to use his learning from his medication endorsement because management had already established new roles and processes so this could happen. In effect, the change of practice was decided for him and he had not been required to consider this before applying his learning.

> So they've come up with the idea of a team leader who would be an EN [Enrolled Nurse], so I got one of those roles. So now, I work alongside the Div 1's [Registered Nurses] which has… certainly changed my role. There's a lot more responsibility in regards to the insulin and your tablets with your warfarins, your oxycontins and all your DD's. That's changed me a lot where I swore black and blue that I'd never, ever touch a pill trolley. **Graham**

Dana explained how she found an asthma education program enabled her to practise with confidence at a more advanced level in her own practice.

> I've been able to feel confident that I'm telling them the right information...the different medications, the fact that the preventer needs to be taken twice a day, they really push the asthma plan, identifying triggers and what the triggers could be. I mean a lot of it I already knew but it took the learning to another level. **Dana**

Juxtaposed with these positive examples of using CPD learning in practice, Dana noted that in her experience of smaller rural organisations, nurses did not always have an opportunity to regularly practise what was learned from their CPD. This may result from a lack of clinical exposure to the particular situations which required use of this learning. The fact that these kinds of presentations are infrequent did not diminish the need to seek CPD in these topics. Instead Dana emphasised that the lack of opportunity to practise skills and use the information, heightened the requirement for CPD so that nurses were adequately prepared to deal with whatever presented in the Small Rural Health Service setting.

5.5.4 Roles and influence on practice

The measure of the effectiveness of CPD is that the activity is likely to lead to a change in practice and is clearly identified by the Australian Nursing and Midwifery Council (2009). Eight clinical nurses noted that either currently or in the past they had not felt they were in a position to change practice. The lack of knowledge about systems to influence practice or the difficulty in achieving change was compounded by being new to an organisation or being a clinical nurse. In the position of a clinical nurse the processes of changing practice were seen to be outside their sphere of influence. Five of the nurse participants were in clinical roles that were more autonomous and advisory in relation to practice than the clinical nurses who were working solely 'on the floor'. These roles of transfusion nurse, infection control nurse, breast care nurse or clinical support nurse provided them with the opportunity and also the responsibility to influence practice.

Exemplars:

Clinical nurses' perceived lack of opportunity or authority to influence practice was highlighted by their experiences and was compounded by organisational disinterest.

> Probably my main feeling about the clinical role didn't effect change at all really at all. And that developed a sense of frustration that I couldn't effect change and I think part of that had to do with the management structure wasn't really interested. So I suppose I had a bit of a high standard. I thought there shouldn't be a divide between what we say we do and what we do. **Scilla**

Janet had recently joined the organisation and was unsure of the process to share learning from her CPD. Her experiences did not give her reason to believe she had any influence on practice in her work setting. This was also supported by two other nurses who had experienced unwillingness of others to listen and respect the input of the newcomer clinical nurse.

Joylene noted that as a clinical nurse she used to be focussed on the clinical work and would leave practice changes to the nurse manager. She suggested that clinical nurses often lacked understanding of the processes required in implementing learning from CPD and achieving practice change.

> I think in the clinical setting there's a chain of command. If you find something that needs to be changed you pass it on to the nurse unit manager and let them deal with it so you can get back to the clinical stuff. I've had nurses sort of state that they get really frustrated because they mention stuff to charge nurses and because it doesn't happen straight away they get really frustrated that their ideas...hasn't impacted on the charge nurse. I keep on reminding them that things don't change overnight... I think the clinical staff see what may need to be done but don't have the ideas or knowledge of the process of getting something changed. **Joylene**

The roles of transfusion nurse, clinical support nurse, infection control, clinical nurse educator and breast care nurse gave them credibility and influence in being able to implement the practice change that was guided by their learning from CPD. Scilla discussed how there was an expectation of the clinical educator role that she would suggest new and different practice. Whilst she had tried to make changes to practice in the past, it was not until she had the credibility of the new role did she get to influence practice change.

> I think that is the challenge isn't it? To make some sort of practical application to what you go out and see and learn. I think in some ways when you go and see a new practice or new technology or whatever it is, you can find yourself thinking it's bigger than you. Sometimes perhaps, you can't effect any change. But being in this role in education, it's certainly made me more aware of how to effect change and perhaps I have a little more power to do that in this role. But then, in reflection, perhaps as a clinical nurse had I been more aware of the different paths that I could have taken and the different sorts of things I could have done, perhaps I could have effected more change than I ever attempted. **Scilla**

The importance of the workplace, management and peer attitudes also were influential in implementing CPD learning.

5.5.5 Workplace culture and CPD effectiveness

In this study, six of the nurses from the large regional health service and the smaller rural health services specifically made comment about organisational culture, its role in developing attitudes to CPD and the implementation of learning to the practice setting. The work place culture was described as either an enabler or a barrier to the nurses' engagement in their professional development and the ability to influence practice. Where CPD access and support was encouraged there was comment from five nurses that this made them feel valued, enhanced a positive workplace culture and resulted in improved opportunities for reviewing and changing practice. Likewise

it was suggested by three nurses that in an organisation that did not support CPD by the release from work to attend or provide financial assistance, staff were often more reluctant to consider new practice in the workplace.

Exemplars:

The support for CPD in an organisation was perceived by nurses from a range of settings as a positive influence on the workplace culture. Scilla commented that being provided access to CPD has an influence on nurses feeling valued.

> ...I really think how you're supported in education to some extent is how you feel valued. **Scilla**

Denise and Harold noted that the support of their employer to participate in postgraduate study as part of their CPD was seen by them as positive acclamation, valuing their contributions, and thereby contributing a positive influence in the culture of the workplace.

> ... When I did my post grad last year the Director [of] Nursing took it upon herself to get me a scholarship. I was really amazed. I wasn't expecting it. **Denise**

Stephanie also suggested that the culture of an organisation and attitudes towards modifying nursing practice in the light of new knowledge made a difference to how she could apply her learning from CPD.

> I'm always trying to change whatever I can and I know the staff I work with here are big on evidence-based practice and the minute we think we should be doing better or different we will research it. So I've been quite lucky in this role and the previous one. That is the culture of the place. **Stephanie**

In the experience of Janet, there was little opportunity to feedback on her learning from CPD in her organisation. There was no evidence of organisational valuing of CPD and its links to practice.

> With the wound care day, there were definitely suggestions that they had and... I thought "oh gosh that would be good at work". And the reason for not taking it any further has really been the lack of time. It feels like there isn't enough down time to do it in work hours and because I'm only part time. I need time to implement... And the meetings that we have are so packed with things that are hot agendas about the way the unit is run that there isn't time to give feedback about a study day or a conference day that they've been to. **Janet**

Scilla also commented that in her experience in the perioperative environment, the culture of the workplace can be influential in the processes of practice development where learning from CPD can be implemented.

> I think...when you have a poor work place, people can't be bothered to take on change, but when people feel empowered, then change is easy to effect , because they feel included. That sort of sounds like it's easy to do, but it's not. It's a long term sort of project I think. I think it's about the bigger culture of any area. **Scilla**

The existence of organisational policy to support practice was identified as an important requirement to enable the implementation of CPD learning by Denise and Harold who worked in the same health service. Harold described the restriction on Enrolled Nurses for administration of intravenous (IV) medication within his organisation after being endorsed to do so. This may relate to the greater availability of Registered Nurses in Harold's organisation to complete medication administration.

> There might be a gap if the hospital's policies, procedures and guidelines doesn't permit what is being learnt from the CPD. Here I could probably see there's probably a bit of difference here. Like for example we don't allow endorsed nurses [Medication Endorsed Enrolled Nurses] to give out IV medications which I think other nurses in Victoria they do allow. So it's a matter of the hospital's policy at the moment that doesn't allow these nurses to give out these IV medications. **Harold**

5.5.6 Peer influences

All the nurses provided comments that indicated management and more often their peers and colleagues were influential in whether they could apply their learning from CPD to the practice setting. The influence of peers links closely to previous data about organisational culture and the ability of clinical nurses to influence practice. The direct influence of peers on the development of practice following CPD had not been considered by me prior to the study. The way in which it was raised by nurses has led me to the view that peer influence is a separate subset of the influence of organisational culture on how CPD learning could be implemented in the practice setting.

Five of the RNs commented that they had observed that where nurses tended to stay a long time in the one organisation in rural and regional settings, they became

entrenched in ways of thinking and doing things. It was suggested that this may be a result of limited exposure to new ways of thinking and doing associated with their degree of isolation and the lack of CPD.

Exemplars:

Stephanie suggested that when she had worked in an oncology unit based in a small private organisation located in a regional centre, it was easier to implement changes in practice as her peers and management encouraged the feedback on CPD. Julie suggested the reluctance by her peers to engage in new practice was possibly because they were not exposed to the new thinking and new practices that would normally be presented each week in CPD sessions in the major teaching hospitals. Dana referred to her past experience where nurses were reluctant to change wound management practice and linked this to long staying nursing peers as well as the lack of organisational support for CPD. Stephanie and Julie echoed these sentiments in relation to long staying nursing peers in a larger rural and the regional health service. This may indicate that some saw it was not just an issue directly related to rurality and that it may be more associated to the lack of a culture of practice critique in the clinical setting.

> Look there were some fantastic staff who worked really hard and they had good skills and they treated the residents in the nursing home like people not just bodies in a bed. But in terms of wound care; no it wasn't very good. And I think it was because they had worked in the same place for so long and they got into a routine "well, this is what we do." In that place there wasn't a lot of CPD and with management you had to justify going and with management they preferred for you to pay for it alone and to do it on days off. **Dana**

> I think people have been there such a long time; it's just a common [name of large regional centre] thing. I don't know if it's common around other places, but other friends that I know work at the other big hospital here. Some people have been there a lot of years and [they say]"we just do things this way and that's the way things are done". It tends to be a common attitude you hear. **Stephanie**

> I worked in theatre for a few years and there are a couple of women who have worked there for thirty years...The young girls who had just got their periop[erative] certificate come through and say "this is not right [or] the latest way, [it] is something different". They [older staff] would be very resistant, [saying] "oh we've always done it that way". And that's not always the best way. We need to stay up to

> date. There's a couple up there who just do night duty and it's like they're in a comfortable little spot. **Julie**

Joylene and Janet noted that the ability of the newcomer to implement new learning from CPD into practice also had difficulties. The lack of respect for the ideas and experience of peers limited the opportunities for practice development.

> I have seen it so many times that somebody new will come in with so many new ideas. The trouble is that comparing this place to the other place, it can get staff backs up and [they will be] saying "well if you were so happy there, why don't you go back then" and sort of that effect. So I've found that people coming in really need to stop and bide their time and really get into the place. Find what their procedures are and get to know the staff before comparing the new employment against the old employment place. And it tends to build a barrier and it gets them nowhere, other than [getting] staff members' backs up. I've seen it numerous times and you think," just settle in first and talk about different techniques. Don't just come in and change it to what you're used to, especially in the country areas when the girls have been here twenty to twenty five years." They feel threatened. **Joylene**

Whilst finding the reluctance to engage in developing practice frustrating, Joylene was able to step back and consider why this kind of response may occur.

> ... Some people feel threatened by change. "I've done this for the past twenty five years, why do I have to change things now?" Because there's new evidence and new rules and these are the requirements. "But I've been doing this, this way." I'm thinking you're a nurse. Medicine is always changing and you've got to keep up with the times or you are going to get left behind. **Joylene**

Joylene described how building relationships and trust with fellow staff members was an essential component to being able to implement learning and change in the workplace. Working with and alongside nurses to influence practice was part of her understanding of the way to implement practice change. She noted that in her experience, incremental practice change was better received by her peers rather than a major restructure of practice.

These experiences of nurses in the study have demonstrated that their ability to use the learning from their CPD was at times restricted by the culture of the organisation and also their peers. They observed that the nursing practice in these circumstances lagged behind the contemporary best practice guidelines and may not have provided

optimal care for their patients. The opportunity to improve and develop practice was missed by not bringing the learning from their peers and CPD to the practice context.

5.5.7 Professional and personal growth

One of the intended outcomes of CPD should be to 'develop the personal and professional qualities required in the nurses' professional lives' (Australian Nursing Midwifery Council, 2009). Continuing Professional Development was noted by the participant nurses to have a major role in supporting their clinical practice which in turn resulted in personal confidence in their practice. The opportunity to establish and actively network with others from different areas was mentioned as an important outcome from attending CPD particularly for rural nurses who were more isolated. The establishment of contacts in these networks was seen as being just as important as the clinical information provided.

A 'circle of confidence' is a term I have used to describe the situation where each of those in that circle knew the context in which the other was practising, their level of skill and the ability to manage the clinical situation at hand was developed within and beyond the region. This was reflected by nurses with speciality clinical roles who found that they needed to purposefully build professional networks with others in their speciality both within and beyond the immediate region. This network provided information about available CPD and the contacts to discuss clinical and professional issues. Sometimes networking occurred through membership of professional groups or other less formalised linkages established at courses or conferences, through telephone and personal contact within the region with others with similar roles.

Exemplars:

Janet referred to building personal confidence as well as competence in discussing her involvement in the supported model for midwifery.

> ... I'm currently doing a regional midwife program through [major level B hospital] where they have offered me ten shifts whenever I want to go within maternity [or] neonatal. If I wanted them all to be supernumerary, because I wasn't confident, they could all be supernumerary where I could buddy with another midwife. Or if I felt confident to go off supernumerary, I could go onto the paid model as soon as I was ready and be counted as part of the staff. I'm already on the paid model, I've just

> about finished my ten shifts and it was just such a big confidence booster. I really, really needed it. **Janet**

Stephanie described a conference in Sydney that she had attended where she had not necessarily learned a lot of new information but it had put her in touch with others who could provide ongoing help and assistance in her practice.

> ... I found it really good to develop those contacts and knowing where to go to get the resources. **Stephanie**

Janet noted the regional approach to providing CPD enabled networking within the immediate region and was as beneficial as the clinical information. The role of CPD in enabling this professional networking was seen as a by-product of CPD.

> The Highway Model is fantastic. It does recognize that there are small regional hospitals and coming together with other colleagues from [names of two other local small regional health services], it's great for networking. And when I go to [name of level B rural health service] and I meet people who are travelling from Mildura and all over, you hear that we've all got similar circumstances and similar frustrations. I think that networking is invaluable. Yes and once again that networking when I pick up the phone now and call [name of level B regional health service], I know who I am talking to and they know who I am. **Janet**

Little comment was made by nurses about their personal growth although the use of terms such as 'confidence' and 'security' would indicate some unstated but positive outcomes in this domain. Although many of the activities had resulted in their enhanced clinical skills, this concept of developing personal and professional attributes was a less acknowledged potential outcome from CPD for these nurses.

5.5.8 Theme Summary

In examining the connecting relationship between CPD, learning and practice it was noted that:

- In this sample, nurses did not regularly use structured reflective processes to identify learning outcomes from CPD.
- As nurses had not identified learning outcomes, it was hard to identify the influence of CPD in practice and professional life.
- When directly questioned, some nurses were able to recount positive experiences of the use of CPD in practice enabled by a variety of strategies that

included presentations to management, small incremental change and personal practice change.

- Clinical 'on the floor' nurses were not usually in a position to influence practice and did not always understand the processes required to enable practice change or implement their CPD learning.
- Organisational culture and systems could determine access to CPD and the implementation of learning in the clinical setting.
- Organisational systems for feedback of learning from CPD were not always evident.
- Management functioned as either barriers or enablers to implementing learning and practice development.
- Nursing peers were seen as a barrier to implementing learning, especially if they had been employed for long periods of time in the same role in either the regional or rural organisations.
- Professional networking as an outcome from CPD was considered important and nurses from rural health services particularly noted its positive effect in building a 'circle of confidence'.

5.5.9 Issues for further consideration

a. The nurses in this sample identified barriers and enablers to implementation of CPD learning. Despite this there were positive examples of implementing their learning from CPD which would indicate they were using informal processes in identifying learning outcomes from CPD that they could put into practice. How could processes be supported to provide better links between CPD, learning and practice?

b. Nurses in this study demonstrated limited use of reflection in the CPD cycle. This appears to have restricted their ability to develop and optimise the connection between CPD learning and practice. What strategies can be adopted to improve the use of reflection to enhance the learning from CPD?

5.6 Conclusion

The purpose of this chapter has been to describe in a thematic presentation the experiences of CPD in the professional lives of nurses in this study. The data from the study have been analysed and the four themes of Context, Motivation, Activating and Connecting have provided a framework to examine the experiences and meanings attached to CPD in their professional lives. A range of issues for further consideration has emerged from the themes and exemplars offered in each of these themes. In the final chapter the discussion will be expanded to explore how the experiences of these nurses align or differ from that described in the literature. It will also address and explore the implications and recommendations for CPD in the professional lives of nurses.

Chapter 6: Discussion and recommendations

6.1 Introduction

The final chapter of this thesis draws together the knowledge that has been gained from the research process which is then examined alongside the aim of the study. The identification of the themes of Context, Motivation, Activating and Connecting provide a framework for examining the experience of CPD in the professional lives of nurses in the study. The questions that were identified in each of these themes in Chapter 5 are brought forward to this chapter to be explored in the following discussions. I have related the discussions to existing research literature and made recommendations with a focus on enhancing the relationship between CPD, learning and clinical practice.

6.2 Discussion

The following discussions are underpinned by the observation that by utilising the definition of CPD provided by the NMBA and the data from this study, there is support for the concept of two categories of CPD that can inform practice. The first category involves the learning and resulting knowledge that is gained externally from the practice setting which can and should inform it. This encompasses formalised learning at courses, workshops and on-line learning programs. The second category of CPD is the learning and resulting knowledge which is embedded in the practice setting which is context specific and needs based. The association of CPD, learning and nursing practice in regional and rural contexts is expanded in each discussion.

6.2.1 Discussion related to the theme Context (see 5.2.1)

The examination of the data around the theme of 'Context' highlighted the multiple clinical roles of nurses working in rural settings. The data also indicated a variety of issues that were particularly relevant for rural contexts including CPD access, financial support and the range of topics available. The findings from this study support the assertion that there are particular CPD needs for nurses in rural areas. The question which arises from these findings is *how CPD can be developed and delivered to meet the particular and differing practice requirements of rural and regional nurses?*

The differences underlying rural nursing practice are well documented in the literature where it is noted that the breadth of knowledge and skills required of each individual nurse may be greater than that required of an individual nurse in a larger regional setting (Francis & Mills, 2011; Hegney, 1996; Hegney, et al., 1999). As predicted by Duckett (2005) nurses in rural areas of Victoria are taking on advanced practice roles to meet healthcare workforce shortages. These include Nurse Practitioners and Rural Isolated Practice Endorsement for Registered Nurses (Department of Health Victoria, 2009; Mills, et al., 2010).

This study's findings confirm that rural nurses' multiple roles and extended scope of practice require an extended range of CPD topics and also a range of delivery modalities to facilitate access. The data also suggested that this differs from the CPD needs of nurses from regional contexts. It does not in any way diminish the need for accessible, cost effective and appropriate CPD for nurses in the regional health service, but the range of topics required by individual nurses is not as extensive as in rural contexts. These findings align with those reported in Australian studies (Hegney, 1996; Hegney, et al., 1999) and internationally by Winters and Lee (2010), reaffirming the understanding that the degree of rurality continues to be an influencing factor on the requirements for CPD for rural nurses. As outlined by Mills et al. (2010), rural and regional nurses in speciality and advanced practice roles require appropriate types of CPD to support their practice. They identify that there are potential risks to patient outcomes, work satisfaction and retention of nurses in rural and regional communities if nurses are expected to function in isolated settings or with an expanded scope of practice without consideration of their CPD support.

The face-to-face program is an integral component of regional and rural CPD options. To ensure applicability, the content should be context appropriate to the nursing audience's practice setting. While this is a generalised ideal it may not be achievable to meet every nurse's specific needs for their practice context and it could be construed that it is the responsibility of the nurse to extrapolate the information provided and apply it to their particular setting. Where metropolitan clinical management strategies are presented in CPD it was identified by participants that they may not be applicable in the context of small rural healthcare settings. It is

possible that the CPD developed for remote area contexts may provide more directly transferrable clinical management approaches in small rural health services. These observations do not appear to have been previously explored in the literature, but support the view that context of practice influences the range of topics, focus of content and delivery mode of CPD.

The differing approaches to adult learning have required the development of a range of delivery modalities for CPD activities. This study's data supports that this variety is also driven by factors of rurality including the diverse learning needs from different practice settings, clinical specialities and nurses' respective degrees of geographical and practice isolation. The reliance on some delivery modes more than others is influenced but not dictated by the associated issues of access and costs. Within this study all nurses included face-to-face CPD programs as the predominant type of CPD learning opportunities despite the logistical difficulties in attendance. The foundation for this predominance is explored fully in the discussion of the theme 'Activating'. It appeared that face-to-face programs provided valued opportunities for professional networking, benchmarking and learning from experts in a field of practice. Nurses' use of internet based mediums for CPD was perceived as a cost effective and accessible option, but this relied on internet connectivity which reportedly was difficult for some nurses. The literature does not explore the way nurses in rural and regional contexts use CPD in their practice, the types and delivery of CPD that best suits their needs and the factors influencing their decisions.

6.2.2 Discussion related to the theme Motivation (see 5.3.6)

This study identified a range of intrinsic and extrinsic motivations for why nurses engaged in CPD. Continuing Professional Development was a valued part of these nurses' professional lives, although they observed a failure to engage with CPD by some of their work colleagues. These findings support the view that CPD has failed to connect with all nurses. The question which arises for further consideration is *what can be learnt from the reported failure of CPD to engage the entire nursing profession as indicated by this data?*

Exploring the lack of engagement of all nurses with CPD is hampered by a lack of literature to frame the discussion. Most of the literature that explores CPD involves participants who have been active in pursuing their own professional development. The views of nurses who do not engage in CPD is noted as difficult to capture (Furze & Pearcey, 1999). Furze et al. (1999) suggest that around 25% to 35% of members of a profession are 'laggards' who have fixed ideas, deteriorated skills and do not regularly engage in Continuing Professional Education (CPE) and that making CPE mandatory is designed to focus on these 'laggards'. Barriball and While (1996) in their study in the UK also noted that older nurses tended to be less likely to attend CPE regularly. The observation of nurses in this study indicating that some of their colleagues are not readily engaging in CPD supports the findings in the literature.

Does the adoption of mandatory CPD help to address the lack of engagement of all nurses with CPD? In the year preceding this study the Nursing and Midwifery Board of Australia (NMBA) introduced a mandatory requirement for twenty hours CPD. Prior to its implementation there was concern expressed about the incompatibility of mandatory CPD with the principles of self-determined learning as a key component of lifelong learning (Australian Nursing Federation (Victoria), 2006; James & Francis, 2011). The mandatory nature of CPD does not fit well with the concept of self-motivated lifelong learning but does perhaps address the need to ensure competence to practice by at least achieving a minimum exposure to CPD. The untested assumption is that CPD will in fact have a positive influence on competence (Slusher, Logsdon, Johnson, Parker, & Rice, 2000; Smith, 2004). Interestingly, the nurses in this study did not identify that the mandatory requirement was a major factor in their own decisions to engage in CPD, giving the impression that they would have been engaging with CPD anyway, which supports the findings in the literature (James & Francis, 2011; Lazarus, Permaloff, & Dickson, 2002). Despite their intrinsic motivation to engage in CPD, each of these nurses expressed varying degrees of anxiety about being audited. Auditing of CPD activity may serve as an external motivation and provide incentive for those who lack the personal motivation to engage with CPD. It may also reflect nurses' concern about

the adequacy of their recording of CPD activity in their professional portfolio even if they were engaged actively with CPD.

As mandatory requirements for CPD were already in place at the time of the study, it appeared that other factors may influence nurses' willingness to engage. The data suggests that remaining in the same organisation over a lengthy period of time, either a regional or a rural health service, nurses were less likely to engage in CPD and practice development. It was also noted that nurses' peers and colleagues influenced their ability to implement the learning from CPD in the practice setting, at times resulting in a loss of potential practice development. This indicates there was a lack of credibility granted to the suggested practice change that was presented by nursing colleagues. The reasons for this may relate to the lack of a collegial approach to delivery of health care and elements of individual defensiveness from those who were not actively examining their practice. These factors are further explored in the discussion of the theme 'Connecting'. Little specific mention of the role of peers as enablers or barriers to implementation of learning from CPD has been made in the literature.

The previous observation from the study findings that not all nurses are actively engaged in CPD indicates this principally results from their identified level of self-motivation. This is further influenced by a poor understanding of what can be included in CPD activity and the barriers to their engagement. Enhancing understanding of the range of activities that can be included as CPD, reduction of barriers to engagement and assistance to complete the regulatory requirements may assist in nurses moving towards self-initiation of learning.

6.2.3 Issues related to the theme Activating (see 5.4.4)

Issues of planning, access to CPD and factors of constraint are identified in the study as influencing the activation of CPD by nurses. This theme 'Activating' also focuses on data indicating that the nurses had limited perceptions of what constituted CPD and they preferred face-to-face program delivery. Two questions arising from this information are *how does the preference for face-to-face programs impact on the experience of CPD for nurses in rural and regional areas* and *does the uncertainty and*

variability of support and opportunities for leave to attend CPD influence nurses' approaches and uptake?

In this study, the nurses' perceptions of CPD focussed predominantly on face-to-face delivery of programs which did not always align with the broad range of activities included in the NMBA descriptions (Nursing and Midwifery Board of Australia, 2010b). This disparity may have been exacerbated by different understandings and the lack of consensus within the literature around the terminology used to describe CPD (Bahn, 2007; Hegney, et al., 2010). Now that there is a national regulatory authority for nursing with national standards and descriptors of CPD, there is a need to clarify with Australian nurses what is meant by CPD to alleviate possible confusion. However, to avoid an isolationist approach we should not ignore international discourse that can further inform the Australian perspective of CPD.

All participants in this study perceived that CPD provided the supportive framework from which they could both structure their professional practice and enhance or extend it into different areas. They most frequently described their engagement with CPD as being planned educational events or learning opportunities that occurred outside of their practice setting. There was a sense of 'doing CPD' as a separate stand alone activity, often by way of face-to-face programs rather than a continuous process of learning connected to practice. The nurses' descriptions align more closely with the understanding of Continuing Professional Education (CPE) as identifiable education interventions. The impact of this understanding of CPD is that while it retains some utility in ensuring competence to practice, it does not fully embrace the opportunities of learning from life and work that is possible with lifelong learning and the broader NMBA definition of CPD. Nurses did not include either incidental or planned learning that can occur within the practice setting in their understanding of CPD.

The perception of CPD separated from practice that can result from face-to-face delivery and online learning poses some difficulties in its application to the clinical setting. The findings in this study that have not been reported in the literature highlighted that bringing new knowledge back into the practice setting was often

hindered by management or peer attitudes and actions, systems, protocols or organisational culture. The findings support the more general statement of Manley and McCormack (2003) who identify that a work environment receptive to learning enables practice to develop as a continuous process.

Nurses in the study were focussed on practising safely and 'keeping up to date' even if they did not have identified learning needs. The absence of identified learning needs was cited by some nurses as the reasons for the lack of support from their organisation. I am aware that 'keeping up to date' is often perceived by management as a less legitimate reason for attendance at CPD than meeting identified learning deficits. As an organisational investment, there is less potential for new learning for the nurse who wants to 'keep up to date' and less subsequent gains for the organisation. In times of economic frugality and staffing shortages this may be considered a reasonable approach, but it does not acknowledge the evidence in the literature about the value of this motivation. The motivation to keep up to date was driving engagement with CPD for nurses in this study, supporting the findings reported in the literature. 'Keeping up to date' and maintenance of skills are noted in the literature as very strong motivations for CPD and ensuring competence to practise (Gould, et al., 2007; Hegney, et al., 2010; James & Francis, 2011; Nursing and Midwifery Board of Australia, 2010b; Slusher, et al., 2000). Keeping up to date is a legitimate and useful function of CPD to sustain currency of practice as well as developing nurses' knowledge base. It also supports the intrinsic motivations of nurses who strive to activate their ongoing professional and practice development.

Face-to-face delivery of CPD for rural and regional nurses provides important secondary outcomes. Professional networking is understood by most nurses as an integral component of being a professional. The development and strengthening of collegial networks allowed the security of what I have termed a 'circle of confidence' for some rural nurses, addressing their professional isolation. However, the social nature of face-to-face CPD may be considered by management as no more than an opportunity to catch up with colleagues.

The ability to benchmark their practice and that of their health service with peers from similar contexts at face-to-face CPD also addressed rural nurses' professional isolation. Benchmarking with peers outside of their regional networks enabled greater access to quality subject experts that were not available in more rural settings. This was essential for nurses in speciality areas of practice from both regional and rural contexts.

Professional networking is not duly recognised as an integral driver for choosing face-to-face delivery of CPD, particularly in regional and rural areas. The value of developing professional networks as a product of the face-to-face CPD delivery for nurses in regional and rural settings has not previously been reported in the literature. It does have some association with the understandings of 'Communities of Practice' where professional networking is seen as integral to the development of practice (Andrew, et al., 2008). However, the 'Community of Practice' that relates to these study findings is really a broad collection of nurses with the common element of rurality rather than a local work environment and is more aligned with the broader descriptions of community presented by le May (2009).

Attending face-to-face delivered CPD imposes logistical difficulties upon nurses from rural and regional health services which were identified in this study. Despite the utility of this delivery mode that was highlighted in the data, the time and cost to travel and access accommodation combines with the absence from the workplace and family to become barriers to participation. In this study, these factors were magnified when the CPD was provided outside of the region in which nurses work. Logistical barriers for rural nurses' attendance at face-to-face CPD are well noted in the literature and continue to pose challenges that may be detrimental to their engagement with this type of CPD (Bushy, 2002; Hegney, et al., 2010; Munro, 2008; Schweitzer & Krassa, 2010; Smith, 2004). If face-to-face programs are the dominant or only form of CPD activity for nurses in regional and particularly rural areas as identified in this study, the challenges of access will constrain their learning opportunities and the opportunities for developing practice. There needs to be an engagement with multiple types of CPD to address the barriers that are encountered in accessing face-to-face programs.

Alternatives to face-to-face delivery include online learning options that provide enhanced access to information and education for many nurses because they can be engaged at the time and location chosen by the individual. Information Communication Technology (ICT) appears a solution for the delivery of high quality, consistent learning material and improving access to CPD. The growth in uptake of ICT approaches to education and training has resulted in the development of a plethora of products. Despite the growth of this medium across regional areas, some nurses in this study found that access, availability and affordability remain a considerable difficulty. The assumption that internet based resources were available to them outside of working hours was not always the reality, with some finding the internet unreliable, expensive and unavailable. They also identified that there was little ability to achieve CPD completion in a busy family life, with unreliable internet connectivity alongside their working hours. These issues are not new to the Australian rural context with mention of IT access issues presented by Heath (2002), which over a decade later remain unresolved in some areas. Apprehension about the personal time requirements to complete CPD is also reported in the literature from experiences with nurses from a range of settings in the UK (Gallagher, 2007; Gopee, 2001; Gould, et al., 2007) and in rural and remote contexts in Canada by Penz et al. (2007). This has not been extensively explored in the Australian literature. The dilemma of professional responsibility matched against the reality of professional and private lives appears to be the nub of the issue within this discussion.

Practice-based or experiential learning (Lave & Wenger, 1991; Wenger, 2012) was seldom mentioned as one of the alternatives to face-to-face CPD delivery by nurses in either the regional or rural context. This would indicate it was perceived as easier to go to workshops, do online learning modules or seek out established courses than to set up practice-based learning opportunities. It may also suggest that the nurses did not understand how to initiate this type of learning activity or had not considered that this type of practice-based learning activity could be considered as CPD. There has been minimal exposure of this type of learning in the discourse about CPD in the rural and regional Australian context which may be reflected in the experiences reported by nurses in the study.

A recurring comment from nurses in the study was the difficulty of predicting organisational support for accessing CPD. All nurses are affected by challenges in accessing CPD, but in rural areas the cost of travel and leave from work to attend can be magnified (Francis & Mills, 2011; Hegney, et al., 2010; Penz, et al., 2007). The issues of financial commitment, release from work and absence from family and travelling requirements were of particular concern for those from smaller rural health services that were at a greater distance from major centres and also for speciality nurses from rural and regional centres. They believed these barriers to CPD attendance increased their professional isolation, supporting the findings in the review of literature on Australian rural nursing by Mills et al. (2010).

The lack of clarity about entitlements for financial support and leave to participate in CPD and the variability in the granting of those entitlements was identified as discouraging for nurses in the study. They noted there had been a decreased level of employer financial support and that CPD was either partially or fully self-funded, much as reported in Hegney's study (2010). Where this reduction in organisational support has occurred without clarification, nurses expressed their frustration and confusion at the lack of explanation and the uncertainty this caused. This was perceived as an organisational barrier to their engagement in CPD. As nurses experienced these barriers, their willingness to seek CPD activity was diminished. This experience of change in organisational support for access to CPD reflects the reported disillusionment and inconsistency of organisational approaches to enabling CPD in both the Australian and international literature (Gopee, 2005; Gould, et al., 2007; Hegney, et al., 2010; Schweitzer & Krassa, 2010).

The organisational barriers for accessing CPD are not an issue that is restricted to these nurses in rural or regional health services, although there is recognition that the support needs for nurses from rural areas to attend face-to-face CPD are magnified (Furze & Pearcey, 1999; Gould, et al., 2007; Hegney, et al., 2010). The budget allocations for organisational CPD support are no greater in regional or rural health services despite this acknowledgement. This difficulty has been poorly addressed, although a supportive initiative by the Victorian government is the funding of a regional CPD education program intended to enable nurses to access

affordable CPD. In the study this resulted in management being willing to support nurses' frequent involvement. However, it was clear that not all CPD learning needs were met by the program and nurses also sought other CPD opportunities.

Another strategy was introduced in March 2012, after the completion of the participant data collection for this study, when nurses and midwives in public health services in Victoria negotiated a new employment Enterprise Bargaining Agreement. This provides entitlement for up to five days study leave and a CPD allowance of nine hundred dollars annually for a full time nurse, or pro-rata for part time employees paid directly to the nurse to help with financial requirements of engaging in CPD. How this will influence the engagement and experiences of nurses with CPD is unclear. In discussing the payment of incentives for engaging in CPD that were implemented in Queensland and the United Kingdom, Hegney (2010) and Furze and Pearcey (1999) noted that there was concern that the direct payment to nurses would not necessarily be utilised for the intended purpose of CPD. This Victorian initiative will assist rural and regional nurses who often bear a greater financial burden to access CPD, but it fails to acknowledge the increased difficulty of accessing leave in rural areas. Anecdotal reports suggest organisations have now chosen to deny additional funding for CPD that is nurse initiated on the premise that the individual has a personal allowance. This payment to nurses is not linked with any measurement of CPD engagement, making impact evaluation problematic. Part-time staff that are paid a proportional amount of these funds based on hours worked are still required to fulfil the same twenty hours of CPD. This may be an inequity that causes frustration for some nurses. This CPD allowance and study leave initiative still does not address the needs of nurses outside of the public sector or the difficulty for rural and regional health organisations to release nurses to attend CPD because of the lack of staff to replace them. The variability and uncertainty of nurses' release for attendance at CPD programs will therefore remain and will influence their ability to activate CPD engagement.

6.2.4 Discussion related to the theme Connecting (see 5.5.8)

Data associated with this theme 'Connecting' provided information about the relationship between CPD, learning and practice. It found that the experiences of

nurses in being able to apply their learning to the workplace varied according to factors such as role requirements, the nature of the learnt material and the organisational culture in which they worked. Many nurses identified these factors as barriers to implementation of their learning. However, others did identify that they were able to implement their learning through structured systems and informal processes in practice. On a broader level, the data indicated nurses rarely utilised reflection in their CPD process or followed up with reflection on learning.

Two questions for consideration and discussion arise from this data, namely, *what strategies can be adopted to improve the use of reflection to enhance the learning from CPD* and *how could processes be supported to provide better links between CPD, learning and practice?*

The use of reflection in the discourse of the nursing profession is well established (International Council of Nurses, 2006). Australian and international regulatory bodies require that reflection is used in the process of ensuring competence to practise and for professional development (Australian Nursing Midwifery Council, 2009; Nursing and Midwifery Board of Australia, 2010b; Royal College of Nursing Australia, 2012b). The CPD cycle is part of the processes of maintenance of competence to practise described by the Australian Nursing Midwifery Council (2009). It involves reviewing practice, identification of learning needs, planning and participating in relevant learning activities and reflecting on the value of those activities. While reflection is referred to within the CPD cycle in the literature, there is little research information about how nurses implement its use as part of the CPD processes.

Given the recommendations for including reflection in the CPD cycle, it was surprising to find that most nurses in the study were not including its use to determine their learning needs and strategically plan their CPD. The absence of reflective evaluation of completed CPD indicates the potential benefit of the CPD activity is not fully realised. Instead, nurses focussed on collecting evidence to meet the regulatory requirements for completion of CPD hours. The rationale for documenting reflection on CPD in the nurse's personal portfolio is to enhance the

value of learning (Alsop, 2000) and also provide a personal, reflective record for review (Kottkamp, 1990).

Despite this validation of its use, the reasons why nurses in this cohort did not include reflection after completion of their CPD (reflection-on-action) remain unclear. Some nurses spoke of a lack of time to use reflection in the cycle of CPD. Taking the time for reflecting and then documenting these reflections in a professional portfolio could seem an unrealistic expectation by some nurses. However, without reflection nurses can lose the ability to learn from how they practise (Alsop, 2000; Boud & Walker, 1991). These lost opportunities for learning not only affect the profession but may have impacts on the delivery of care for patients. Howatson-Jones (2012, p. 45) suggests nurses can use reflection on their own activities to enhance learning and they can develop 'compelling spaces' for learning where nurses take time out to reflect on practice, to question with others and seek meaning and learning (Howatson-Jones, 2010). The place of reflection in experiential learning and professional development is identified by her as a key component to drive action. Whilst not expressed openly by nurses in this study, there may have been a lack of understanding and confidence in how to go about reflecting on practice and documenting reflection. Often workplaces are not focussed on providing the opportunities or 'compelling spaces' for discussing practice. The relevance of linking reflection and professional learning in the practice setting is an emergent theme identified in literature (Boud & Hager, 2012). If this kind of reflective activity on practice is seen to be a valuable strategy for learning, it will require systematic and organisational redesign.

The focus of nurses in this study on CPD external to their practice setting may result from their lack of exposure to the literature suggesting practice-based learning as an effective and sound way to ensure that CPD is related to the clinical setting (Boud & Middleton, 2003; Gould, et al., 2007). This suggested re-orientation in focus of learning is described in the literature as Practice Development, which acknowledges the complexities of the workplace practice environment and the influence of assumed and acknowledged beliefs and values (Manley & McCormack, 2003; Manley, et al., 2011; McCormack, et al., 2009; McCormack, et al., 2013; Ward &

McCormack, 2000). An integral component of this approach is the development of nurses' critical reflective skills and their engagement in active learning.

To advance the links between practice and learning will require nurses to integrate reflection into their everyday practice. However, it will require more than the change of focus of individual nurses to really build these links. To optimise the success of practice-based learning initiatives requires a culture that enables their establishment. The model of 'Communities of Practice' has potential for bringing people together to develop best practice, implement new knowledge and adapt old knowledge to practice (leMay, 2009). This kind of initiative supports Practice Development but requires an organisation-wide perspective and executive support alongside the engagement of other health professionals in the practice setting. In regional and rural health services such approaches will challenge how clinical care and interprofessional work relationships function. As with all change there will be a range of responses that are a product of the organisational culture which will include those who embrace it, reluctant adopters and those who choose to not engage (Deal & Kennedy, 2000). Acknowledgement of the time and cost for implementing practice-based initiatives is required as part of a strategic plan that is underpinned by the examination of the influence of the organisation's culture. This is supported by Boud and Hager who highlight that the "...powerful influence of the organisation in which professionals work and practice ... can have a more substantial influence on continuing professional learning than any program of study" (Boud & Hager, 2012, p. 26). The commitment and the capacity of regional and rural health services to engage with practice-based learning approaches will require external support to achieve or it will remain just a good idea.

The study data highlighted a number of challenges in bringing the learning from CPD to practice that merit exploration. Contradictory to expectation, the nurses perceived their clinical positions limited how they could influence practice. Their lack of understanding about the processes they could use to provide input to practice development resulted in confusion and dissatisfaction. This was exacerbated by their clinical roles that are principally focussed on delivery of patient care and do not provide the opportunities to consider improving practice. The accepted process

of passing ideas to the nurse manager to consider and action appeared to be thwarted as practice development became secondary to operational considerations. In reviewing the study data, the reality may be that clinical nurses are not given the credibility to make comment on practice issues. This is paradoxical when they are at the patient interface, but may reflect power imbalances inherent in the bureaucratic structures of healthcare. Where nurses' roles included more clinical consultancy, they had greater influence on practice in the broader organisational context. Their roles enhanced their ability to perceive the linkage between CPD and practice and provided different opportunities to provide input and activate practice development. The impact of nurses' clinical roles on how they can incorporate learning from CPD into practice has not been previously described in the literature. The extent of this experience across the profession is subsequently difficult to assess. However, the frequency of this discussion topic with this group of nurses would indicate that it may be a common experience and one which warrants further research. The understanding of power in the clinical nurse's professional life and its impact on clinical care has been identified as crucial to enabling excellence in patient focussed healthcare delivery (Benner, 1984; Gilbert, 1995). The findings of this study have emphasised the importance of considering the power balances in organisational systems and relationships in any new initiatives to enhance the association between CPD, learning and practice.

6.3 Recommendations

The examples of difficulties and successes in linking learning from CPD with practice have highlighted that where CPD is separated from the practice setting, it is necessary to build processes to capture learning outcomes, evaluate the applicability to the particular practice context and then set in place an implementation plan. In the analogy of CPD being the supporting framework for practice, there needs to be a bridge from the external framework of CPD separated from practice to reach in to the clinical setting. The learning activities that were emanating from within the practice context were more readily developed and incorporated into the personal, departmental or organisational practice setting. This could be described as CPD building internal supportive frameworks for practice. These concepts have not

previously been described in this way in the literature. However, the recent work of Boud and Hager (2012) clearly identifies the importance of including both structured learning programs alongside everyday practice-based initiatives in the understanding of continuous professional learning.

The information from the discussions (6.2) leads to a number of possible initiatives to enhance the CPD experience and its relationship to practice that involve individual nurses, their peers and organisational processes. These recommendations are not necessarily standalone strategies, but are interrelated and are intended to build enhanced understanding of CPD in the professional lives of nurses.

6.3.1 CPD options

As a strategy to ensure relevant CPD for nurses in regional and rural areas, the study data indicates that face-to-face programs should be retained as part of the suite of CPD delivery options. Despite the challenges for release from work, travel and financial implications the evidence indicates that this avenue of information and professional networking should remain to sustain the practice of nurses particularly in more isolated areas or who work in speciality areas. It is suggested that assistance be provided for nurses in clinically isolated practice settings to attend CPD focussed on isolated practice. This will enable nurses to learn of others' strategies for coping with clinical isolation and be most relevant to their learning and practice needs.

Other CPD approaches are required to meet the varied needs of all nurses in regional and rural settings. The inclusion of ICT based CPD in the suite of options requires acknowledgement that nurses in rural areas may not be able to access this reliably outside of work and in their own time. Enhancing access to computers in the work environment where connectivity is more reliable and there is no direct cost to nurses should be underpinned by the provision of time during shift change and the allocation of study leave to access this CPD learning opportunity. Organisational investment in the development or access to a range of e-learning CPD programs may address the diverse learning needs, ICT connectivity and time issues identified by nurses. This may also reduce the travel and course costs for nurses in regional and rural areas. Practice-based learning is a viable CPD option that could be of particular

relevance for nurses who may find accessing other forms of CPD difficult. The advantages of increasing the emphasis on learning within the practice setting in rural and regional areas would address some of the issues of travel and time release from work, at the same time building the sustainability and linkage of CPD with practice.

6.3.2 Support for reflection, learning and practice

The development of an initiative to raise awareness and provide skills in the establishment of practice-based learning is required. In rural areas, the reality may be that this is difficult to achieve given the limited resources to assist in developing practice-based learning opportunities or even enabling exposure to these concepts. Notwithstanding this difficulty, it does provide a valuable and accessible way of considering CPD learning, linking directly to the practice setting. The possible opportunities for CPD learning from the practice setting have not been described in the literature as an approach for rural nurses, so there are no models on which to base such an initiative. The opportunity to focus learning within the practice setting may address some of the difficulties of release from work, travel and costs associated with alternative CPD activities.

External support from professional bodies or the regulatory authority could be engaged to develop resources for clinical staff. The purpose of these resources is to prompt nurses to reconsider the range of activities that can be included in CPD and increase their use of reflection in both the CPD cycle and practice encouraging action outcomes. This would result in moving nurses from skills based 'surface learning' to a more comprehensive understanding seen in 'deep learning' (Kirby, et al., 2003). Resources should provide clarification of the difference between reflection-on-action and reflection-in-action (Schön, 2009) and provide examples that demonstrate how reflection can be incorporated in all stages of the CPD process (Boud & Walker, 1990; Kottkamp, 1990). Specific examples of how to document reflection will also develop its practical application in their professional lives. A range of alternatives for establishing this program include on-site delivery by external agencies or the provision of resources for use by local educators. Given the paucity of educators in rural areas, this may be difficult to achieve. Alternatively resources could be made

available directly to nurses in hardcopy or via websites of the regulatory body or professional organisations.

6.3.3 Clinical conversations

The creation of systems in workplace settings would enable clinical nurses of all levels to participate in conversations about clinical practice, providing an opportunity for nurses' reflection and practice-based learning. This approach also establishes a way of bringing the CPD knowledge that is gained outside of the practice environment to the clinical conversation. These conversations need to involve those who have responsibility for making decisions about practice so that change can occur. This process acknowledges the credibility of clinical nurses' contributions and optimises the use of power in the healthcare setting to enable practice development that will promote quality patient care. Ideally this would be an interprofessional activity to enable learning from all aspects of care delivery, although it may not be possible in some smaller rural health services where allied health and medical workforce is limited. However, it could gain acceptance in these settings as this kind of collaborative, collegial approach to healthcare delivery is a key component to practice in rural communities (Mills, et al., 2010). It will require leadership and organisational involvement to ensure the inclusion of all parties.

As a process of changing culture, initial steps may include utilising existing systems such as staff meetings but could also include less formal opportunities like tea room conversations. This could expand to involve nurses in case presentations and discussions. This can commence the building of the 'compelling spaces' for learning (Howatson-Jones, 2010) and a culture of critical enquiry. An example of this kind of strategy has been embraced in the Australian context by New South Wales Health in their introduction of the Essentials of Care program which provides a framework for the ongoing critical evaluation of nursing and midwifery practice and health care delivery. It is underpinned by the principles of transformational practice development enabling the development of clinical environments that enhance patient care, teamwork and satisfaction (New South Wales Health, 2013). These kinds of strategies will assist the reflective processes and clinical questioning

required for professional learning and practice development particularly from within the practice setting.

6.3.4 Enhancement of CPD understanding and access

The data from this study and the literature indicate a need for employing organisations to provide accessible, transparent information about entitlements for study leave, professional development payments and their support options for CPD. This will require organisations to clearly articulate their processes and ensure they align with entitlements to avoid confusion and enhance nurses' ability to collaboratively plan for their CPD to meet personal and organisational learning needs.

In line with the previous recommendations there is a need to underpin them all with a consistent and enhanced description of CPD for nurses. Currently the Australian model of CPD provided by the regulatory authority does not provide clarity about the relationship of CPD, learning and practice. Nor does it identify the place of reflection or action in the CPD cycle. Modifications to the model are needed to include these aspects and provide descriptions of reflection-on-action and reflection-in-action to identify the value of embedding CPD in the practice context, promoting action outcomes and the continuous nature of professional learning.

6.4 Conclusion

The aim of this study was to explore and establish an understanding of the reality of CPD in the professional lives of clinical nurses in rural and regional settings in Victoria, Australia. In the study I examined the nurses' experiences and understanding of CPD, the way they go about arranging their access to CPD, the types of CPD utilised and its relationship to clinical practice.

In numerous areas data from this study have aligned with previous literature. Findings from this study that have not been previously reported in the literature include the difference in nurses' understanding of CPD from that provided by the regulatory authority, the lack of strategic planning to identify learning needs and engage in CPD, the lack of structured reflection and linkage of CPD with practice as

well as the formerly unreported influences on implementing learning in the practice setting.

The findings indicate that the processes used to identify learning needs, arrange CPD and utilise the learning in the practice setting could be optimised by the greater use of reflection. Nurses' motivation for CPD was based on their need for a sound framework to support their practice and they frequently reported their enthusiastic engagement with CPD of various types. Their perceptions and understanding of CPD did not align with the breadth of the NMBA description and was more restricted to structured education programs and did not incorporate practice-based initiatives. Where such practice-based initiatives occurred they had not perceived this as CPD. The mandatory nature of CPD was not a significant factor in their decisions about undertaking CPD. The interplay between CPD, learning and practice was fragmented and the macro environmental factors as well as those of the learner exerted influences on this aspect. In the experience of these nurses the opportunity for enhancing their personal professional practice from their CPD could have been expanded. The overlay of rurality on the experiences of these nurses required a variety of content and approaches to the way CPD was accessed and utilised.

To increase the value of CPD for nurses in rural and regional areas it is recommended that organisations, regulatory bodies, educational institutions, professional bodies and individual nurses review the use of CPD as integral to practice development.

Organisations are recommended to:

- Assist and encourage the development of practice contexts that promote clinical questioning and reflection on practice.
- Develop and provide strategies that support nurses of all levels to participate in the conversation about clinical practice.
- Invest in ICT infrastructure and work with education providers or professional bodies to develop appropriate online learning programs to support nurses' CPD and relate it to their clinical practice.
- Provide study time by paid study leave hours or within staff shift change time to enable nurses to access online learning within the organisation.

- Provide clear and accessible information about nurses' entitlements related to study leave and CPD payments and the organisational processes required to access them.
- Incorporate a range of modalities of CPD delivery that include and acknowledge the value of face-to-face programs to develop the 'circle of confidence' that comes from professional networking for clinical nurses and the value of keeping up to date. This will address professional isolation identified in rural settings and encourage the building of 'communities of practice'.
- Provide a program inclusive of all nurses that demonstrates and explores how they can optimise the learning from their CPD by the use of reflection and action and the inclusion of practice-based learning.

Regulatory bodies are recommended to:

- Develop resources for use online or in presentations that identify the breadth and continuous nature of CPD that builds on the NMBA description. This should include examples of CPD that are practice-based.
- Provide a model of the CPD cycle in the NMBA description that explicitly highlight links with practice and encourages both reflection and action to develop practice.
- Include reflection in all aspects of the CPD cycle and provide education and information tools for nurses to use reflection and then document their reflections. This may include posting resources within an online learning setting and may require collaboration with professional bodies.

Educational institutions are recommended to:

- Develop education resources that meet the CPD needs of nurses in advanced practice roles in regional and rural settings.
- Include undergraduate teaching on CPD, the value of practice-based learning opportunities and the use of reflection in a more descriptive model of CPD that promotes continuous professional learning.

- Develop CPD education programs that utilise a blended delivery approach that includes ICT and face to face modalities.

Professional bodies are recommended to:

- Provide workshops, publications and presentations that promote the expanded model of the CPD cycle and its links with practice in collaboration with regulatory authorities, educational institutions, health care organisations and individual nurses.
- Provide access to tools and resources developed collaboratively with the regulatory authority that explain the use of reflection within the clinical setting and as part of the CPD cycle.

Individual nurses are recommended to:

- Adopt the model of CPD that is more aligned with continuous professional learning and be alert to the learning opportunities in their everyday work setting.
- Use their reflective skills and share in the conversations about practice. This will provide additional opportunities for ensuring their competence to practise alongside the more structured programs and courses more usually considered as CPD.
- Develop their understanding of how to use reflection in practice and the opportunities this may create for professional and career development.

In times of frugality in the healthcare setting and the simultaneous focus on the importance of quality, safe patient care, the optimisation of time and resources invested by nurses and their organisations in learning becomes increasingly important. It requires a review of the current perspectives on CPD and encourages innovation in the way learning is embedded as a continuous process in everyday practice that promotes action. The understanding of CPD, its potential breadth and continuous nature as part of the nurses' lifelong learning may challenge some in the profession to reconsider their own understandings. This study of nurses' experiences of CPD in regional and rural Victoria, affirms there is a need to rethink the

understanding of the role of CPD in professional practice, to foster further exploration and support for how professionals learn and relate to their everyday practice.

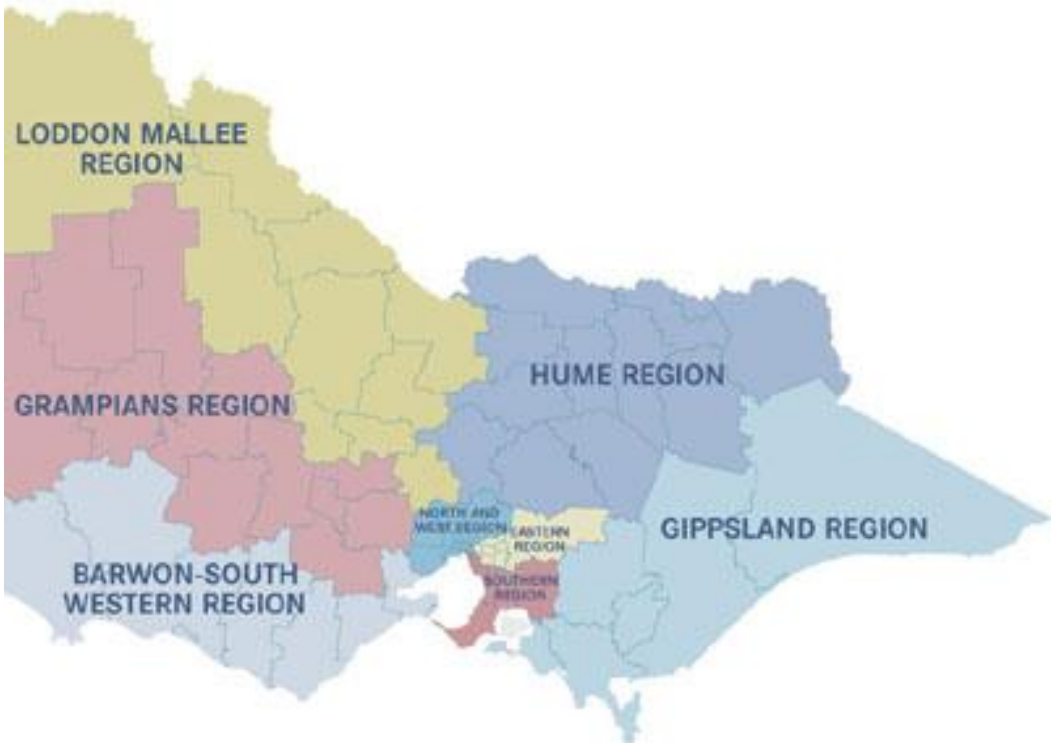
Appendices

Table 2 Grampians Health Services

Grampians Region Health Services	Locations	Health Service Description
Ballarat Health Services	Ballarat Base Hospital, Queen Elizabeth Centre	Major B
Beaufort and Skipton HS	Beaufort, Skipton	SRHS
Djerriwarrh HS	Bacchus Marsh, Melton	C
Dunmunkle HS	Rupanyup, Minyip, Murtoa	SRHS
East Grampians HS	Ararat, Willaura	C
East Wimmera HS	St Arnaud, Birchip, Charlton, Donald, Wycheproof	SRHS
Rural Northwest Health	Warracknabeal, Beulah, Hopetoun	SRHS
Stawell Regional Health	Stawell	C
Wimmera Health Care Group	Horsham, Dimboola	B
West Wimmera HS	Nhill, Jeparit, Kaniva, Rainbow, Goroke, Natimuk	SRHS
Edenhope & District Memorial Hospital	Edenhope	SRHS
Hepburn HS	Daylesford, Clunes, Creswick, Trentham	SRHS
Categories determined by types of services delivered **Major B = Base Hospital and Regional health service** **B = Regional health service** **C = Rural health service** **SRHS = Small Rural Health Service**		

Appendix A: Victorian Department of Health Regions Map

(www.health.vic.gov.au/regions)



Appendix B: Discussion guide

La Trobe University
University Human Ethics Committee

Discussion / Interview Guide

Full Project Title:

CONTINUING PROFESSIONAL DEVELOPMENT AND NURSING CLINICAL PRACTICE: AN EXPLORATION OF RURAL AND REGIONAL NURSES' EXPERIENCE OF CONTINUING PROFESSIONAL DEVELOPMENT AND PRACTICE CHANGE IN THEIR WORKPLACE.

Opening discussion about purpose and conduct of the study, completion of consent and advice regarding any concerns

Discussion / questions / prompts

- Inviting participants to share nursing background – years in nursing, practice context and specialities
- Regarding current practice context – organisation size, services, roles in practice, nature of practice community
- Regarding organizational culture, approach and support for CPD, approaches to change
- About participant experiences of CPD – how does nurse decide, types, barriers & enablers
- About how participant views the relationship of learning and CPD - use of a reflective cycle in determining learning needs and assessing effectiveness of CPD activity on practise
- Regarding memorable experiences of practice change in their workplace following CPD – positive, limited success, negative
- About perceived influencing factors on ability to implement practice change
- Regarding any further information they wish to provide for the study

Final provision of information about opportunity to review interview transcripts and how to make further comment and contact

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