Explaining nurses' decisions to participate in a Professional Development and Recognition Programme: A mixed methods study

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Samantha Heath
ID 14129138

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Institute of Education
Massey University

Abstract

Continuing professional development (CPD) has been of concern since Florence Nightingale made it her mission to improve hygiene practices to lower hospital death rates. Whilst the century may have changed, the task has not and, in an increasingly challenging healthcare environment, nurses must keep abreast of extensive technological advancements. Ongoing education has become essential rather than optional in modern healthcare. CPD is considered so important to maintaining the safety of the public, Nursing Council of New Zealand has mandated that nurses complete a required number of CPD hours every three years. Linked to renewal of Annual Practising Certificates and demonstration of Registered Nurse recertification competencies, entire education programmes have grown up around mandatory CPD.

Particular types of CPD, Professional Development and Recognition Programmes (PDRP), have been widely adopted by public and private healthcare organisations in New Zealand. Where PDRP is mandatory, engagement rates are more than 90%. In organisations where participation is voluntary, engagement rates are below 20%. Disparities between these participation rates do not deter a diverse and influential range of programme stakeholders who include the Nurse's Union, Nursing Council and District Health Boards. Programmes are linked to financial allowances, nurses' regulatory requirements and workforce planning. PDRP has become an 'ecology'.

Previous research had not ascertained nurses' views about PDRP and little is understood about their experience of participation. Considering the large personal investment required in mandatory CPD, together with the low voluntary engagement rates, it is important for nurses to contribute to the conversation about participation in

programmes like these. Low participation rates also make it relevant to ask if intended organisational staff development outcomes of supporting PDRP are being met. Such a consideration is highly relevant to an organisation like New Zealand Blood Service (NZBS) where the minimisation of clinical error is essential and PDRP objectives relate to the development of expertise among its staff.

Presented in this thesis is an account of a mixed methods study designed to explain factors affecting nurses' decisions to participate in PDRP at NZBS. The work makes use of Cross' (1981) Chain of Response Model as the conceptual framework. Participants were 129 Registered Nurses at NZBS who were direct mailed a survey to determine their knowledge about the programme, attitude to learning and response to factors affecting engagement with CPD.

Quantitative data provided by 82 respondents showed that PDRP requirements were largely known, but their relationship with the mandatory regulatory requirements of Nursing Council of New Zealand were not. Nurses' indicated that PDRP could meet their education needs and it was felt to be within their capability. Nurses were positively disposed to engagement with it.

In the qualitative phase, 14 semi-structured interviews were conducted with volunteers who had participated in the survey. Interviews with participants revealed significant differences between the nurses' and educators' understanding of the programme purpose and its connectedness to mandatory regulatory requirements. Nurses explained how a personal landscape of factors affected their decision to participate in PDRP including the significant impact of career-long exposure to vicarious learning experiences about PDRP. Nurses also explained the critical importance of their direct manager in creating a workplace culture of completion, promoting a narrative of

encouragement and in supporting nurses to navigate the complexities of the employment/regulatory context in which PDRPs operate. However, PDRP was not seen as a legitimate tool for professional development among the nurses in this study.

Recommendations include the need for NZBS to consider whether the presentation of mandatory regulatory and professional education requirements should become distinct from one another until a nurse chooses to submit a professional portfolio for assessment. Key stakeholders need to consider supporting all programmes to be compulsory at entry level. Stakeholders should also review areas of incongruence between the needs of the regulator, the employer and the nurse regarding CPD. The intention should be to ensure clarity about these relationships, making mutual benefits transparent. It would be advantageous too, to consider the implementation of personalised education assessment for PDRP participants to promote the ongoing development of the workforce. For the regulator, Nursing Council of New Zealand, the resources available to assist nurses understanding the link between their professional and regulatory accountabilities need to be refreshed as a matter of urgency since this is the fifth piece of work that has raised issues about nurses' understanding of continuing competence requirements.

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1. Introduction and Background

1.1 Introduction

Asserting that the Nightingale tradition of 'once and for all training' was at an end, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (UKCC, 1986) signalled the need for significant change in both the purpose and outcome of continuing professional development (CPD) for nurses into the new millennium. The UKCC envisaged a future where self-direction, flexibility and practice focus were essential to creating a practice-ready workforce that could provide high quality nursing care to meet the changing healthcare needs of the population. A decade later, Hinchliff (1998) attempted to itemise the components of contemporary CPD for nurses. She concluded, CPD should be brought directly to the workplace using a range of teaching and learning strategies; that it should meet professional and personal needs, fitting with the learner's work and lifestyle; that there should be an acceptance of professional learning accruing from practice experience and that this type of learning should be considered valuable to nursing. Hinchliff (1998) defined CPD in nursing as,

> *The maintenance and enhancement of the knowledge, expertise and competence of professionals throughout their careers according to a plan formulated with regard to the needs of the professional, the employer, the profession and society. (p. 38)*

In the second decade of the new millennium, Hinchliff's (1998) definition endures. Keeping abreast of new treatment modalities, incorporating emerging technologies and delivering supportive, high quality nursing care present challenges for the modern nursing workforce. CPD for nurses has become an everyday necessity rather than a luxury (Barriball, 1995; Murphy, Cross, & McGuire, 2006; Pena & Castillo, 2006; Pool, Poell, & Cate, 2013). In the wider contemporary healthcare context, nurses'

CPD has come to serve multiple interests, reconciling organisational objectives and professional regulatory mandates with individual learning needs and the commensurate expectation that it does so in a socially responsible way (Collin, Van der Heijden, & Lewis, 2012).

Globally, nurses have embraced the challenges of modern CPD. They have accessed a wide range of educational opportunities to meet their learning needs and the literature is abundant with examples of the education they have undertaken. In the United States (US), Boltz, Capezuti, Wagner, Rosenberg, and Secic (2013) provided examples of context specific programmes in medical/surgical nursing. In New Zealand, Heath and Utiera (2014a) evaluated a programme where practitioners had developed skills sufficient to run nurse-led clinics. Other nurses produced a professional portfolio of evidence as means to determine career pathway progress like that indicated by D. C. Casey and Egan (2010) in the United Kingdom (UK). Access to digital technologies for sourcing education material related to particular diseases was reported by Khatony, Nayery, Ahmadi, Haghani, and Vehvilainen-Julkunen (2009) in Iran.

The amount of effort required to complete ongoing learning did not go unnoticed. Emerging from the US over several decades, career ladders became a preferred option for providing organisation-wide CPD programmes that acted as a means to develop nurses' clinical capability and to financially reward them for their commitment and ability to provide increasingly complex nursing care (W. J. Jones, Jenkins, & Johnson, 1988; Korman & Eliades, 2010; Malik, 1992; Riley, Rolband, James, & Norton, 2009; Schmidt, Nelson, & Godfrey, 2003; Warr, 1994). In New Zealand, CPD programmes were also developed with similar features to the career ladders observed in the US.

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Called Professional Development and Recognition Programmes (PDRP), ladder programmes became widely available to New Zealand nurses. More than 20 programmes are now accessible through different healthcare organisations (Nursing Council of New Zealand, 2016a). Engagement with these programmes is often voluntary, although in some organisations, completion is mandatory. Nurses must complete a portfolio of evidence that meets the criteria for assessment. The portfolio of evidence demonstrates an increasing depth of clinical understanding and ability to use this knowledge to make nursing decisions. As with the US version, nurses are financially rewarded for completion of a PDRP portfolio at higher ladder levels. In New Zealand, PDRP includes demonstration of recertification (continuing competence) requirements for the regulatory body, Nursing Council of New Zealand (Nursing Council).

Nursing Council have developed a formal PDRP approval process because of the PDRP connection with regulatory process. This means that where a nurse has successfully engaged with an 'approved' PDRP, they are also excluded from random regulatory recertification audit. Where a programme does not have 'approved' status, PDRP is still helpful. Participation under these circumstances means that nurses will have collated all the necessary evidence for submission to Nursing Council if selected for recertification audit (Evidential Requirements Working Party, 2009; Nursing Council of New Zealand, 2004). However, despite the apparent benefits of regulatory compliance, exclusion from recertification audit and financial reward, nurses do not voluntarily engage with PDRPs in large numbers (National PDRP Co-ordinators, 2014, 2015, 2016). Herein lies the focus of this inquiry. There is a need to explain why this phenomenon might be so. Therefore, the purpose of this chapter is to identify the uses and characteristics of PDRPs, situating them as a tool for CPD within the timeline of

contemporary nursing education, in order to provide the reader with the necessary background information to view this thesis in context.

Beginning with an overview of PDRPs using the New Zealand Blood Service (NZBS) programme as an example, their emergence in New Zealand will be traced. The role of PDRPs as a tool to support nurses' CPD will be summarised. The contribution of PDRPs to post-registration nursing will be outlined including the relationship these programmes now share with Nursing Council's mandatory recertification requirements. Using the 'ecology' metaphor described by Weaver-Hightower (2008), the relationships between mandated regulatory requirements, individual learning needs, organisational objectives and the wider health and academic sectors will be explored. Professional and regulatory tensions will be explained including discussion of the important antecedents that have shaped both the pre- and post-registration nursing education in New Zealand. PDRPs will be considered central to a CPD ecology and I will show how my professional experience as a Nurse Educator and manager of professional development programmes has brought me to investigate factors that affect nurses' engagement with PDRP and thus, foreshadow the scope of the subsequent literature review and organisation of the remainder of the work to be presented.

1.2   Locating the inquiry at New Zealand Blood Service

New Zealand Blood Service (NZBS) is the only facility in New Zealand that collects blood and its components for manufacture into medically therapeutic products. The institution employs a range of professionals including between 140-160 Registered or Enrolled nurses. Typically, nurses employed by NZBS work directly with donors collecting blood, plasma or platelets. Some undertake specific skills education so that they can perform additional procedures like stem cell harvests or therapeutic plasma

exchanges in partnership with local District Health Boards (DHBs). In order to carry out these functions, NZBS is highly regulated by Medsafe, New Zealand's Medicines and Medical Devices Safety Authority. To meet Medsafe's exacting standards, nurses are highly skilled, regularly updated and are subject to practice audits for compliance with institutional standard operating procedures at least annually. NZBS provides a significant amount of job specific and professional CPD.

My association with NZBS began in 2009 when I was employed as the Nurse Advisor: Professional Development. My accountabilities were to lead the development and implementation of a modular education system that supported nurses through their initial orientation to more advanced practice. The more advanced practice modules were designed to facilitate learning the complexities of nurse-led haemochromotosis clinics, stem cell harvests for those with haematological disease or therapeutic plasma exchanges in a variety of healthcare contexts. All process related education had to be compliant with Medsafe requirements for product handling. A system for annual review of 'key knowledge and skills' was also developed and implemented. This annual audit of clinical practice ensured that nurses remained knowledgeable about the processes being undertaken and capable of demonstrating compliance with current standard operating procedures. I was also responsible for implementing, and the eventual day to day management, of PDRP. Management of the programme included quarterly reporting to Nursing Council; programme maintenance like developing elearning resources; updating documentation; assessor support and delegation of portfolios to appropriate assessors.

NZBS offered a variety of staff benefits and in particular, professional education and development opportunities like PDRP for nursing staff. Commitment to ongoing

staff development was visible in actions like those of the NZBS Executive who followed

through with a significant overhaul of the remuneration system to support the reward

aspect of PDRP. Resources to implement, maintain and support nurses were also

sanctioned and the programme was submitted for Nursing Council approval in 2013.

The NZBS PDRP received the maximum five-year term of approval with the requirement

that a midterm review was submitted to Nursing Council.

     The programme was well received although engagement was slow. In 2014,

nurses' intention to engage with PDRP was measured in an organisation-wide training

needs analysis (Heath & Utiera, 2014b). When asked whether they intended to engage

with PDRP in the next 12 months, 12 participants indicated they had already done so,

61 that they intended to do so and 14 were undecided (*n* = 87). The needs analysis

gauged acceptability of support available for engagement with PDRP, providing the

opportunity to indicate what else might be needed. Various strategies to promote

engagement had been made available and these included on-site PDRP workshops and

one to one assistance with understanding requirements. Nurses agreed that these

resources were appropriate and no additional strategies were identified.

     In its first five years of approval, the NZBS PDRP attracted only 50 participants.

No more than 25% of NZBS nurses were participating in the programme at any one

time. The year on year average annual participation rate varied between 12-19%.

Although nurses appeared keen to have a PDRP at NZBS, their level of engagement with

it exemplified the low participation rates that were being seen at national level

(National PDRP Co-ordinators, 2014, 2015, 2016). These insights from practice, together

with my in-depth understanding of the workplace, validated the need to undertake an

investigation to explain why nurses did not engage with the NZBS PDRP (Teddlie &

Tashakkori, 2009). As Onwuegbuzie and Johnson (2006) and Robson (1993) suggested, real world research finds solutions to practical problems and helps to find answers that are valued and can contribute to improvements.

1.3 Overview of a PDRP

PDRP can be considered as a professional development framework or pathway for nurses. The underpinning programme proposition is that professional and skill development occurs incrementally and that consequently, the nurse shows an increasing depth and breadth of knowledge and skills to be used for patient benefit. Individual PDRPs have varied educational aims. In some PDRPs, the development nurses' clinical expertise is viewed as being of primary importance whereas for others, incremental skill acquisition for specialty clinical nursing is intended. In either case, clinical performance is assessed at a level relevant to the individual practitioner as defined within each PDRP (See Appendix A).

There are three levels of portfolio, Competent, Proficient and Expert. Each portfolio level has its own requirements and includes continuing competence requirements mandated by Nursing Council (See Appendix A). At Proficient and Expert levels, the nurse's portfolio must also contain a number of prescribed written options such as a case study, exemplar or an account of a teaching session delivered to colleagues. These options are designed to evidence increasing critical thinking and decision making ability relative to the level chosen. To support engagement with PDRP, CPD is available and nurses make choices to access particular learning events. These decisions occur with reference to the nurse manager and in respect of the specific clinical skills needed in the workplace.

Those nurses who choose to engage with PDRP do so by submitting a professional portfolio for review. Portfolio assessment is made against programme criteria and submission requirements including for example, reflection on professional behaviours that are consistent with Benner's (1984) 'Novice to Expert' practitioner characteristics. Successful assessment enables progression, and at the two highest levels provides a financial reward. Portfolios are valid for three years after which they must be re-presented with new examples of evidence demonstrating how the criteria continue to be met. In the intervening years, a statement is required from both the nurse and their line manager to the effect that the level of practice has been maintained.

PDRPs are now a well-established part of the CPD landscape in New Zealand nursing. From an inauspicious start 30 years ago, PDRP is now commonplace. The process of programme adoption by healthcare organisations in New Zealand continues. Yet globally, this form of CPD has an even longer history.

1.4 The emergence of PDRP

In 1984, Patricia Benner published her research on the development of expertise in nursing. Her phenomenological study revealed how nurses developed a tacit understanding of clinical situations using a repertoire of developing skills to make decisions about the best care options for patients. Benner (1984) proposed that a sense of salience, together with developing health assessment and clinical skills, gave nurses the ability to continuously improve the care they delivered. Importantly, Benner hypothesised that when appropriately used, educational strategies like reflection and critical thinking could facilitate nurses' professional growth. Here, the task of writing practice exemplars to encourage nurses' reflective abilities and the opportunity to 'see'

their clinical practice was proposed. Following the emergence of Benner's findings, professional portfolios that contained reflections and exemplars of practice began to prevail.

Motivated by the idea that production of prescribed evidence could demonstrate career advancement, career ladders had been used as early as the 1970's by many hospital boards across the US (Corley, Farley, Geddes, Goodloe, & Green, 1994; Costa, 1990; W. J. Jones et al., 1988; Malik, 1992; Roedel & Nystrom, 1987). Benner's (1984) work gave ladder programmes greater respectability especially in the now well-known nomenclature of levels of practice that indicated clinical progression. The characterisation of Benner's levels of expected clinical behaviours were reflected in the title of her book, *"From Novice to Expert",* and could be adopted within ladder programmes. Consequently, the definition of advancing nursing practice and the 'novice to expert' taxonomy became synonymous with CPD programmes internationally. Newly emergent PDRPs in New Zealand echoed US developments.

In the US, clinical ladders became associated with pay increases as a way of rewarding nurses' development of the clinical expertise needed for service delivery. Benner's (1984) research findings suggested that financial reward might well be pertinent given her conclusion that there was a distinct difference between the decision-making of a newly qualified practitioner compared with one who had several years 'on the job'. It also raised the likelihood that greater expertise could be equated with better patient outcomes and a clear indication that nurses' CPD might be staged to capture the increased depth and breadth of practice understanding. These propositions were certainly cemented in subsequent investigations that validated Benner's seminal

work (Manley, Hardy, Tichen, Garbett, & McCormack, 2005; Minick & Harvey, 2003; Morrison & Symes, 2011).

1.5   PDRP in New Zealand

The introduction of PDRP in New Zealand differed slightly from international uptake. Portfolios came first in 1988 as a proactive response to the likely impact of the State Sector Act (New Zealand Government, 1988). In one of the biggest health reforms of the last five decades, Peach (2013) reported that at the time, there was a fear of dilution in both the visibility and contribution of nursing to healthcare. It was supposed that the unique contribution of nurses and nursing would become invisible because of a shift in professional reporting lines from nurse managers to general managers in the healthcare overhaul. This initial purpose of the professional portfolio in in New Zealand nursing has been utterly transformed over the last 25 years.

The development of a portfolio to validate nursing work had served some New Zealand nurses well. The New Zealand Nurses' Organisation (then the New Zealand Nurses' Association) had shown there were likely benefits for New Zealand nurses in adopting career ladders to support remuneration packages (Buchan & Thompson, 1997) since Benner's (1984) work had demonstrated clearly that merging the two was likely to benefit both for nurses and their patients. Gradually, PDRPs emerged. At first, there were very few programmes and all were driven by individual DHBs. Programmes were vastly different in their inception, development and educational purpose, and no option existed to transfer between DHBs to maintain allowances or career development. Pedagogy it seemed, was driven by whether the local aspiration was for the development of expertise or pay for incremental skill development. Had it not been for the introduction of a key piece of legislation, programme individuality may have

remained a feature of PDRP. Serendipitously, a major overhaul of the Nurses Act (1977) and implementation of the Health Practitioners Competence Assurance Act (HPCAA); (New Zealand Government, 2003) provided the profession with the opportunity to develop some common purpose.

1.6   The role of Nursing Council

As the regulatory body for more than 50,000 nurses, the HPCAA requires Nursing Council to protect the health and safety of the public by implementing appropriate mechanisms to ensure that practitioners remain competent throughout their career (Nursing Council of New Zealand, 2016b). To meet their obligations to the public, Nursing Council mandates that all registered and enrolled nurses annually 'sign' an on-line declaration stating that they meet continuing competence (or recertification) requirements when renewing their annual practising certificate (APC) (Nursing Council of New Zealand, 2004). Nursing Council randomly selects five percent of nurses for recertification audit. If selected, nurses must submit evidence directly to Nursing Council validating how they have met recertification requirements. The current requirements are: 60 hours of CPD in the last three years; 450 hours of clinical practice in the last three years, and written examples of practice identifying how competencies for the relevant scope of practice have been met.

Notwithstanding their obligations to the public, Nursing Council had a significant logistical issue to overcome to meet their five percent audit target. Employers for their part, wanted to be reassured by Nursing Council that their workforce were compliant with the new regulatory mandate. Nurses too wanted reassurance from their employers that they would be supported to meet the new continuing competence and therefore, recertification requirements, especially for CPD. Fitting neatly into this space,

PDRP emerged as a solution for all parties. Nursing Council continuing competence requirements were easily included in those for PDRP by a small amendment. Employers knew that those who successfully engaged with PDRP met regulatory compliance and nurses who did not participate were able to seek support locally to ensure that their continuing competence requirements were met if they were audited by Nursing Council. For Nursing Council however, the practicalities of the solution remained a little more complex. Having continuing competency requirements situated within a PDRP framework was an effective strategy. Yet, the issue faced by Nursing Council was its need to validate that all PDRP assessors were reviewing requirements consistently and reliably.

The situation was resolved with an approval process similar to that used to approve pre-registration education programmes. Nursing Council developed standards for the approval of PDRPs and rolled these out nationally (Nursing Council of New Zealand, 2013b). Individual organisations could choose whether or not to be audited against the approval standards. Successful assessment conferred 'approved' status for a PDRP up to five years. The process provided necessary assurance that nurses who engaged with an approved programme indeed met recertification requirements and further, it provided Nursing Council with an additional way of demonstrating its commitment to public safety required under the HPCAA (New Zealand Government, 2003). Consequently, it enabled Nursing Council to reduce its internal workload in meeting the five percent target set for recertification audits across the profession.

Overall however, Nursing Council's input into individual programme learning intentions and their particular requirements remains limited. Their part simply ensures that procedural aspects of individual programmes are sufficiently robust to ensure that

each participant has met regulated requirements to a satisfactory standard. The recommendation for requirements at each level of the programme is undertaken by the Evidential Requirements Working Group, independently from Nursing Council (Evidential Requirements Working Party, 2009; Nurse Executives of New Zealand, 2017). Made up of a number of key nursing committee representatives like the PDRP co-ordinators; New Zealand Nurses Organisation (NZNO); Maori Nurses' Association, and Nurse Executives of New Zealand (NENZ), the Evidential Requirements Working Group first published guidelines for PDRPs in 2009 (Evidential Requirements Working Party, 2009). These guidelines included general aims and standards for all programmes and the extent of evidence required for each level. The latter advice was offered because of the extensive evidence required for progression by some organisations. However, in 2009, PDRP working group guidelines remained advisory.

The group convened once again in 2016, publishing an updated version of the guidelines in 2017 which further reduced recommendations for the amount of evidence required for each level (Nurse Executives of New Zealand, 2017). This time, the guidelines were published with the caveat that all organisations should work towards their implementation within five years and hence, signalling the intention to work towards a national programme. However, the wider issue associated with achievement of this goal will be reconciliation of individual programme intentions, learning objectives and employer requirements.

1.7   The Ecology of PDRP

From validating nursing amidst massive healthcare reform, to professional portfolios of evidence demonstrating mandatory regulatory requirements and associated CPD, the transformation of PDRP can at the very least, be described as

remarkable. Now, the outcomes of PDRP are synonymous with validation of Nursing

Council requirements for continuing competence purposes; evidencing professional

progress by meeting increasingly complex criteria, and supporting the organisational

development interests of human resource departments regarding their workforce.

PDRP has created relationships between unlikely allies and is underpinned by a level of

support that maintains its influence and ability to command considerable resource; it

has become an ecology (Weaver-Hightower, 2008).

Once, PDRP facilitated the documentation and/or development of expertise

whereas now some PDRPs are used simply as a vehicle for verifying the achievement of

workplace goals, job related skills and compliance with professional competencies

(Carryer, Russell, & Budge, 2007; Havill, 2010; Peach, 2013). In other words, the

learning intentions and pedagogical foci of PDRPs nationally, have become disparate.

Furthermore, the strategic and executive interest in PDRPs has gone beyond their use

as a tool to support the professional development of nurses or their remuneration.

Programme administration and management of PDRPs now includes a range of

occupations for example, a PDRP Co-ordinator might be appointed to maintain a

programme and Nurse Educators or senior staff nurses might be paid to review and

assess completed portfolios. External stakeholders like the NZNO have a vested interest

linked to contractual and financial remuneration during renegotiation of the Multi-

Employer Contractual Agreement (MECA). Essentially, the ecology of PDRP stretches

further than the boundaries of individual nurses or the organisations they work for.

Longstanding stakeholders include the regulator, Nursing Council and the

nurses' Union, NZNO. For its part, Nursing Council has approved more than 20

programmes (Nursing Council of New Zealand, 2016a). The net result is that many more

nurses' continuing competence requirements are reviewed than the expected five percent. The NZNO has continued to be part of the ongoing PDRP conversation for many years, participating in the Evidential Committee Reviews undertaken for more than the last decade (2005, 2009, 2016). The Union has further provided input into the employment pay and conditions that support nurses' engagement with PDRP. The NZNO lead discussion through pay bargaining that concluded with the award of two days of paid study leave for nurses to develop or maintain a PDRP portfolio. Honouring study leave requests for PDRP is a contractual obligation for employers who use the MECA. Payment of the financial allowances negotiated for successful achievement of Proficient and Expert levels is also required. These are currently set at $3,000 (Proficient) and $4,500 (Expert); (pro-rata) at the time of writing.

Human resource departments across the sector have largely welcomed PDRP. PDRP provides a tailor-made career framework for nurses which has measurable fiscal risk. When linked to internal education programmes, PDRP frameworks are robust tools in the organisational development space. They are useful as a recruitment tool and have simplified the ability to 'sell' an organisation based on its commitment to professional development. Furthermore, PDRP has enabled organisations to remain attractive to prospective employees when transfer of a PDRP allowance is possible between employers.

1.8 CPD hours and PDRP

In a single stroke, Nursing Council's response to their HPCAA (2003) obligations created a market for 3 million hours of compulsory CPD every three years. New Zealand has not been alone in setting a minimum number of hours for CPD as part of the professional recertification process. Continuing education has been increasingly

considered as part of the debate on continuing competence requirements in the US, UK and Australia. The Post-Registration Education and Practice (PREP) requirements (now revalidation requirements) in the UK have required nurses to be able to demonstrate the impact of CPD on their nursing practice for at least 20 years (Allen & Dennis, 2012). Australia is exploring the inclusion of continuing competence requirements from a federal position rather than a state-wide perspective.

However, simply achieving a set number of hours does not mean that CPD activities are planned, nor does it guarantee any application of learning to the clinical practice setting. In other words, both the process and product of CPD are important in order to observe the positive patient care impacts identified in the literature (Boltz et al. (2013), Gillespie, Chaboyer, Wallis, and Werder (2011); Manley et al. (2005); Minick and Harvey (2003) and Morrison and Symes (2011)). Nevertheless, like other international nursing regulatory bodies, Nursing Council does not mandate activities that might constitute appropriate CPD, thereby allowing the activities chosen to reflect the individual's identified professional development needs (Allen & Dennis, 2012; Nursing Council of New Zealand, 2004, 2016b). All types of learning that contribute to the expansion of a nurse's understanding or skill base are deemed to be acceptable.

1.9   PDRP and the tertiary education sector

Some nurses turned to the tertiary sector to meet the hours required for CPD. However, the implementation of an all graduate entry profession had changed the overall structure of post-registration nurse education, adding obstacles especially in relation to academic entry criteria for those who had entered the profession via the apprenticeship model. Meanwhile, the need for postgraduate qualifications to meet ongoing professional development requirements and to secure senior positions became

a necessity. Furthermore, the outcome of the Evidential Requirements Working Group (2009) guidelines reinforced the need for nurses to engage with the tertiary sector by introducing the requirement that postgraduate study (or its equivalent) was essential to meet the criteria for an 'expert' practitioner. The meaning of 'equivalence' to postgraduate study was neither well-articulated nor well understood by PDRP Co-ordinators or nurses.

The notion that postgraduate level could be assessed by 'equivalence' created a difficult situation. Where nurses had not undertaken postgraduate study, PDRP co-ordinators had to find ways of assessing 'equivalence' of work presented to that of Masters level academic study. In essence, the Evidential Requirements Group recommendations (2009) aligned with evidence from the literature which had indicated the potential improvements in critical thinking that might be found through engagement with postgraduate study (Pelletier, Donoghue, & Duffield, 2003). However, the recommendation also exposed a lack of appreciation of the intrinsic value of PDRP for its contribution to the development of clinical expertise and the use of heuristic knowledge or sense of salience to support nursing decision-making (Benner, 1984; Carr, 1986). Instead, the Working Group's recommendation introduced an element of academic achievement never originally envisaged in Benner's (1984) seminal work. Consequently, those nurses who had seen PDRP as a legitimate alternative to an academic pathway were affected. Their lack of previous tertiary education or preference not to engage with postgraduate nursing left them in a position where completing PDRP to the highest (expert) level would be difficult.

Moving undergraduate nurse education into the tertiary sector at all had occurred largely because of an historic demand by nurses themselves to be considered

as a profession and to be treated as such (Lusk, Russell, Rodgers, & WIlson-Barnett, 2001; Ministry of Health, 1988). The move into higher education has undoubtedly brought rewards for example, the advent of postgraduate pathways for Nurse Practitioners in New Zealand. However, the all-graduate preparation has significantly changed both the purpose and expected outcomes of ongoing education for nursing, and consequently, CPD as a whole (Aitken, Clarke, Cheung, Sloane, & Silber, 2003; Pelletier et al., 2003). Perhaps the most significant outcome of having graduate entry has been that universities have begun to determine the ways in which postgraduate education will be delivered. In many cases, the content has remained generic and applicable to most specialist areas, maximising course availability to fee paying students. CPD to support the development of particular specialist knowledge relies heavily on clinically based education and continues to be delivered in work areas.

The move to higher education has also been widely debated in terms of the benefits for new nurses. From a hands-on, practical apprenticeship model to graduate entry profession, nursing made a major transition from small schools of nursing attached to local general hospitals into the tertiary academic sector following the Carpenter Report in 1971 (Ministry of Health, 1988). Student nurses no longer deliver direct care as part of the hospital workforce and have become university students in their own right. As a result of fitting nursing courses into university semesters, the length of time spent engaging in hands-on clinical practice initially raised debate particularly about the relationship between theory and practice (Carr, 1986; Ingram, 1991; S. Jones, 1989; Miller, 1985). There is no doubt that the introduction of graduate entry to the nursing profession changed the new graduate nurse 'product'. However, the advent of Nurse Entry to Practice programmes (NEtP) from 2009 onwards in New

Zealand has ensured that newly registered nurses can experience an internship year whilst making the transition from student nurse to Registered Nurse. Most are linked into postgraduate certificate courses (Doughty, McKIllop, Dixon, & Sinnema, 2018) as well as being inextricably linked to PDRP in DHBs that run both programmes. NEtP candidates must submit a portfolio that meets the competent level of the local PDRP.

1.10 PDRP and Health Workforce New Zealand funding

A secondary influence on access to postgraduate study for nurses has been the impact of funding availability. The funding distribution model used by Health Workforce New Zealand (HWNZ) has never been completely abreast of the planning required for future nursing workforce preparation based on health policy, expected population models and quantity of nursing staff likely to be needed (Nursing Council of New Zealand, 2013). Nursing's share of the funding has been significantly less than some other groups of health professionals leaving gaps in provision (Ministry of Health, 2009). Administered by DHBs, nurses have always endeavoured to ensure that the allocated funding has been shared among primary, secondary and tertiary care services. However, criteria stipulating that courses must be endorsed by Nursing Council or HWNZ has meant that nurses are channelled into choosing these particular courses if they intend to apply for funding. Given that HWNZ has not updated its criteria for funding distribution since 2009, it is arguable that this approach tends to make provision for the current local need rather than a future workforce vision. In addition to meeting the criteria for HWNZ and their university of choice, nurses must also meet the DHB's requirement that PDRP is completed beyond competent level (proficient or expert level) as evidence of previous commitment to professional development. The

result is a somewhat haphazard approach to the overall development of the future workforce and a potential loss of quality and speciality focussed education.

The picture is further compromised by a lack of continuing commitment to the completion of qualifications. Funding rounds are completed on an annual rather than by qualification basis meaning that funding might be achieved in one year but not the next. This adds uncertainty to nurses' applications when the qualification takes longer than a single academic year to complete. The demands for annual application seem unreasonable and those nurses who are unsuccessful in securing continuing financial support must consider self-funding or scholarship options to complete their qualifications. Others simply meet CPD requirements via entirely another route. To fill these gaps, alternative models of education have been variously implemented outside of the tertiary sector.

Endorsed by the NZNO and the National Nurses' Organisation (NNO), key skills frameworks (KSFs) for specialty nursing have been developed. The learning intentions reflect the knowledge and clinical skills required in specialities such as pain management, cancer care and diabetes. KSF programmes were designed to develop all nurses' ability to care for patients with these types of conditions across the healthcare spectrum. Supposedly aligned to PDRP levels and Nursing Council competencies, these frameworks have reported limited uptake although they provide nurses with yet another option through which CPD can be completed. Clearly, nurses have a large number of CPD opportunities from which to choose. Yet, outside tertiary study, KSF and PDRP, there is little evidence to show how or with what types of CPD nurses are engaging.

1.11 Engagement with PDRP

The National PDRP Co-ordinators Group (NNPC) undertakes monitoring of national uptake of PDRPs. Year on year, data shows participation rates are highest across all organisations where programmes are compulsory. Engagement rates drop proportionally where only certain employees are required to submit a PDRP portfolio. Typically, this phenomenon is found where nurses are employed on the Nurse Entry to Practice (NEtP) programme. Where engagement is entirely voluntary, rates of uptake remain at less than 20% of the workforce (National PDRP Co-ordinators, 2014, 2015, 2016). Whilst previous studies (Carryer, Budge, & Russell, 2002; Carryer et al., 2007; Havill, 2010) have addressed nurses' perceptions of PDRP, there does not appear to be any that have specifically addressed the decision making involved in programme participation. Reasons for low engagement rates among nurses where PDRP is voluntary remain unknown. Clearly, there is a need for greater understanding if PDRP is to remain a realistic option for CPD. Yet, the limited formal documentation of engagement issues does not mean that nurses' views of PDRP have been completely ignored. Indeed, efforts have been made to resolve some of the highly visible tensions of engagement with PDRP.

1.12 Resolving PDRP tensions

Two issues that have been actively reconciled since the inception of PDRP have been ensuring transferability between organisations and equity in the amount of evidence required at each level of practice. Initially, organisations looked to collaborating using memoranda of understanding to allow easy transfer between programmes where staff were mobile within regional health services. More recently,

the approved status of programmes has superseded the need for formal memos making transfers easier and available outside of regional consortia. In regard to evidential requirements however, the path has been less simple.

Anecdotally, the volume of work required is leveraged as a reason for non-participation in PDRP. The first Evidential Requirements Working Party recognised this and worked towards delivering agreement on what should constitute reasonable and appropriate evidence and how this might be managed. In 2009, the Working Party report presented 'options' (like written case studies, exemplars, presentations) from which nurses could choose in order to demonstrate their level of practice. The changes were largely successful where implementation saw a reduction in the onerous amount of evidence to be submitted on some programmes. However, as previously outlined, the Working Group's first statement on requirements also introduced the need for expert level practitioners to have gained a postgraduate qualification or be able to demonstrate their 'equivalence' of doing so (Evidential Requirements Working Party, 2009).

Implementation difficulties were raised by PDRP co-ordinators. They were given the complicated task of assessing whether the expert evidence submitted was in fact, equivalent to postgraduate level study. This occurred, without any agreement or publication of criteria with which to do so. Some organisations simply avoided the prospect of articulating an equivalent pathway, instead opting for the requirement for expert practitioners to have completed postgraduate study for the level. It quickly became clear that the introduction of postgraduate equivalence had unintentionally excluded those it was designed to assist.

The evidential requirements were reviewed and updated by a second working party in late 2017 (Nurse Executives of New Zealand, 2017). In this iteration, the issue of postgraduate equivalence was resolved when it was removed from the new edition of requirements. Rather, PDRP Co-ordinators were tasked with ensuring that PDRP participants characterised the definitions of proficient or expert practitioners within the evidence submitted for their portfolio. Importantly, this review also removed the necessity for nurses to produce 'options' (case studies or teaching sessions) for demonstrating proficient and expert levels. Instead, characteristics of proficient and expert practice were to be demonstrated in practice vignettes written as evidence for self-assessment of Nursing Council competencies. Additionally, NENZ, who sponsored the Evidential Working Group, indicated it was their expectation that all organisations offering PDRP would comply with these new requirements within five years. This expectation has effectively signalled the advent of a national programme.

The difficulties with the directive from NENZ is that nationally, the educational purposes of the programmes still differ; the newly proposed format may not fit with the terminal educational objectives of all currently approved programmes. Those programmes that subscribe to the view shared by Peach (2013) that PDRP is a tool through which the value of nursing can be demonstrated, might see that the production of a case study as completely relevant to their purpose and might not wish to exclude this from their own programme requirements. Similarly, this could be the case for programmes where the educational purpose is more aligned to the development of Benner's (1984) expert practitioners. For these PDRPs, it appears that the production of documentary evidence which articulates reflection on practice, the illumination of embedded learning, the supporting discussion and critical thinking exposed, can no

longer be required. Other programmes that favour the demonstration of particular tasks and clinical capability at a job specific level may find that the supply of evidence can be completed within nurses' own testimony and that it also provides evidence of self-evaluation against Nursing Council competencies. It is clear that tensions remain and in attempting to resolve them, the relevance of PDRP to nurses as evidenced by the poor voluntary participation rates needs to be explored. The context for doing exactly that within this study is the NZBS PDRP.

1.13 PDRP at New Zealand Blood Service

The view of PDRP taken by NZBS is aligned with Benner's (1984) novice to expert model. NZBS PDRP is a professional development programme designed with the key purpose of developing expert practitioners in their clinical field. NZBS has a Nursing Council approved PDRP. The programme is arguably an evidence-based programme since it meets and was approved on programme requirements aligned to those published by the Evidential Requirements Working Party (2009); a MECA agreement is ratified providing entitlement to the option of paid leave and allowances at agreed levels of practice for all nurses, and internal training programmes beyond initial orientation are linked to PDRP requirements. The outcome is that through their planned, experiential learning and by providing examples of reflection and critical thinking from everyday clinical practice, nurses are able to demonstrate achievement of incremental levels of expertise. External courses can be credited to the programme for the purposes of CPD hours or as a means to meet the options work required. NZBS is highly supportive of CPD that is accessed both internally and externally. The organisation subscribes to the view that expert practitioners are cost effective and part of the national Professional Development Team's role is to support staff as they

develop their professional portfolios for submission. Launched in 2010 and approved by Nursing Council in 2013, the engagement rate with NZBS PDRP follows the national trend for voluntary programmes despite repeated participation initiatives and increasing accessibility options such as the development of an on-line resource library via the eLearn platform. At the time of the 2014 training needs analysis, 61 nurses identified that they intended to complete a portfolio in the following year (Heath & Utiera, 2014b); three portfolios were actually submitted. Clearly, there is an issue with nurses' engagement with NZBS PDRP when the uptake rate has never exceeded 20%.

1.14 Summary

It is difficult to fathom why engagement rates continue to remain low where PDRP completion is voluntary. Significant endeavours to address identified programme issues have been made with little change to uptake. PDRP meets all of the conditions submitted by Hinchliff (1998) as nurses' likely requirements of contemporary CPD programmes. PDRP is based in the workplace using practice examples as the basis for learning and professional development; PDRP meets continuing competence requirements, including an extensive range of choices of activity to generate 60 hours of CPD. Practice experience is central to the endeavour. PDRP also appears to serve several beneficial purposes within the ecology metaphor used here, but is complicated by the historic and political influences that surround it. Furthermore, the educational outcomes of programmes might be altruistic, but the intended audience appears to find little incentive to engage save where the programme is a compulsory element of employment. Consequently, it is possible that beneficial outcomes, especially those for patients, are not fully realised. There appears to be little in the literature that addresses the poor level of engagement with PDRP and little is known about the reasons why

nurses choose to participate at all. Hence, there are few recommendations or solutions. What can be deduced however, is that where nurses do engage with a programme, Nursing Council, and therefore the public, can be assured that many nurses who are not audited directly by Nursing Council do meet professional requirements for continuing competence. Yet, where programmes are entirely voluntary, uptake is poor, the reason for which is not well understood. If PDRP is to be a realistic option for the future, it is imperative there is greater understanding of nurses' knowledge, attitudes and behaviours in relation to participation thus, addressing the current gap in the literature. At the beginning of this thesis then, the broad aim of the work can be expressed as the intention to better understand nurses' decisions to participate in PDRP.

In the next chapter, related literature will be examined. The purpose will be to connect appropriate research from both nursing and education disciplines that focuses on nurses' relationship with continuing professional development. From this position, any gaps in the literature will be identified and the initial questions to be answered will be formulated. In subsequent chapters, methods and the philosophical stance to be taken will be articulated together with the implications for choosing Cross' (1981) Chain of Response Model as the conceptual framework for the work. Further, reasons for choosing a mixed-methods methodology as the appropriate approach for the work will be justified. Data collection methods will be explained. The outcome of the pilot study undertaken to test the data collection methods will be presented. Amendments made as a result of the testing that took place will be outlined. In a professional doctorate where the researcher is often practitioner, it is imperative that the actual and potential ethical issues are carefully considered. As such, actions taken to ensure and maintain safety of participants throughout the entire work will be explained and justified.

In chapter 4 results of the quantitative phase of the research will be presented. Analysis of the data is dovetailed here to provide a logical flow to the work because the subsequent qualitative phase was dependent on the analysis of the quantitative phase to determine both the questioning strategy and questions to be posed in the semi-structured interviews. Chapter 5 contains the findings from the qualitative phase of the work and includes nurses' explanations of the areas they had identified in the quantitative phase as influencing their decision to participate in PDRP. Discussion, conclusions, limitations and recommendations in the light of this work are made in chapter 6.

2. Literature Review

2.1 Introduction

It would be realistic to propose that those who access healthcare facilities have an expectation that the nursing service they receive is from a Registered Nurse who is constantly learning and developing expertise within his or her specialty practice area. To be attended to by such a practitioner would be to receive the highest standard of care and to be assured that individual health outcomes would be the best possible. Undeniably, evidence exists to support that view. Where care is provided by nurses who are expert practitioners, detection of deterioration is enhanced, there is timely mobilisation of pertinent healthcare resources and improved clinical decision-making (Manley et al., 2005; Minick & Harvey, 2003; Morrison & Symes, 2011). Furthermore, the characteristics of expertise have been well conceptualised and taxonomies with which to classify its expression within individual practitioners now exist (Benner, 1984; Manley et al., 2005). Desirable then, would be to better understand how contemporary pedagogies in continuing professional development (CPD) might promote acquisition of expertise among nursing staff following initial registration. In a healthcare context which is likely to remain fiscally constrained and where preparation for forecasted changes in the population base will require nurses to be more adaptable and responsive to emerging healthcare needs (Nursing Council of New Zealand, 2013), such a strategy could be extremely beneficial.

The work to be presented in this chapter is a review of the literature accessed for the purposes of understanding what research has already been completed in the field and an appraisal of that research in terms of its quality (Boote & Beile, 2005). The

chapter will place this study within the wider context of existing literature on nurses' CPD. Furthermore, gaps in the literature will be identified making it possible to justify the place of this work and its intention to extend available knowledge. To guide the search for the purposes of this study, the literature will be reviewed in respect to the following broad questions:

1. What evidence exists to support the use of professional portfolios as a tool for CPD for nurses?

2. What is the relationship between CPD and patient or practice outcomes for nurses?

3. What is known about nurses' engagement with CPD?

Subsequently, gaps will be identified within the literature and the boundaries for this investigation will be identified, resulting in formulation of the questions that will direct the remainder of the work (Boote & Beile, 2005).

2.2 Search Strategy

The initial search was undertaken using the on-line library databases provided by Massey University Library in the subject guides for Nursing (Health databases on EBSCOhost which includes CINAHL Complete, Health Source, Health Business Elite, Academic Search Premier, Australia/NZ Reference Centre) and Education Discover (which includes ERIC, Education Source, PsycINFO and Australia/New Zealand Reference Centre). All media types were included to maximise return in the initial search between 1970 and the present. This date was chosen to enable inclusion of any potentially relevant material that preceded Benner's (1984) publication which, at the outset was the oldest seminal work certain to be used in the literature review because of its significance to the types of programmes under scrutiny. To support thorough searching,

the questions were broken down into concepts and individual searches were performed using selected keywords and their synonyms using 'AND' and 'NOT' in the search criteria to focus further.

Relevant studies were retrieved via the electronic database for further consideration and application of the inclusion and exclusion criteria relevant to each search sub group. For example, the strategy for searching professional portfolios included studies that evaluated usefulness from a pedagogical or assessment perspective across all disciplines. Studies were excluded when the investigation was located at the baccalaureate level or conducted solely in pre-registration nursing or non-healthcare environments. This was because the thesis context is related to post registration education (i.e. CPD occurring after initial qualification however that might have been achieved). For CPD and nursing, all types of post registration education were included where research had been intended to demonstrate the impact of education on patient outcomes. Further, all studies that were related to CPD in the context of regulatory and credentialing requirements were included to enable comparison of international requirements, practitioner response and the possibility of practice improvements following implementation. Where New Zealand authors or publications were found, resulting material was hand-searched to locate any additional sources that would add to the development of a timeline that could map local endeavour in order to better understand the historical antecedents of the New Zealand situation and to show where new knowledge was needed.

Discussion with key individuals who were architects in the process was also considered as an option. Where possible, meetings with them were arranged. During the process of completion, these discussions included for example, staff at Nursing

Council of New Zealand identifying that this work was being undertaken because of the likelihood of some outcomes being relevant to them, email communication with journal editors, consultation with Dr Burke Johnson and Dr John Creswell during a workshop on Mixed Methods Research at Massey University, and request to Professor Jenny Carryer, Massey University, for permission to access and use her validated questionnaire.

Other significant strategies which yielded appropriate material were the keywords and MeSH headings provided in some of the selected papers. Hand searching reference lists provided identification of additional international sources. During electronic searching, the Science Direct link via Massey on-line library suggested additional relevant links to full text articles which were also followed up. All research-based sources were reviewed using the Common Guidelines for Education Research and Development published by the Institute of Education Sciences, the US Department of Education and the National Science Foundation (2013). These guidelines set out principles for the appraisal of research. They allowed each source to be evaluated for its place in the 'pipeline' of research from exploratory to efficacy, effectiveness and scale-up research against well-articulated criteria. They were chosen in preference to evidence based nursing taxonomies because of their discriminatory power in relation to the assessment of educational research. However, all sources that met inclusion criteria were considered for possible contribution to the literature review, even if the evidence presented was opinion. In some cases, this constituted best available evidence.

2.3 Professional Portfolios

The literature is abundant with opinion supporting the use of portfolios and their perceived potential to provide desirable outcomes when used as a learning tool. Mathers, Challis, Howe, and Field (1999) documented the advent of portfolios across all

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health disciplines during the 1990's. Nurses were early adopters of professional portfolios because of their versatility as a means for planning and validating CPD activities across a range of speciality clinical areas. Nurses were not alone in their enthusiasm (Mathers et al., 1999; Peach, 2013). The need to record learning activities and to reflect on practice appears to be important in many disciplines, and there is historical evidence to show that the contribution of portfolio development has also been seriously considered in allied health disciplines and teacher preparation (Austin, Marini, & Desroches, 2005; Byrne, Schroeter, Carter, & Mower, 2009; H. Coleman, Rogers, & King, 2002; Hespenheide, Cottingham, & Mueller, 2011; Klenowski, Askew, & Carnell, 2006; McCready, 2007; Ng, White, & McKay, 2007; Tofade, Hedrick, Dedrick, & Caiola, 2013).

Extending from a purposeful collection of artefacts, to summative assessment in postgraduate education, portfolios have been shown as an adaptable tool which can support learning in a variety of situations. With reference to nursing, Williams and Jordan (2007) indicated that the production of a portfolio could assist demonstration of competence. Hespenheide et al. (2011) expanded the idea, regarding portfolios as an inclusive mechanism through which professional development could be recorded and clinical leadership advanced. Further, these authors argued that professional development could be rewarded via progression on a clinical ladder. These themes were repeated throughout the literature where illustrations could be found of the very high esteem in which portfolios appeared to have been held by professional nursing leaders, national and international nursing organisations and nursing regulatory bodies (Jasper, 1995; Manning, 2015; National Council of State Boards of Nursing, 1996; Nursing and Midwifery Council, 2016; Peach, 2013).

In allied health, Ng (2010) undertook an extensive review of portfolios as a learning tool. He suggested that when using a portfolio for CPD purposes in radiography, its emphasis needed to be focused on competency-based professional and occupational standards as well as being able to provide evidence of practice development in the workplace. McColgan (2008) included consideration of the relationship between lifelong learning and statutory requirements in her literature review. Here, McColgan (2008) referred to the established use of the portfolio as part of the Nursing and Midwifery Council's recertification and CPD requirements in the UK. Byrne et al. (2009) added nurse credentialing in the US. Clearly, documented support of this calibre indicated that there were a number of compelling reasons to choose portfolios as a tool for CPD. Yet, some commentators counselled that there was an urgent need for clarity regarding the scope of their use, rather than simply revering the portfolio as a kind of educational 'magic bullet' (McMullan et al., 2003). Spence and El-Ansari (2004) advocated for a common understanding among practitioners and definition of terms within the literature. Klenowski et al. (2006) called for the conversation to include consideration of the theoretical perspective and intended learning outcomes; in other words, they reminded teachers that the choice of portfolio preparation as a learning strategy needed to be fit for educational purpose. The former view was strongly echoed by Ng (2010).

Citing a series of his co-authored and published works, Ng (2007, 2010) developed links between portfolio pedagogy and learning outcomes. Unable to reconcile extremes, Ng (2010) proposed a complex series of definitions separating the term 'portfolio' from 'portfolio pedagogy' and 'portfolio learning' and 'portfolio assessment'. Combinations of the definitions he argued, provided greater

understanding of the pedagogical focus. However, Hespenheide et al. (2011) developed a more accessible taxonomy when they reclassified Endacott et al.'s (2004) list of four portfolio types and instead, described two main types of portfolio as 'best work' and 'growth and development'. In short, Hespenheide et al. (2011) demonstrated that portfolios could usefully be underpinned by either a behaviourist or constructivist pedagogy which gave them wide professional appeal.

Hespenheide et al. (2011) suggested that a 'best work' portfolio comprised of evidence of competencies and expertise that could be used for promotion, job applications and meeting regulatory requirements. A 'growth and development' portfolio by contrast, contained material through which nurses could self-assess progress towards professional goals or indeed, interests of their self-determined learning (Bhoyrub, Hurley, Neilson, Ramsay, & Smith, 2010). Perhaps over-simplified, these definitions excluded acknowledgement of a purpose which Byrne et al. (2009) articulated several years previously; that the principal purpose of the portfolio in the clinical setting was to enable demonstration of reflective and critical thinking, using experience, narrative and personal understanding to illustrate competence. However, the importance of reflective, critical thinking had been grasped by researchers in higher education. Almost unanimously, available research from this sector detailed the centrality of reflection to the successful use of the portfolio as a learning tool.

Reporting on their English National Board for Nursing, Midwifery and Health Visiting (ENB) commissioned research, Endacott et al. (2004) provided evidence from a four-centre, comparative case study that enabled the identification of four types of portfolio in use across the selected higher education institutions (HEI). Using their emergent theme of characterisation of portfolio type as 'the shopping trolley', 'the

toast rack', 'the spinal column' and the 'cake mix', the research team reported the ability to predict the effectiveness of portfolios in each centre as a result. Their findings suggested that learning outcomes could be more easily assessed in the presence of not only artefacts or documentation, but also in the requirement for reflection. Here, they indicated that the two most effective portfolio models were the 'spinal column' or 'cake mix' alternatives where reflective commentary joined portfolio artefacts with critical analysis, identification of learning progress and planning for future learning.

Endacott et al's (2004) work added to that of researchers like Mathers et al. (1999) who had previously identified the potential of reflection in their two-cohort cross-over study comparing traditional approaches to CPD with portfolios for general practitioners (GPs). In drawing conclusions in this cogent study, the researchers determined that portfolio-based learning enabled GPs to reflect on the application of their learning to their current practice and to develop their future learning objectives and plans. Likewise, Spence and El-Ansari (2004) established the portfolio as a tool which helped to promote self-evaluation and reflection when compared with traditional course assessment practises.

Spence and El-Ansari (2004) adopted a mixed methods approach including questionnaires and interviews in their study with teachers and their students. The students were all nurses enrolled in a specialty community nursing course. In roles like this, case-loading, where a nurse remains accountable for the same group of patients, is the preferred method of patient distribution. This is opposed to daily allocation where different nurses would see the patient for each episode of care. Consequently, the nurse's autonomy is increased and commensurate reflective skills are needed as a professional imperative. The use of the professional portfolio to facilitate progress to

improve reflective skills on the basis of reflection-on-action then, might well be considered as a measured strategy. Further, such a conclusion can be corroborated by the seminal work of Schön (1983) who comprehensively demonstrated professional progress through reflection on, or in, action. Evidence has also shown that the development of reflective, critical thinking skills are an important professional characteristic which can be effectively learned or enhanced by the adoption of portfolios as a learning and teaching strategy (H. Coleman et al., 2002; Hoffmann, 2013; Samy, 2008). However, other less obvious themes emerged from the literature and are worthy of consideration here in that they might add to the wider consideration of the efficacy of the portfolio in the context of CPD itself or within career ladders or programmes like Professional Development and Recognition Programmes (PDRP).

2.4 Portfolios and learning enhancement

Closer inspection of the works by Mathers et al. (1999), Spence and El-Ansari (2004) and Endacott et al. (2004) showed that facilitation was an intervention common to all studies. In its various guises as a group activity (Mathers et al., 1999) or teacher/student meeting (Endacott et al., 2004; Spence & El-Ansari, 2004), facilitated reflection appeared to have been key in enabling positive, desirable outcomes. Such outcomes, also identified by Weddle, Himburg, Collins, and Lewis (2002) as well as Hoffmann (2013), Coleman et al. (2002) and Samy (2008) showed that professionals were supported to challenge, clarify and develop their learning goals through reflection and discussion. Whilst Weddle et al. (2002) only suggested the potential usefulness of facilitated reflection, Mathers et al. (1999) determined that there was some value in the use of portfolios in a double-loop learning cycle within their crossover cohorts. What Mathers et al. (1999) showed was the usefulness of reflection for highlighting areas of

practice that could be improved. In the second learning loop, characterised by the time when the practitioner was in a similar clinical situation, the new learning was applied and consequently reflected upon for its efficacy. McColgan (2008) too, made reference to the benefits of facilitated reflection and goal setting in her literature review related to portfolios as part of the regulatory framework in the UK. Manley, Martin, Jackson, and Wright (2018) added that skilled facilitation is as potent as any of the previously cited strategies. Further, their significant contribution to understanding healthcare practitioner CPD using case study research has indicated that supported knowledge translation can result in lower costs of service delivery and improved patient experience.

Tiwari and Tang (2003) emphasised the application of learning to the clinical context. In their evaluation of portfolios as a means for improvement in academic assessment, they showed that portfolios supported reflection on the application of learning to practice, providing evidence of gains in both competence and confidence among their study participants. Klenowski et al. (2006) sustained this view in their discussion of their tertiary education based case study research in which the use of portfolios were considered for learning and professional development. Also studying the potential of portfolios for academic assessment, Baeten, Dochy, and Struyven (2008) examined the relationship between students' personal approach to learning where assessment was by portfolio rather than more traditional methods of assessment. These writers determined that there was greater evidence of learning being applied to practice when incidents were reflected upon as part of portfolio development. Yet, even in the light of the range of research approaches appearing to demonstrate the value of facilitated reflection and learning application in conjunction

with portfolio development, both Byrne et al. (2009) and McColgan (2008) suggested

caution against becoming carried away with the idea that learning is enhanced.

Endacott et al. (2004) simply reminded readers that not all lecturers or clinical staff

make the best facilitators.

With the exception of Mathers et al. (1999), all writers connected the process of

learning using portfolios with meeting pre-set competencies or behavioural learning

objectives. In other words, much of the available literature appeared to assume use of

portfolios that verified achievement or advancement towards particular, specified

outcomes. Remarkably, in asking their cohort to develop their own learning objectives,

Mathers et al. (1999) like several others had supported Benner's (1984) proposition

that portfolios could be used to develop expertise by making use of knowledge

constructed by the learner through reflection, from the cumulative knowledge gained

from practice within an authentic learning context (Benner & Tanner, 1987; Carlson,

Crawford, & Contrades, 1989; H. Coleman et al., 2002; Hoffmann, 2013; Manley et al.,

2005; Samy, 2008). Effectively, commentators were agreed on the wide professional

appeal of portfolios, but recommended that clarity of pedagogical purpose was explicit.

The study by Mathers et al. (1999) is exceptional in that its authors used a

robust methodology, located their work in an appropriate theoretical paradigm and to

date, it appears to be the only study of the specific use of portfolios in the CPD context.

These writers were able to pinpoint what had made engagement productive for

participants and, as well as being theoretically sound and using various congruent

learning strategies, their work supported both constructivist and adult learning

principles. These actions culminated in the demonstration of meaningful and relevant

real-world problem-solving that could be achieved by combining the clinical context

with which learners were deeply familiar; setting learning against personally developed objectives with the opportunity to collaborate in social, facilitated groups; and recording learning progression using a portfolio. This strategy met most of the conditions for successful adult learning in a constructivist paradigm such as social interaction; incorporation of experience, collaboration, and self-direction (Curzon, 2003). Yet, Tiwari and Tang (2003) reflected on the assumption that all learners have the necessary writing skills to meet the demands of portfolio submission. Here, it was suggested that even with pedagogical congruency, it could be unwise to accept that portfolios were guaranteed to work for all participants.

McCready (2007) and McMullan et al. (2003) offered opinion on the difficulties faced by the less 'academically mature.' Here, the plight of those learners who required additional instruction to be able to use higher order cognitive skills was highlighted. Higher order cognitive skills it was argued, were those which required the learner to evaluate and reflect on their practice; the very skills that were raised in the literature as being integral to how portfolios 'work'. These are important considerations for nursing where there are practitioners who may not have been graduate entrants into the profession and for whom this type of writing skill may be as Tisani (2008, p. 553) describes, 'an alien form of discourse.' Successful use of the portfolio then, may actually depend on more than one dynamic being in place; the intended learning outcomes, the incorporation of a range of supportive strategies including facilitation of the reflective process, as well as adherence to specific contextual and learner requirements. All are relevant, supplementary considerations to be made when the use of portfolios is considered as a strategy in the CPD context.

2.5 Summary: Portfolios as a tool for professional development

This section of the literature review has shown that clarity of educational purpose is an imperative in the effective use of professional portfolios (Byrne et al., 2009; Endacott et al., 2004; Manley et al., 2005; Mathers et al., 1999; McColgan, 2008; Ng, 2010). Further, it has been possible to identify that the reasons to pay attention to portfolio purpose were mostly connected with the type of portfolio to be constructed to meet intended learning outcomes (Byrne et al., 2009; Hespenheide et al., 2011; Spence & El-Ansari, 2004). Where the learning intentions were related to best work, reflection on practice did not appear to be as important as when the purpose was related to monitoring growth or to the development of expertise and adding to the practitioners' available range of clinical options (Benner, 1984; Benner & Tanner, 1987; Endacott et al., 2004; Manley et al., 2005; Mathers et al., 1999; Spence & El-Ansari, 2004). However, the skills of portfolio writing were identified as being of a higher order, and so for two important reasons, the facilitation of reflection was shown to be important. Firstly, because it enabled clarification of objectives, learning progress and future learning needs and secondly, because it provided support for the development of critical thinking and reflective, evaluative writing skills (Baeten et al., 2008; Tiwari & Tang, 2003). Outcomes of portfolio use could best be summarised as the development of learning goals, critical thinking and reflectivity (Weddle et al., 2002). Further, the literature showed that identification of learning progress and the production of evidence to meet specific workplace, competency or credentialing goals was possible using the strategies identified (Byrne et al., 2009; McColgan, 2008; Ng, 2010).

Intuitively, these findings seemed practical and at face value, generations of writers appeared to be building on previous work. Yet, both the lack of abundance and

limited methodological coverage of the topic by empirical work suggested that there was more to be done. When compared to the Joint Committee (2013) framework, all of the research accessed contributed to the provision of core knowledge and basic understanding. Empirical work falling into this category is important for its contribution to understanding both the systems and processes involved in learning and teaching. Further, the joint committee identified such works as being fundamental and have suggested that outcomes in this category are foundational or early stage/exploratory. The case-study approaches and the small cohort studies reviewed exemplified the kind of work that could be included here. Consequently, it can be asserted that limited evidence does exist to support the use of professional portfolios for the purposes of validation of nurse advancement in the context of CPD. However, the work available is not exhaustive and there is considerable room for development of other studies that could add to the understanding of portfolio use as a means to support the ongoing professional development of nurses.

The focus of the literature examined so far has provided a foundation of information about the purpose and types of portfolio that can be used. What cannot be well understood from the work to date is the role of portfolios where learning outcomes are not related to specific occupational or regulatory requirements. Where learning objectives are learner directed, the literature is mostly silent on both the use and potency of the professional portfolio, save for the work of Mathers et al. (1999) and Manley et al. (2005). However, it might be possible to deduce that matching purpose with type of portfolio could be helpful.

The literature presented here then, constitutes distillation of the best available evidence for the ways in which a professional portfolio could be used to demonstrate

the acquisition of progress towards the advancement of desirable characteristics for example, nursing expertise. Still, the problem remains that the potential for the use of professional portfolios in this way must be reconciled with the current picture of the nature, purpose and rhetoric that surrounds CPD in nursing more generally. Furthermore, documentary evidence of nurses' views on the legitimacy of using a portfolio as a means for professional development remain scant, providing an opportunity for explanation of its relevance to PDRP engagement within the current study.

2.6   CPD as a mandatory requirement

Nursing Council of New Zealand (Nursing Council) like other international regulatory bodies in Australia and the United Kingdom, have mandated 60 hours of CPD must be achieved over a three year period as part of their recertification requirements (Nursing and Midwifery Board of Australia, 2017; Nursing and Midwifery Council, 2018). Lifelong learning and investment in one's career through CPD is intended to ensure that nursing skills are maintained and practice is continually developed and consequently, competence is assured. Yet, writers like Gallagher (2007) and Thomas and Qui (2013) rightly question the place of a mandated number of hours of CPD in nurses' annual recertification requirements.

In her well-constructed paper based on the guidance of the Rogers Evolutionary Method of concept analysis, Gallagher (2007) provided an account of the antecedents to the contemporary professional assumption that continuing education (CPD) was essential for advancing professional competence. Following a cogent line of argument, Gallagher (2007) identified a significant facet to the linguistic relationship between education and competence. Here, she recorded how the term 'competence' had been

transformed by contemporary writers to mean not just, "The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions" (Nursing and Midwifery Council, 2014), but also the prevention of obsolescence. By obsolescence, Gallagher (2007) referred to the possibility that knowledge and skills for current practice had become outdated. Subsequently, the proposal that mandatory CPD reduced obsolescence was disseminated globally by repeated iteration in published works. Consequently, CPD is now a requirement of many international regulatory bodies for nurses' annual re-registration on just this basis. There is no empirical work to show that CPD does the job intended either in preventing obsolescence or, as the regulatory bodies anticipate, in guaranteeing the health and safety of the public. Finding similarly, although from a different viewpoint, Thomas and Qiu (2013) also examined the impact of CPD.

Thomas and Qui (2013) compared the accountabilities of five professional groups in relation to their policies on mandated CPD. In a critique of the influence of neoliberalist politics, they observed that the mandatory requirements expected of different professional groups was at best, inequitable. These writers argued that setting mandatory CPD requirements primarily served the interests of regulatory bodies and governments rather than the professionals or service users because of the need to be seen to have acted in such a way as to have upheld the quality of service available. Thomas and Qiu (2013) continued their critique using an examination of workforce statistics and examples of media reporting on cases that were purported to be in the public interest. These writers demonstrated that benefits of CPD for consumers (patients or service-users) could not be guaranteed because there was no obvious association between the number of mandated hours for CPD and a reduction in

mistakes by professional practitioners. Exploration of the related literature, provides some insight as to why this might be so. The answers it seems are complex and lie in the consideration of the types of CPD chosen by the nurse; the likely practical outcomes and the level of congruency between the type of CPD, the learning outcomes articulated by the nurse (if any), their employer and the regulatory body.

2.7 CPD activities and stakeholder outcomes

There are a wide range of options available to support completion of CPD and many of these were reflected in Gallagher's (2007) concept analysis. Gallagher (2007) first demonstrated the myriad of terms used to describe CPD for example, on-going education, Professional Development (PD); Continuing Education (CE) and Continuing Professional development (CPD). She concluded that all terms generally referred to the education available for nurses following their initial education leading to professional registration. For this reason, most articles sourced met the criteria for selection in the review outlined earlier.

Employers appeared to be a key stakeholder in nurses' CPD. Many supported CPD activities through funding, time-off or other resources they provided. In some cases, it was reported that employers had even developed bespoke courses, created to support learning about specific specialist knowledge that related to the objectives of their healthcare business (E. Coleman et al., 2009; Gillespie et al., 2011; Heath & Utiera, 2014a; Jordan, Coleman, Hardy, & Hughes, 1999). In doing so, the value of situated learning or CPD for nurses and their employers was exemplified (Lave, 1996). For employers, research findings or training evaluation showed the direct benefits for patients and the potential to extend service provision because of the speed in which gains in specialist knowledge could be made (Ekmekci, 2013; Heath & Utiera, 2014a;

Kruijver, Kerkstra, Francke, Bensing, & van de Wiel, 2000; Wenghofer et al., 2015). Pena and Castillo (2006) further perpetuated the importance of situated learning when they observed that keeping up to date with technological advances for example, in life support technologies, was best undertaken at the bedside because it directly affected any nursing care delivered. Situated learning and the 'practice-near' clinical exposure involved seemed to be key in maximising the outcomes of the entire endeavour.

There were several papers that clearly showed the significance of clinical experience in both its potency and reach as a CPD option (Coleman et al., 2009; Heath & Utiera, 2014; Gillespie et al., 2011; Tennant & Field, 2004). Related to bespoke courses where the subject matter was directly linked to the specialty nursing competencies required, Tennant and Field (2004) and Gillespie et al. (2011) demonstrated that CPD alone did not provide the whole explanation for improvement in skill development. In their quasi experimental study located in an intensive care unit, Tennant and Field (2004) used two cohorts of nurses to determine the impact of a specialty based education programme on attainment of specified competencies for the clinical area. The researchers collaborated with hospital managers to determine what competencies should be achieved. One cohort undertook a bespoke CPD programme whilst the others did not. Acquisition of the required competencies for both cohorts was rated throughout the programme by local managers and an independent assessor. Unremarkably, this design showed that the experimental cohort achieved the competencies required. However, the noteworthy findings of this study were in the control cohort results. These results revealed that whilst not reaching the same level of advancement as those who also received the aligned training programme, exposure to the setting and accumulated clinical experience had also impacted positively on their

clinical skill development (Tennant and Field (2004). Similarly, Gillespie et al. (2011) demonstrated evidence for the existence of a relationship between years of experience and specialty education. Using a postal survey, these researchers sampled over 300 nurses who worked in the operating room. Using demographic data from the returned questionnaires, length of experience within the operating room specialty emerged as a significant factor in the achievement of pre-determined competencies.

Heath and Utiera (2014a) also found experience to be an important factor in their evaluation of a custom made CPD programme. With a small cohort of 10 participants, their programme design allowed for both face to face teaching and a period of practical experience which included scheduled clinical supervision for up to 9 months. The programme was designed as a preparation programme for nurses prior to the implementation of a key business initiative, nurse-led clinics for patients with haemochromotosis. Evaluation showed that the programme had enabled participants to develop confidence in their clinical ability and decision making, and had provided the opportunity to use supervised practice sessions to reflect on case management. This CPD activity actively promoted discussion and reflection with a facilitator on the integration of patient assessment and application of health education concepts to the care of individual patients in their real world contexts. In follow-up interviews at the end of the programme, one nurse reflected on how her capability had advanced. She described how she had learned about the importance of controllable lifestyle factors in the management of haemochromotosis and how she had used her new skills to work with a patient who then re-presented in subsequent months. Having implemented the potential lifestyle changes the nurse had discussed with him, she commented about the patient outcome in the evaluation interview,

…the last ferritin result was 56 [within desirable range]. That's what doing this [CPD course] was all about for me.

These kinds of outcomes when CPD is focussed or 'practice-near' add to the findings from Mathers et al.'s (1999) research outlined earlier, making a stronger case for CPD needing to be explicitly related to the specialty area or interest of the practitioner. The ability to immediately contextualise learning appears to be important in maximising the achievement of learning outcomes and as shown here, making an impact on the clinical practice of nurses and thus, patient outcomes. However, it is worthy of mention that in this case, the business was also receptive to the implementation of the nurse-led haemochromotosis clinics and, whilst no evidence can be located to substantiate the claim, it is possible that receptiveness of the clinical area, and in particular support of line managers for the initiative, could be instrumental in the nurses' success. Furthermore, this assertion appears to hold true in connection with the measurement of other nurse sensitive indicators.

Tangible outcomes of CPD are often difficult to determine. Some writers have looked towards the incidence of patient falls and wound care morbidity and other treatment indices as a measure of a specific CPD activity (Boltz et al., 2013; Burket et al., 2010; Gillespie et al., 2011). Others have suggested measurement against pre-determined competencies (Clarke, Abbenbroek, & Hardy, 1996; Cole & Johnson, 2014; Duff, Gardner, & Osborne, 2014; Kao, Hsu, Hsieh, & Huang, 2013; Marshall, Currey, Aitken, & Elliott, 2007). Where competencies were used to measure CPD outcomes, they were locally determined by the programme management committee as part of the preparation for the study (Gillespie et al., 2011; Tennant & Field, 2004). This technique has clearly provided the opportunity to measure any desired skills or behaviour and

return on investment where, without clear learning intentions, this might have been difficult. However, it is interesting to note that the competencies used in these studies were written by managers, and therefore a directed approach is implied to what was to be learned by nurses as a result of the CPD activity. There are parallels here between the previous discussion on portfolio requirements being tailored to workplace requirements and competencies, and the lost opportunity for learners to take a self-directed, and perhaps more meaningful, approach to their own CPD.

For nurses, participation in employer provided CPD activities showed that they were updated with current clinical practices or had extended their capability to provide healthcare (Cole & Johnson, 2014; Coleman et al., 2014; Gillespie et al., 2011). Further, demonstration of how each nurse had achieved the required number of hours could be easily articulated. Yet, in their survey research with perioperative nurses, Gillespie et al. (2011) showed that a CPD course alone did not account for all of the knowledge gains observed. Their work showed how knowledge developed through clinical practice alone was cumulative but that this could be further enhanced by engagement with a concurrent education programme. The potency of either the clinical experience or the education programme were enhanced when they were used together; the connections between the two clearly impacted positively on nurses' developing repertoire of skills and knowledge. However, Gillespie et al. (2011) pointed out that strategies should also be implemented that continued to increase the development of nurses' expertise and leadership skills after the course had completed. Unfortunately, the exact nature of the strategies envisaged was not explained. However, the description of a combined practical and education approach is not dissimilar to that proposed in Mather's (1999) study.

Postgraduate study was also related in the literature as a means by which nurses had advanced their clinical practice. More generic in nature than the situated learning of the workplace, postgraduate nursing education aspires to develop critical thinking; advanced health assessment skills; evidence based decision making, and application of learning to clinical practice. Several researchers have investigated the various ways in which postgraduate study, offered by New Zealand tertiary institutions, have provided positive CPD outcomes for nurses and their employers (Barnhill, McKillop, & Aspinall, 2012; Doughty et al., 2018; McKillop, Doughty, Atherfold, & Shaw, 2016). Barnhill et al. (2012) attempted to determine the local impact of postgraduate study on nurses working in acute care.

Making the case for the volume of resource invested and engagement with postgraduate study, Barnhill et al. (2012) inferred that positive clinical impacts should be evident. Their observation was related to the amount of postgraduate study undertaken by staff in their clinical area. Much of it had been funded by Health Workforce New Zealand (HWNZ) and 249 nurses had undertaken courses of study. Using postal surveys and a quantitative-descriptive design, these researchers undertook 3-way data collection between postgraduate study participants, their clinically based managers and nurse educators. Although the researchers indicated that the impact of postgraduate study had been positive, it was not possible to say from the results presented how this had occurred since the statements were unqualified, for example, they reported positive impacts on career development, documentation practices and managing emergency situations as well as 'increased clinical responsibility'. Whilst the outcomes as stated might be useful facets of nursing practice, they were unable to be correlated with any tangible, practice outcomes. In fact, the work rather appeared to

support the contention that postgraduate study is not the best option for demonstrating specific effects on specialist clinical practice areas; there was no evidence provided that partners in the three-way data collection had been able to identify specific practice benefits associated with the post course clinical behaviours of staff who had completed postgraduate study. Consequently, Barnhill et al.'s (2012) paper raises a number of concerns about the value of postgraduate study in relation to developing clinical skills in a specialty area.

Studies like that of Barnhill et al (2012) foster the notion that postgraduate education for CPD may not be right for a proportion of the future workforce or that other formats of CPD might be better placed to meet particular learning purposes. Indeed, the authors recommended that further investigation is needed into ways of linking postgraduate education with career pathways and ensuring that nurses are undertaking the most appropriate education for their career plan and clinical area. Given the large amount of resource directed towards postgraduate education in nursing, these findings provide a significant rationale to determine nurses' explanations for their engagement with programmes like PDRP. Unravelling these factors may illuminate how practice-near professional education with facilitated learning might be used more effectively to improve patient outcomes.

The lack of support for a large number of positive patient outcomes following postgraduate study was not an unusual finding when compared with the international literature. Cotterill-Walker (2012) completed a literature review from which it was determined that the outcomes of postgraduate study in nursing globally had produced a very limited number of reports of any positive patient outcomes. Where patient benefits appeared to be detectable, Cotterill-Walker (2012) noted that the studies were

limited in their generalisability because of small sample sizes or because of the difficulties in managing extraneous variables within the clinical centres used in the studies (Aitken et al., 2003; Considine, Botti, & Thomas, 2005; Considine, Ung, & Thomas, 2001). Where completion of postgraduate study and patient outcomes were connected, personal and professional growth were among the few outcomes reported in separate studies by Pelletier et al. (2003), Gerrish, McManus, and Ashworth (2003) and Hardwick and Jordan (2002). It would also be fair to add to Cotterill-Walker's (2012) critique that even where patient benefits appeared to have been identified in studies like that of Aitken et al. (2003), the measurement parameters used were somewhat extraordinary and included for example, the likelihood of the patient dying within 30 days of admission and the odds of failure to rescue (Aitken et al., 2003). Whilst these parameters may be important, they do not perhaps provide the most directly observable improvements in nurses' capability, skills or knowledge. More useful, would have been measurement in relation to nurse-sensitive indicators like falls and wound care for example (Boltz et al., 2013; Gillespie et al., 2011). Similarly, there is a paucity of evidence for the impact of digital learning.

Over the last decade, there has been an explosion in available digital technologies that have provided the backbone for the emergence of elearning and mobile learning as yet another option to support nurses' compliance with mandatory requirements. There are a myriad of reports showing how the 'just in time' accessibility of short, sharp learning modules can assist nurses in taking on new or advancing their knowledge very quickly. Furthermore, learning can occur by the bedside, providing assistance in refreshing knowledge or repeating learning modules where needed (Bond et al., 2017; Considine et al., 2005; Fleet, Fox, Kirby, Whitton, & McIvor, 2011; Higgins,

Keogh, & Rickard, 2015; Phillips, Heneka, Hickman, Lam, & Shaw, 2014; Powers, 2016; Shaw et al., 2014; Shin, Issenberg, & Roh, 2017; Spiva et al., 2012; Stout, 2013). Yet, only a few studies have been able to show the outcomes or any impact of digital learning on patient care.

Bond et al. (2017) showed how elearning could ensure that many health professionals (n = 163) across multiple wards could be effectively updated on the prescription and use of Vancomycin to combat methicillin-resistant Staphylococcus aureus (MRSA). Using a pre-test, post-test design, areas of knowledge deficit were identified using interaction with previously prepared online learning material. Areas of practice improvement included calculation of the loading dose and the timing of the blood sampling for the first and subsequent trough levels. This clearly impacted on wastage or missed data ensuring that patients were treated more effectively. Other studies have reported varied outcomes where they have been concerned with the development of nurses' specific assessment skill capability for example, pain assessment, neurological status assessment or management strategies for patients with delirium in aged care.

Based on the elearning proposition that education could be undertaken 'just in time', Phillips et al. (2014) used a quasi-experimental design and showed how QStream (software package) could be used to deliver clinical scenarios by email to participants (n = 34) in order to develop their pain assessment skills and practice. The researchers claimed that improvements in participants' knowledge of pain management and the ability to document pain assessment were shown. However, they noted nurses' clinical decision-making did not change significantly as a result of the online learning intervention and even this appeared to lapse once the study period was completed.

Notwithstanding the admission that clinical practice changes were not sustained, there were significant shortcomings in the study overall. The researchers reported a substantial 20% drop-out rate from the small original sample. Further, statistical tests were unnecessary in such a small sample and it is doubtful that the findings are trustworthy in this case.

In a different study, Shin et al. (2017) had more success in determining improvements in nurses' neurological assessment abilities. The premise of this work was that a good understanding of neurological assessment was required for optimal patient outcomes. Using a pre-test, post-test design, these researchers took a convenience sample of nurses (n = 50) who were randomly assigned to either the experimental or control group. The experimental group undertook the elearning programme whilst the control group used non-digital, self-directed resources to work through material related to the specific assessment requirements. The researchers clearly showed that the nurses in the experimental group had improved their assessment ability when compared with the control group. However, despite the basis for the study being that good understanding equated with better patient outcomes, no data was presented to demonstrate whether the nurses who had undertaken the online learning had managed to impact patient outcomes.

Like Shin et al. (2017), Detroyer et al. (2018) also struggled to show how online learning had yielded any beneficial patient outcomes when using elearning to teach nurses about delirium management in the aged care sector. In their pre-test, post-test study, these researchers found no difference in the abilities of either the control or experimental groups post elearning intervention. Concluding that there might be issues with the choice of learning strategy, these writers characterise how some topics are

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simply not suited to delivery using digital learning tools. Unfortunately, despite the attempts to show how elearning can impact on patient care like those presented here, evidence remains scant for the case that it actually does so. However, the field of investigation is relatively new and given the volume of reports available showing the usefulness of online learning in a blended learning context, evidence may yet be forthcoming (Higgins et al., 2015; Spiva et al., 2012; Stout, 2013). The same may not be true where commercial elearning is concerned.

Implementation of a mandated number of hours of CPD for recertification purposes created a market for the commercial production of online learning modules supposedly to support practitioners to achieve their required number of hours of CPD. Indeed, nursing organisations like NZNO have endorsed providers of online learning (e.g., CPD4 nurses) with links from their website directly to the provider (CPD4Nurses, 2018; New Zealand Nurses' Organisation, 2018). In their rightful contexts, information technologies are powerful supports for nurse education (Bond et al., 2017; Carter, Hanna, & Warry, 2016; Fleet et al., 2011; Higgins et al., 2015; Powers, 2016; Spiva et al., 2012; Stout, 2013). Yet, commercially developed, user-pays elearning packages are unproven regarding either the quality of the education material presented or their ability to impact nurses' clinical practice. There was an absence of evaluative work within the literature reviewed.

Whatever type of CPD is considered, a number of contemporary professional assumptions seem to emerge from the literature. These assumptions are that all types of CPD inevitably increase nurses' abilities to impact patient outcomes; that CPD enables nurses to maintain their competence, and that as a consequence of their engagement with CPD, nurses' service level care delivery will be positively impacted

and the safety of the public can therefore, be assured. Yet, the outcomes of the kinds of CPD activities presented so far in this review remain difficult to measure, and any direct patient benefits of CPD are only seen where objectives and competencies exist and are explicitly measurable. However, there was one form of CPD widely reported in the literature which made use of explicit learning objectives and competencies and about which evidence was cited for its impact on practice. These reports were connected to the implementation and use of the 'career ladder'. This is an important area of the literature to consider since PDRPs closely resemble clinical ladders.

2.8   Career ladders

The emergence of clinical ladders is documented in the literature as early as the 1970's when Zimmer first began to address what she saw as the failure of the US health system to regard the continuing career needs of nurses and to recognise clinical excellence (Buchan, 1999; Sanford, 1987). Zimmer's vision, related by Sanford (1987), was to negotiate a career advancement framework that both recognised and rewarded excellence in clinical nursing. The outcomes proposed as a result of adopting such a framework would be beneficial to nurses, their patients and supporting institutions. Patients would benefit from care delivered by nurses with greater expertise; nurses would be rewarded financially for the investment in their own career and institutions that supported career frameworks were likely to realise less staff turnover and thus, create a stable, experienced staff base.

In subsequent decades, a limited amount of research was published that tested Zimmer's original hypothesis. Most available work focussed on job satisfaction and patient satisfaction as indicators for a successful career ladder. This focus was also due to the endorsement of Zimmer's ideas by both the American Academy of Nursing and

the American Nurses' Association in their Magnet Hospital Study published in the early 1980's (McClure, Poulin, Sovie, & Wandelt, 1983). Magnet Hospital Status was highly desirable in the US, indicating to all that a particular hospital had satisfied criteria that measured the strength and quality of nursing. Not surprisingly, in the light of such a notable endorsement, it appears that researchers have investigated their own career ladders and consequently, published work is reflected in single institution, small sample studies. Other work focussed on how evaluation was undertaken (Burket et al., 2010; Goodloe et al., 1996; Goodrich & Ward, 2004; Gustin et al., 1998). Thus, the level of the work has remained at the early stage/exploratory criteria advocated by the Institute of Education Sciences, the US Department of Education and the National Science Foundation Joint Committee (2013). Nevertheless, there are a number of valuable insights.

By far the most inclusive study undertaken was that reported by Koch (1990). Participants represented various stakeholder groups from the state of Victoria, Australia, where Koch (1990) reported on a comprehensive review of the earlier pilot implementation of a nurses' career ladder. Using the results of interviews with Directors of Nursing, nurse surveys and case studies together with vacancy, staff absence and quality data, the writer concluded that the career structure was valuable for nurses and contributed significantly to their job satisfaction and recognition of their unique place within the healthcare process. So popular was the pilot implementation of a career ladder with Australian nurses, they marched to Victoria Square in Melbourne, to make it known to the state government that they wished to support the new structure. Other studies were not quite so inspiring but yet, contributed to the overall

acceptance of the perspective that job satisfaction was an indicator of career ladder success.

Following their evaluation of a clinical ladder programme, Roedel and Nystrom (1987) reported job satisfaction was an outcome engagement. Specifically, they found that job satisfaction was related to just those nurses who had achieved the higher levels. Interestingly, in later work, Krugman, Smith, and Goode (2000) provided validation of this finding in their study. Krugman et al. (2000) showed that job satisfaction was a largely neutral outcome of career ladder implementation save for where nurses were at a level where they had learned to integrate problem solving and patient data analysis. Here, these researchers argued, nurses who had higher order synthesis and analysis skills were better positioned to be able to make autonomous decisions about patient care and therefore, were more satisfied with their work. Malik's (1992) earlier work with a small group (n = 17) of intensive care nurses also showed greater job satisfaction where their autonomy was increased. However, it is possible that the characteristics of the clinical environment in both studies may have been a significant contributor to satisfaction, rather than the ladder alone. The function of a career ladder may have added clarity to performance expectations as Goodloe et al. (1996) found in their study. Other work showed less support for the ladder approach like that of Thornhill (1994) who demonstrated that there was a limited impact on nurses' job satisfaction following the introduction of a ladder programme. In another study, Schultz (1993) similarly demonstrated that nurses had mixed opinions about career ladders, but was able to show that there had been a reduction in nurse turnover following ladder implementation as Begle & Johnson's (1991) cost benefit analysis had done previously.

If Koch's (1990) work was the first to demonstrate comprehensive stakeholder evaluation of career ladders and their impact on nurse's job satisfaction, Corley et al. (1994) were probably the first to ask nurses for their views on participation in the validation process. This study is further significant because there are a number of similarities between progression requirements on the career ladder and those of contemporary PDRPs. Corley et al.'s (1994) work came about as part of a larger study that evaluated implementation of a state wide career ladder. In it, the researchers administered a questionnaire to nurse participants (n = 322). Expected to submit a portfolio of evidence to support completion of the criteria for the appropriate level, the nurses responded that they found gathering testimony about their clinical practice from their peers as being difficult. They further reported finding difficulty with being able to express themselves effectively in exemplars or case studies about their practice. Completion of the necessary paperwork had proven to be time-consuming and overwhelming and the remuneration available on successful assessment was described as insufficient. Nurses also reported that their personal obligations were often a barrier to completing ladder progression requirements as was their manager's limited understanding of the career ladder programme. Other studies uncovered additional frustrations of the ladder programme and these were related to support for ongoing CPD activities (Goodloe et al., 1996; Krugman et al., 2000). Thornhill (1994) by contrast found no such frustration and concluded that age, education level, years of clinical practice were unlikely to influence voluntary engagement with career ladders.

2.9 Factors affecting engagement with CPD

Anecdotal evidence might suggest that nurses remain interested and engaged in continuing their learning and development throughout their careers. The vocational

aspects of the job and the Nightingale aspiration to 'do no harm' could arguably be suggested as one of the main reasons for doing so. It is interesting to note though, that prior to the implementation of CPD as a regulatory requirement, the literature contained very little discussion about any barriers related to the completion of CPD. Following formalisation of mandated CPD by regulatory bodies however, its completion appeared to become a contentious issue. An issue perhaps, because the status of CPD had changed from simply being desirable to have, to an essential, regulated requirement. Moreover, non-completion had consequences that could be perceived as a threat to a nurse's livelihood when conditions for recertification with the regulatory body were not met. The attendant professional anxiety is subsequently reflected in the literature by an increased number of papers that raised issues with mandatory CPD requirements. These published works referred to the time taken for CPD to be completed; the actual and hidden costs for both employers and nurses, and further included debate about who should bear its cost among a myriad of other concerns related to compliance (M. Casey et al., 2017; Donyai, Herbert, Denicolo, & Alexander, 2011; Gould, Drey, & Berridge, 2007; Harrison, 1993; Haywood, Pain, Ryan, & Adams, 2012; Ross, Barr, & Stevens, 2013; Schweitzer & Krassa, 2010; Spurr, 1996). The scale of the problem was considerable in the light of the previously stated need for millions of hours of professional development.

Internationally too, regulatory bodies had also mandated a required number CPD hours for nurses, increasing global demand for education across numerous markets. Furthermore, advisory guidelines for what constituted 'good' CPD choices did not appear to be available in the literature, potentially leaving nurses to navigate the CPD landscape with limited guidance on how to choose options purposefully. Yet,

despite CPD availability through postgraduate study; employer based course provision, and latterly, digital learning, there appears to be a further gap in the literature. There appeared to be limited understanding about the educational activities that nurses' determined they would like to participate in. There appeared to be no evidence to suggest that nurses have ever been consulted about the design or development of CPD opportunities. Rather, they have been expected to comply with regulatory requirements using choices provided to them. Unfortunately, even when suitable choices had been made to engage with a particular CPD activity, it seems that nurses faced further problems.

Gould et al. (2007) presented serendipitous findings from their larger study of nurses experience with regulatory compliance for CPD in the UK. Respondents' answers to one of the open ended questions were so powerful that the research team felt compelled to re-analyse and share their findings with the profession. Using a thematic approach, the original responses were analysed by members of the research team. The process used for re-analysis was coherent, strengthened by regular provision for discussion and had a focus on inter-rater reliability. Of the five main findings reported in this re-analysis, the most frequently reported challenge to be overcome by individual respondents, was the critical position of the line-manager as gatekeeper for access to CPD (Gould et al., 2007). These researchers showed that managers effectively decided whether it was possible for a nurse to attend a course by their approval (or not) of study leave or roster requests. When courses were attended, nurse managers also decided whether any innovations in clinical practice were to be supported or whether any new knowledge gained was integrated into nursing practice.

It was also evident from Gould et al.'s (2007) re-analysis that UK nurses had questioned for whom or to what CPD was relevant. Indeed, the New Zealand picture also initially suggested that nurses were not sure about the relevance of CPD from either a career or regulatory perspective (Carryer et al., 2002; Carryer et al., 2007). By 2013, the context had clearly changed when Vernon, Chiarella and Papps (2013) reported that New Zealand nurses ranked CPD as part of an appropriate suite of activities that would assist in the demonstration of continuing competence, unlike their UK counterparts. A positive view of CPD was also observed in literature emerging from Africa (Richards & Potgieter, 2010); Midwestern US (Jukkala, Henly, & Lindeke, 2008) and Ireland (M. Casey et al., 2017). In Australia, Ross et al. (2013) articulated nurses' additional perspectives of CPD and regulation.

This time, themes related to responsibility for supporting engagement with CPD were discussed in a comprehensive review of the literature (Ross et al., 2013). These writers proposed that whilst there was a moral-professional obligation for nurses to keep abreast of current issues and practice developments, they identified that practitioners saw professional learning differently and as belonging exclusively to their work-life, rather than being part of the role and accountability of a modern, professional nurse. Furthermore, the hidden costs of attendance were identified and these included things like child care and travel; all of which were borne by nurses themselves. Both Ross et al. (2013) and Gould et al. (2007) demonstrated resentment among nurses that mandatory CPD was not fully supported by their employers presumably because of the association that CPD was a work-life concern. Internationally, the same point was echoed; the associated costs of engaging with CPD appeared to be an ongoing issue for nurses attempting to meet the respective

requirements of their regulatory bodies (Boeren, Nicaise, & Baert, 2010; Brekelmans, Poell, & van Wijk, 2013; Cleary, Horsfall, O'Hara-Aarons, Jackson, & Hunt, 2011; Dowswell, Bradshaw, & Hewison, 2000; Joyce & Cowman, 2007; Lee, Tiwari, Choi, Yuen, & Wong, 2005; Moore, Klingborg, Brenner, & Gotz, 2000; Murphy et al., 2006; Pena & Castillo, 2006; Schweitzer & Krassa, 2010). Developing their integrated model of participation in adult education, Boeren et al. (2010) described this reaction as part of the personal 'cost-benefit' analysis of participation. Interestingly, costs appeared to be more frequently reported than benefits.

Reporting on their postal survey of nurses intending to undertake a nominated programme of degree level study in the US, Joyce and Cowman (2007) identified a range of reasons for CPD engagement. They found, as Dowswell et al. (2000) had done earlier when interviewing a cohort of 89 nurses participating in informal courses, that there was an important connection between the need for self-development and being fit for promotion as an outcome of CPD (Joyce & Cowman, 2007). Respondents told of the need to engage with CPD because of pressure from the workplace (Dowswell et al., 2000; Joyce & Cowman, 2007). These pressures were said to emanate from the need to keep up with others who had degrees so that they too could broaden their perspective on nursing; improve their knowledge-base, advance their clinical skills and increase standards of patient care as a result (Dowswell et al., 2000; Joyce & Cowman, 2007).

Cleary et al. (2011) undertook structured interviews with a group of 50 mental health nurses in Australia. Arguing that CPD should be a core business commitment of any organisation, these writers submitted that their cohort rated 'time off' as a significant commodity in being able to engage with CPD. Yet, Cleary et al. (2011) reported their cohort as being sensitive to the bearing their absence had on their

colleagues from a staffing perspective and furthermore, the impact that attendance and completion of course requirements had on family life. These themes were not unusual. Following focus groups with veterinary surgeons a decade earlier, Moore et al. (2000) had identified similar findings. They also uncovered additional issues for the self-employed where the resulting loss of income was a particular issue connected with attendance. The freedom to choose to attend in any case however, was not independently available across all studies. Like Gould et al. (2007), Cleary et al. (2011) found that line managers were often gatekeepers of CPD and their approval of release time was an imperative. Although line managers were viewed by their staff as being role models for completion of CPD, Cleary et al. (2011) proposed that collegial support from peers and colleagues for the duration of the CPD activity was necessary. Unfortunately, respondents did not elaborate on the type of support they required, but it remained evident that a support network for completing CPD was welcomed by many. This view was supported in recent case study research that identified the important contribution of those in leadership roles (Manley et al., 2018).

2.10 Explaining nurses' engagement with CPD

In an opinion piece, Collin et al. (2012) made the point that there were significant social, economic and workplace benefits of compulsory CPD among professional groups. For healthcare professionals, Fleet et al. (2008) contended that CPD in fact contributed to the overall health of the population because up-to-date knowledge could increase clinical skills. Agreeing, and acknowledging that the general aim of CPD is to increase professional expertise and competence, these writers noted that there were considerable challenges involved when CPD was expected to take into account the needs of the worker, the organisation and the profession for the benefit of

all parties (Fleet et al., 2008). Indeed, previously identified research studies cited in this work show that there are often complex issues to be reconciled. These issues can be sorted into the institutional, dispositional and situational factors identified by Cross (1977) enabling clarification of an entire range of problems with CPD engagement. Such sorting makes it absolutely clear that merely fixing one aspect to promote engagement is unlikely to be a definitive solution for all professionals. Moreover, the literature suggests that individual character attributes are also at play.

Some writers have looked to Human Capital Theory (HCT) as a way of explaining why professionals are motivated to engage with CPD (Dowswell et al., 2000; Gorard & Smith, 2007). HCT proposes that the personal investment or opportunity costs of engagement with education provide downstream benefits for example, greater salary expectations or promotion prospects for the individual. Certainly, there is evidence in the literature supporting this explanation in the studies by Dowswell et al. (2000) and Joyce and Cowman (2007) cited earlier.

Social role theory (SRT) has also been hypothesised as a useful way of understanding reasoning behind CPD engagement particularly with reference to the needs of professionals who are also parents. Social role theory contends that there are a set of expectations associated with each social role for example, that of a mother or nurse. Dowswell et al. (2000) showed how there might be conflict between roles assumed by one person. Using the example of a mother who was also a nurse and was required to compete mandatory CPD, these writers proposed that there might be a situation where she would only accept CPD opportunities to support her nursing obligations when she perceived that it would not result in poorer performance as a mother. Interestingly, 70% of the interview participants in the study by Dowswell et al.

(2000) indicated they had experienced difficulties in attending some educational opportunities precisely because of their domestic responsibilities. Other explanations were less grounded in particular theoretical positions.

Gorard & Smith (2007) reviewed evidence for the determinants of participation in post-16 education. They concluded that participation could be rooted in family dynamics, geographic location and learning history. For those individuals that did choose to participate, Gorard & Smith (2007) contended that engagement was part of a lifetime pattern of behaviour. One might regard this suggestion then as evidence for the existence of a particular attitude to oneself as a learner. Indeed, learner confidence was the subject of a small-scale study undertaken by Norman and Hyland (2003). These writers concluded that confidence in oneself as a learner was a primary factor affecting engagement in post-16 education. As a solution, they proposed that programmes could be adapted to increase the amount of social interaction since they argued that strong relationships in a learning context improved confidence levels among learners. This perspective sits easily with both the work of Bandura (1977) and Lave (1996) whose seminal works gave great credence to the impact of the social contexts in which learning is negotiated and situated.

2.11 A conceptual model of engagement with CPD

Until this point of the literature review, the landscape of what is known about nurses' engagement with CPD has revealed that a large number of factors are at play. The factors identified can be arranged according to their situational, institutional and dispositional impacts but yet so visualised, they do not provide a complete picture of nurses' engagement with any type of CPD. Some writers offered recourse to the discipline of psychology to provide understanding of the sources of motivation related

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to ongoing learning, but again, without providing a comprehensive understanding of all relevant issues for nurses' CPD. Furthermore, review of the available literature did not yield any specific models of CPD to explain engagement for nursing and nor was it evident that nurse educators had ever considered conceptualising the modern requirement for mandatory CPD within any type of model. The exception however, was a conceptual framework prosed by Urbano and Jahns (1988) based on the work of Patricia Cross (1977, 1981).

It would have been useful at this juncture to have demonstrated how Urbano and Johns (1988) used Cross' (1981) model to conceptualise nurses' CPD. However, as a result of an unfortunate publication erratum, it is not possible to offer critique or commentary on their position. The page containing information on the outcome of their work was omitted from the publication. Communication with the current journal editor, gleaned an apology for the error, but sadly, no copy of the missing page existed. Therefore, any outcomes for this use of the Cross' (1981) Chain of Response framework are unreportable. Cross (1981) however, regarded that there were a myriad of factors affecting an individual's decision to participate in adult learning as a whole. Developing her conceptual framework from available evidence and critique, Cross (1981) showed how a chain of seven responses could be used to better understand participation in adult learning activities (Cross 1981; See Figure 2.1).

Figure 2-1: Cross' (1981) Chain of Response Model
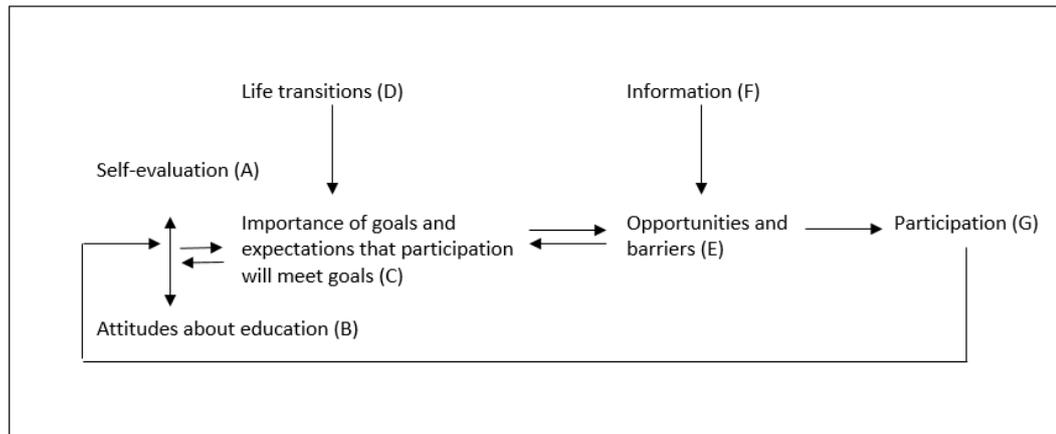
(Reproduced with permission from J. Wiley and Son Publishers)

As a starting point (A), Cross (1981) indicated that prospective learners needed to have confidence in their own abilities. Explaining the interrelationships between this factor and others within the framework, Cross (1981) provided a way of considering a more complete picture of adult engagement with further education. Cross (1981) included the learner's attitude towards education in general; the importance of the expected outcomes from the educational activity; current situation relative to life-cycle; information about opportunities available, individual willingness to see education as an opportunity and to overcome barriers and, ultimately, participation. Indeed, from the literature presented previously, it is possible to see how individual aspects of this conceptual framework might still be important in a contemporary context.

2.12 Summary: Nurses' engagement with CPD

Overall, the emerging picture from the literature is that a collective belief exists that CPD is valuable to the profession and to patient care. Nurses are mandated to obtain a certain number of hours of CPD but in order to achieve this, they must negotiate their way through a myriad of factors that affect their ability and inclination to do so. Where CPD can be considered as practice-near, the outcomes for nurses'

clinical practice is clearly beneficial, but the literature lacks perspective on the type of learning activities that nurses themselves would like to see, settling instead for commentary on engagement with management and academic institution driven learning outcomes. No one factor or group of factors emerged from the literature as being more significant in determining engagement than any other. Rather, it was clear that there were a number of factors that had the propensity to affect individual nurses' engagement and that there were particular dynamics between each as Cross (1981) cogently illustrated in her conceptual model. Again, overall evidence available falls within the early stage/exploratory criteria advocated by the Institute of Education Sciences, the US Department of Education and the National Science Foundation Joint Committee (2013).

2.13 Literature insights

The literature provided useful insight in to the state of current research and opinion in relation to portfolios as a tool for CPD, the relationship between CPD and practice outcomes and understanding nurses' engagement with CPD. When measured against the US Joint Committee criteria (2013), the evidence available is assessed as being early stage/exploratory. This means that there is currently a lack of methodological coverage of the issues surrounding nurses' CPD and, as indicated within the review, no strong theoretical base for considering the issues has emerged. What the literature does contain however, are a few studies which robustly address the problem, with Mathers et al. (1999) providing the most comprehensive experimental design. Evaluation studies appeared to show the impact of CPD on nurses, their health professional colleagues and patients. Other works included survey research and case studies which were sufficiently cogent to add to foundational understanding but were

by their nature small, localised and limited in their generalisability. Consequently, no one methodology emerged as a stronger option than any other in developing a comprehensive understanding of the topic area. Further, the use of one particular methodology among all of the research cited has not distorted the eventual landscape of current knowledge. Under the right conditions, the studies reviewed for example, Mathers et al. (1999), Ng (2010), Manley et al. (2005) and Heath and Utiera (2014a) have shown that CPD has much to offer nursing beyond regulatory compliance and that there are practitioners and their patients who do inevitably benefit from the endeavour. Current work also showed that portfolios are a realistic teaching and learning strategy with which to map benefits for the practitioner.

The use of professional portfolios to validate learning and professional progress was certainly shown to be possible. Portfolios appeared to be a useful way of developing practitioners' reflective ability and this was also shown to be a realistic expectation of the learning strategy. Yet, no evidence emerged regarding how these tools might assist the development of expertise. More, the available evidence provided some suggestion that professional supervision or facilitation was implicated for individual development although it is acknowledged that the current state of knowledge lacks sufficient depth and breadth to make this assertion more persuasively.

Career ladders were shown to have provided a convenient way of adding stability to the workforce, both for their contribution to job satisfaction as well as scaffolding increased clinical capability and responsibility which could be rewarded. The similarities between clinical ladders and PDRP was evident and the publication timeline that emerged from the literature showed how the ladder programme had been continuously updated eventually incorporating Benner's (1984) practitioner

development perspective. Whilst evaluation had taken place to support and justify outcomes of clinical ladders, as with PDRP, research was scarce and was completed on a single study, small scale basis. Positive patient outcomes as a measure of clinical ladder implementation were measured indirectly using nurse turnover, absenteeism or vacancy rates as an indicator of a stable, grounded workforce.

The literature reviewed also showed the purposes for which nurses positively viewed their engagement with CPD. There were a number of factors that emerged, often diverse and certainly, individually comprised. The idea that engagement was multi-factorial and individual was conceptualised in the work of Cross (1981) who proposed that the personal disposition toward several characteristics was relevant. All of the levels of response identified within the Chain of Response Model (Cross, 1981) have subsequently been reported on in the review of the completed work on the topic of nurses' CPD. Hence, it might be realistic to propose that the Chain of Response model is a useful way to bring the studies together and to conceptualise the current state of knowledge about nurses' engagement with CPD. Accordingly, it is possible to conceive that Cross' (1981) model might further be useful as a framework to guide the forthcoming research in the absence of a clear theoretical position.

2.14 The New Zealand PDRP context

With respect to direct evidence to support PDRP programmes in the context of appropriate CPD activities, there were no evaluative studies available for review. Instead, local studies emerged that examined nurses understanding and attitude to PDRP in New Zealand. The picture presented from these works showed that nurses' understanding was incomplete and that attitudes to PDRP varied (Carryer et al., 2002; Carryer et al., 2007; Havill, 2010). Other studies evaluating the implementation of

continuing competence requirements, further validated the findings of the research directly undertaken with PDRP, but also showed that there were shortcomings in nurses' appreciation of their continuing competence requirements (Vernon, Chiarella, & Papps, 2013; Vernon, Chiarella, Papps, & Dignam, 2013).

Review of the literature together with the consideration of the background and emergence of PDRP enables the perspective that they have become intrinsically linked to pay, recruitment and advancement within organisations. Yet, no evidence can be found to determine the clinical impact they may actually have. It further remains unknown whether PDRP improves the nurses' depth and breadth of knowledge and the ability to plan and deliver care despite the command of human and physical resources that they engender. There has been no evaluation of the impact of PDRP in New Zealand to date.

In considering mandatory CPD requirements themselves, the literature reviewed provided no resolution among contributors or indeed, any discussion on the differences that may exist when learning is undertaken to simply maintain competence versus learning for practice development and lifelong or speciality knowledge development. What is known however, is that no matter how it is conceived, a diversity of factors affect CPD engagement. Whether these also apply to PDRP is questionable because of the lack of information available in the literature, although parallels could be drawn with clinical ladder programmes that have emerged from the US. Furthermore, how the known factors are collectively understood is also difficult to gauge as no theoretical stance has been proposed or adopted and there appears to be an absence of any conceptual model specific to nursing education.

The landscape of CPD for nurses, together with the gaps identified in the current literature; the context of the NZBS PDRP within its host organisation, and the purpose of this thesis within the structure of a professional doctorate, provide the opportunity for a practical approach to understanding nurses' engagement with PDRP at NZBS. It is proposed that an explanation of the nurses' position would enable programme adjustment in order to increase engagement rates or alternatively, to inform any decision to consider implementing other options for staff development. To accomplish that level of understanding, it seems reasonable to ask nurses about their knowledge of the programme; their disposition to it and the factors that affect their decision to voluntarily participate. Therefore, the questions to be answered in the subsequent research are:

1. What do New Zealand Blood Service (NZBS) nurses understand about PDRP?

2. What are NZBS nurses' attitudes to PDRP?

3. What factors do NZBS nurses identify as affecting their decision to participate in the NZBS PDRP programme?

4. How do NZBS nurses explain current levels of PDRP programme engagement?

2.15 Summary

In this chapter, the literature related to the topic area has been examined. Gaps in the literature have been identified and the place of the NZBS PDRP within the context of the current professional landscape and knowledge base has been asserted. The research questions to be answered have been proposed and are developed from the current view of the literature together with the practical context of the researcher. In the next chapter, the methodological approach for answering the questions posed will be related and justified.

3. Methodology

3.1 Introduction

There are many methodological options available to use to answer the questions posed in this study. As with other choices made during the course of this study, the values and viewpoints of the researcher were brought to bear. As Crotty (1998) identified, the researcher perspective cannot be ignored. It is at the heart of any assumptions made about knowledge and reality and therefore, the theoretical perspective brought to the work. Using Crotty's (1998) framework as a basis to guide explanation of the epistemological principles, theoretical perspectives and methodological decisions, this chapter will outline the necessary preparation required to implement the research project. Justification for the chosen courses of action, data collection instruments and methods of analysis will be included together with consideration of the ethical implications of the study.

3.2 Research aim and questions

At the end of Chapter 2, four key questions were derived from the background context to the work and the available literature. The questions posed were aimed at explaining nurses' decisions to participate in the New Zealand Blood Service (NZBS) Professional Development and Recognition Programme (PDRP). The questions were as follows:

1. What do NZBS nurses understand about PDRP?

2. What are NZBS nurses' attitudes to PDRP?

3. What factors do NZBS nurses identify as affecting their decision to participate in the NZBS PDRP programme?

4. How do NZBS nurses explain current levels of PDRP programme engagement?

3.3 Research paradigm

In Chapter 1, I indicated that the purpose of this research stemmed from my work as a Nurse Educator in New Zealand clinical settings for more than 15 years. In this time, I have had significant involvement in the implementation and ongoing management of PDRP. My anecdotal observation was that following the implementation of a PDRP, nurses' engagement with them has been slow. This, despite crafting programmes that accounted for best practice in teaching and learning, incorporated professional regulatory standards and for which financial allowances were available. I am curious about the factors that affect nurses' decisions to participate in PDRP. Furthermore, I would like to better understand the complexities that appear to be associated with nurses' engagement with this professional development activity.

Teddlie and Tashakkori (2009) and Robson (1993) explained that insights from the workplace are often justifiable reasons for undertaking research since areas of interest can develop from in-depth understanding of the field. Onwuegbuzie and Johnson (2006) explained that searching for solutions through research helps to answer questions that are valued and can contribute to improvements in the real world. Further, Teddlie and Tashakkori (2009) proposed that articulating the practical reason to undertake research directs the kinds of questions and methods to be used, as well as illuminating the influence of personal values.

A number of authors (Cohen, Manion, & Morrison, 2011; Crotty, 1998; Grix, 2002; Punch, 2014; Waring, 2012) have considered the relationship that exists between the choice of research methods and their underpinning ontology, epistemology and methodology. Articulating the importance of these components to research as a whole,

Grix (2002) introduced the concept of these being the researcher's 'tools of the trade'. Elaborating, he suggested that their purpose was threefold. First, in understanding the purposeful interconnectedness of the research components as being instrumental to the endeavour and second, in providing the lens with which to establish the approach to phenomena. Third, Grix (2002) contended that armed with such understanding the researcher could recognise and ultimately, defend their own position and its attendant assumptions. In other words, he advised that research questions are asked and answered within a particular philosophical context. Other writers (Cohen et al., 2011; Crotty, 1998; Ellis, 1996; Waring, 2012) concurred and added that it is this context, rather than particular research methods, that should logically frame and direct the work. In this case, the intention is to explain a practice problem where there is yet unexplained low uptake of a particular professional development activity. In looking to solve this practical, real world problem, the philosophical perspective is one of pragmatism.

Pragmatism occupies the middle ground of a quantitative-qualitative philosophical continuum. From this position, Onwuegbuzie, Johnson, & Collins (2009) take the view presented by Dewey that knowledge is regarded as being constructed and based on both the realities of the world and one's experience within it. However, the dynamic nature of experience means that there is constant change and consequently, multiple realities and current truths exist. Thus, knowledge is tentative and constantly changing and each individual has a different perspective. A pragmatic philosophy therefore, supports the use of combinations of both quantitative and qualitative methods or 'mixed methods' in order to best answer research questions (Onwuegbuzie et al.). Pragmatism furthers the argument that knowledge can be accumulated using

both inductive and deductive approaches. The ultimate intention is to build on previous

understanding (Johnson & Onwuegbuzie, 2004).

3.4   In support of a mixed methods inquiry

Previously, in the background and introduction to this work, the potential

benefits associated with uptake of the NZBS PDRP were discussed. Summarised, these

benefits related to PDRP outcomes for nurses which were described as being attractive:

PDRP was approved by Nursing Council; PDRP enabled nurses to meet their continuing

competence requirements and in some cases, PDRP provided financial reward. The

argument was made that the programme was based on a sound pedagogy and PDRP

outcomes not only had tangible benefits for nurses' ongoing professional development,

but also for the healthcare institution. It was noted that the programme fulfilled

recruitment and retention objectives and contributed to an organisational initiative

promoting staff development. Yet, NZBS nurses' voluntary uptake of PDRP remained

around 20%.

The literature review showed that there were a number of factors that might

affect a nurses' engagement with Continuing Professional Development (CPD) as a

whole e.g. time of life; associated costs; support from the employer; impact on career

prospects. These factors were classified into institutional, dispositional and situational

categories. Visualised in Cross' (1981) Chain of Response model which was developed

from the consideration of learning engagement among post-16 learners in general, the

complexity of the problem for nurses became apparent. Cross' model connected the

learner's self-assessment of their ability to succeed with their attitude towards learning.

The model took account of an individual's desire to achieve an educational goal with

the possibility that in doing so, particular reward would be gained. Cross argued that

previous learning experiences were a considerable influence when new learning activities were under consideration. Self-belief was important to motivation and the willingness to overcome lifestyle or other barriers and opportunities that presented before or during the learning experience.

Insights from other literature (e.g. Benner 1984; Boeren et al. 2010; Gould et al. 2007; Hinchliff 1998; Jasper 1995; Ross et al. 2013) published over the last three decades highlighted how nurses might respond to CPD in a similar way to the pertinent areas indicated within Cross' (1981) model. However, the studies examined were not directly related to PDRP. Instead, they were taken from wider CPD literature since there appeared to be a number of gaps in the literature. The factors affecting nurses' decisions to engage with CPD may not mirror those related to PDRP. Consequently, the need to explain why NZBS nurses do not choose PDRP to evidence their continuing competence requirements or as a means for professional development remains. Thus, the decision to engage with PDRP needs to be better understood. Further, it would be desirable for nurses to explain the current level of uptake in their own words given the lack of commentary on PDRP in the literature and the prospect that greater understanding may allow for programme development to promote further engagement. These reasons are in keeping with the research aim of explaining NZBS nurses' decisions to participate in PDRP.

3.5   The value of a mixed methods approach

Johnson & Onwuegbuzie (2004) highlighted the level of creativity and breadth of understanding that becomes possible when fitting together the complementary strengths of quantitative and qualitative paradigms. These writers also identified how corroboration of findings could be produced by using two different data collection

methods. Where data from one phase of a study informed proceedings in the next, elaboration and clarification was possible even when two data collection methods were used simultaneously or subsequently to one another. Fundamentally, Johnson & Onwuegbuzie argued that data collection in mixed methods research should be used to enhance the quality of research and uncover meaningful answers. Creswell (2015a) and Creswell and Plano Clark (2011) concurred, but cautioned that mixed methods is not simply the ad hoc gathering of quantitative and qualitative data. More, it is the "combination or integration of quantitative and qualitative data using a specific type of mixed methods design, and interpretation of this integration" (Creswell, 2015 p. 3).

Collins, Onwuegbuzie, and Sutton (2006) argued that a mixed methods approach provided the opportunity to increase the richness of data which enhanced understanding, interpretation and analysis. They further argued that using the approach increased the significance of the data gathered. Johnson & Onwuegbuzie (2004) suggested that a mixed methods approach avoided the philosophical, and consequent methodological dichotomies created, when paradigms were rigidly adhered to. They considered that the theoretical underpinning of mixed methods included viewing knowledge as being both constructed from one's own reality, and experience of the world. In short, these writers valued the importance of both the natural and psychosocial world when attempting to understand phenomena (Johnson & Onwuegbuzie, 2004).

3.6 Justification for using mixed methods

To achieve the value added by a mixed methods approach, use of an appropriate design is a methodological imperative. Options are well documented and validated within the literature (Creswell, 2015; Creswell and Plano Clark, 2011; Johnson

& Onwuegbuzie, 2004; Onwuegbuzie et al, 2009; Teddlie & Tashakkori, 2009). Creswell (2015a) contended that the rationale for choosing a mixed methods approach should be part of the methodological discussion. Design options are varied and can be tailored to the particular inquiry. Some design options are classified as being sequential (where qualitative data collection is followed by quantitative data collection for example), or simultaneous (where data is collected by quantitative and qualitative data collection methods and the results of each are integrated). The type of data collected in each phase of a study foreshadows the world viewpoint being taken and therefore the data type being generated for interpretation. In this study, a sequential design was used since the aim was to *explain* nurses' decisions to participate in PDRP. In order to explain the problem, the current baseline of understanding and attitude must be measured. Data to support this part of the inquiry was collected by quantitative means. Explanation of the data using a qualitative approach followed. Had the nature of the inquiry been to *explore* nurses' decisions to participate in PDRP, the design phases would have been reversed. The essential ingredient of any mixed methods design is that 'mixing' the methods is purposeful and clear.

In order to ensure clarity of decision making for the purposes of this study, the key decision points and questions indicated by Creswell and Plano Clark (2011) citing the work of Bryman (2006 p. 98) were used. The questions were:

1. What is the reason for choosing mixed methods?

2. What is the priority of the quantitative and qualitative phases?

3. What is the level of interaction between the qualitative and quantitative phases?

4. What is the timing of the quantitative and qualitative phases?

5.   Where and how will there be mixing of the quantitative and qualitative phases?

In the context of this study, answers to the questions were as follows:

1. ***What is the reason for choosing mixed methods?***

    The application of both quantitative and qualitative methods in research studies provides the opportunity to answer questions posed in a more comprehensive way than could perhaps be expected using a single approach (Creswell & Plano Clark, 2011; Tariq & Woodman, 2010). The approach has been determined to be especially useful where the phenomena under investigation are interwoven and multifaceted; mixed methods research design assists the researcher to address complexity. It was clear from the literature review that the question of nurses' engagement with CPD was indeed complex. Therefore, answering the research questions in this study using both qualitative and quantitative approaches was assessed as being more likely to result in a comprehensive understanding of NZBS nurses' decisions to participate in PDRP.

2. ***What is the priority of the quantitative and qualitative phases?***

    In this study, the priority of phases was quantitative/qualitative. This choice was made because ultimately, the aim of the study was to explain nurses' engagement with PDRP. Quantitative data collection methods were used to generate data on what nurses knew about the NZBS PDRP including factors that affected their decision-making about participation. The qualitative phase of the study provided the opportunity to ask nurses to explain key findings from the quantitative data where topics had appeared sufficiently important that participation with the NZBS PDRP had been affected.

3. *What is the level of interaction between the qualitative and quantitative phases?*

Questions for the qualitative data were generated from analysis of the data gathered in the quantitative phase of the study. The participants in the quantitative phase were invited to volunteer to participate in the qualitative phase and thus, the data and the participants interacted between the phases. The qualitative data added greater depth, richness and meaning to the data generated in the quantitative phase of the study and importantly, assisted in the explanation of nurses' decisions to participate in PDRP.

4. *What is the timing of the quantitative and qualitative phases?*

The quantitative phase took place prior to the qualitative phase. Hence, the study was explanatory.

5. *Where and how will there be mixing of the quantitative and qualitative phases?*

Quantitative data analysis informed the questions to be explored in the qualitative phase. Participants in the qualitative phase explained the data generated in the quantitative phase. A subset of the participants who took part in the quantitative phase participated in the qualitative phase meaning there was mixing of the participants. In other words, the sample was nested between the phases of the research which further supported an explanatory design (Creswell, 2015b).

The answers to Bryman's (2006) questions are summarised in Table 3-1 overleaf. Figure 3-1 shows the overall design of the study (Creswell & Plano Clark, 2011; Tariq &

Woodman, 2010). Application of the justified design including a research plan is shown in Table 3-2. Appendix B provides a timeline of the work as it was completed.

Table 3-1 Decision Questions and rationale for choosing mixed methods design

Decision Questions	Answer/Rationale
Reason for choosing mixed methods	Questions to be asked in the qualitative phase are **dependent** on findings from the quantitative phase
What is the level of interaction between the qualitative and quantitative phases?	There is an **independent** level of interaction between the phases. The two phases are separate from each other and will be analysed separately.
What is the priority of the quantitative and qualitative phases?	The two phases have **equal** priority. However, they are administered in the order QUAN-QUAL because this order allows for explanation to occur.
What is the timing of the quantitative and qualitative phases?	Timing is **sequential** and the phases are implemented in two distinct phases.
Where and how will there be mixing of the quantitative and qualitative phases?	In this case, the mixing occurs because the questions developed for the qualitative phase are **dependent** on the findings from the quantitative phase.

Figure 3-1 Explanatory Sequential Design
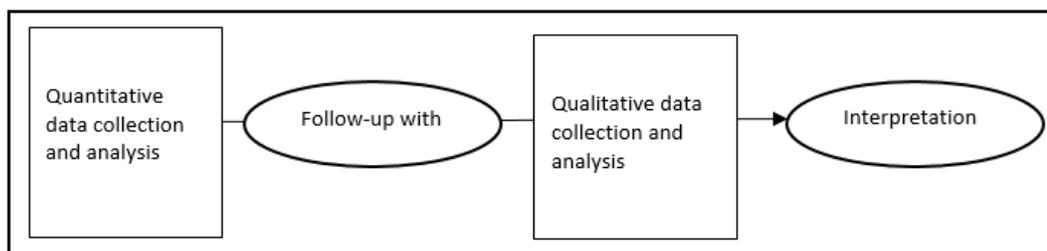
Table 3-2 Research Plan

Step	Activity	Tools
Design and implement the Quantitative phase		
Step 1	Development of questionnaire or negotiate access to use existing questionnaire to identify factors affecting engagement with continuing education from the literature review	Questions developed from the literature which identify areas of interest related to factors affecting engagement with continuing education
	Seek any permissions required including ethical approval	Massey University Human Ethics Committee New Zealand Blood Service
	Pilot study	Tools selected or developed for questionnaire. Adjust as necessary
	Distribute *PDRP Knowledge and Attitude Questionnaire* to all eligible nurses at NZBS	
	Analysis of returned questionnaires	Excel and statistical analysis
	Volunteers for phase 2 (semi-structured interviews) self-select as part of questionnaire	Respond to volunteers and identify likely date of interviews
Use strategies to follow from the quantitative results		
Step 2	Development of semi-structured interview schedule designed to explain the findings from the quantitative phase in more depth	Areas of interest for follow-up and fuller explanation identified through data analysis of the quantitative phase
Design and implement the qualitative phase		
Step 3	Semi-structured Interviews with participants who self-selected from Step 1	Semi-structured interviews developed in step 2 undertaken with volunteers
	General inductive analysis	NVIVO
Interpret the connected results		
Step 4	Discuss to what extent and in what ways the qualitative results help to explain the quantitative results	Interpretation of quantitative and qualitative findings and presentation

In summary, use of an explanatory sequential design (QUAN-QUAL) allowed areas of interest found in the analysis of data from the quantitative phase to be followed-up adding detail and explanation of the phenomena. In this study, the questions developed for the qualitative phase were dependent on the data collected in

the quantitative phase and hence, the methods were mixed. The research aim remained as previously indicated and the phasing of the questions was developed as follows:

Aim:

To explain NZBS nurses' decisions to participate in PDRP.

Quantitative Phase Questions:

- What do NZBS nurses understand about PDRP?

- What are NZBS nurses' attitudes to PDRP?

- What affects NZBS nurses' decisions to participate in PDRP?

Qualitative Phase Question:

- How do NZBS nurses explain key findings from the quantitative data which appear to affect their decision to participate in the NZBS PDRP?

Justification for each data collection method will be made later in the chapter including procedures that were followed.

3.7 Current Topic and available mixed methods studies

The literature review clearly demonstrated that the methodological coverage of the topic area appeared to be limited. Where research had been undertaken, it was mainly reported without reference to a particular philosophical paradigm. Simply, particular studies were reported by qualitative or quantitative data collection and findings. Of those studies reviewed, the only one which took a mixed-methods approach, was that by Spence and El-Ansari (2004). These researchers established the portfolio as a tool to promote self-evaluation and reflection when compared with traditional course assessment practices.

This study aims to make a significant contribution to understanding nurses'

perspectives of PDRP participation. The mixed methods approach will assist nurses to

explain the factors affecting their decisions to do so. This is significant both to NZBS and

the wider nursing discipline since PDRP is commonly used and is resource heavy.

Understanding how nurses' make their decision to participate in PDRP will likely reveal

adaptations that can be made locally to improve PDRP uptake.

3.8   Conceptual framework

Imenda (2014) argued that both conceptual and theoretical frameworks enable

the researcher to clearly see the main concepts and variables within a study and to take

'notice' during data collection, interpretation and analysis. She indicated their purpose

was also to provide structure and organisation. In relation to continuing education in

the post-16 arena there are a myriad of conceptual models available that have

described factors involved in adults' learning engagement (Institute of Education

Sciences, 2013). However, in relation to nursing education there appeared to be none.

Therefore, the Chain of Response Model discussed in the literature review, was chosen

to provide a suitable conceptual basis for this work.

Cross (1981) advanced that the Chain of Response Model demonstrated the

relationships between variables that featured in the decision making processes of

adults considering participation in continuing education. Cross (1981) acknowledged

that there was a relationship between a learner's previous educational experiences;

their attitude to learning; their lifestyle choices and circumstances and their current

situation which were brought to bear when choosing to participate in continuing adult

education. Her model added clarity to the continuing adult education landscape, and

was sufficiently inclusive that it offered potential to organise thinking about nurses'

participation in CPD. Many of the factors affecting CPD engagement found in the nursing literature were highlighted in the Chain of Response model. As Bertels and Nauta (1969), cited in Boeren, Nicaise, & Baert (2010) observed, "models have an operational character and are meant to describe the already known theory in a compact way." (p. 59).

As shown below, Cross (1981) brings together a number of key concerns affecting learner participation. A more detailed overview of each element is provided in this section. Where appropriate, links are made to the literature review in order to demonstrate the appropriateness of the model for use.

Figure 3-2: Cross 1981 Chain of Response Model
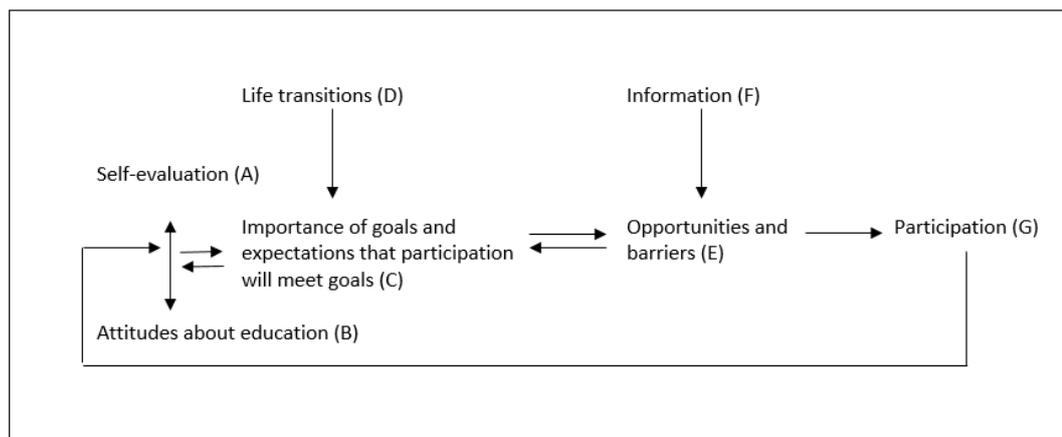
(Reproduced with permission from J. Wiley and Son Publishers)

A: Self-evaluation is concerned with the way each learner sees him/herself and conceives of their ability to succeed. Cross (1981) suggested that learners are unlikely to engage in activities that might pose a threat to their self-esteem. Norman and Hyland (2003) also proposed that this type of dispositional barrier was significant and showed that self-confidence was instrumental to success in a study with a group of student teachers.

B: Attitudes about education is concerned with attitudes learned directly from past experience and indirectly from the experiences of others. These attitudes endure and continue to affect learner engagement. New Zealand researchers (e.g., Carryer et al. (2002); Carryer et al. (2007); Havill (2010); Vernon, Chiarella, and Papps (2013)) have reported varied attitudes to PDRP locally.

C: Importance of goals and expectations that participation will meet goals is concerned with 'valency' of the learning activity. In other words, whether the learning proposition provides reasonable expectation that a learner could meet their learning needs or aspirations. Cross (1981) suggested that the learner needed to feel assured that the learning activity would provide sufficient reward for their engagement. Gould et al. (2007) demonstrated there were times when the valency of nursing CPD activities was not clear during their re-analysis of survey data on nurses' experiences of CPD.

D: Life transitions concerned learners at different stages of their life cycle, meaning that adjustments had to be made. Cross (1981) indicated that life transitions positively promoted learner engagement when new education was required (e.g., when faced with redundancy). Conversely, Cross (1981) considered the possibility that life transitions also deterred engagement where the life cycle phase adjustment excluded the possibility of taking on education (e.g., when raising a family or caring for an elderly or sick parent). In relation to health professional CPD, several authors (Cleary et al., 2011; Dowswell et al., 2000) provided perspective on the latter view and showed that there was indeed an impact on CPD engagement because of family commitments.

E: Opportunities and barriers related to what learners were prepared to overcome to engage with learning. Cross (1981) indicated that a highly motivated learner might overcome many seemingly difficult situations whilst less motivated

learners might be discouraged by more modest barriers. Evidence of healthcare professionals being similarly influenced was apparent within the literature (Boeren et al., 2010; Gould et al., 2007; Murphy et al., 2006; Ross et al., 2013).

F: Information about the learning activity was described by Cross (1981) as being essential. She outlined how failure to provide sufficient information resulted in lost opportunities to link learners with appropriate opportunities. No direct evidence for the importance of healthcare professionals' requirements for information emerged from the literature although Vernon, Chiarella, Papps, et al. (2013) reported a lack of understanding among nurses regarding their continuing competence requirements in particular to CPD.

G: Participation is the ultimate outcome of the Chain of Response model and, depending on how an individual responded to each of the previous elements, participation (or not) was determined. Participation rates for PDRP were shown to be low where participation was voluntary (National PDRP Co-ordinators, 2014, 2015, 2016).

Overall, it was possible to see how Cross' (1981) model could be used in this study to ensure coverage of the topic as Imenda (2014) suggested. The Chain of Response model was developed to explain how adults might respond to the prospect of engaging with further adult education. Nurses must also make decisions about whether to engage with further learning or CPD. They are likely to be influenced by similar factors. Furthermore, searching the nursing literature produced context specific examples of life transitions, opportunities and barriers and attitudes to nurses' CPD. It appeared that Cross' Chain of Response model would sit well within nurse education and there was evidence of one previous attempt to use it in this situation. Therefore,

using Cross' (1981) model as a conceptual framework to explain factors affecting their decisions to participate in CPD, grounded this work within a legitimate model of adult learning which had the flexibility to assist or to at least 'see' and offer explanation for the factors that affected nurses' engagement with PDRP.

3.9 Preparation for conducting the research

Developed from consideration of various epistemological perspectives, philosophical paradigms and available design choices for the research, a plan of work was developed (see page 83 and Appendix B). This plan identified the further decision making, planning and justification needed to produce a detailed outline for how the study would actually be conducted. In the remainder of this chapter, justification relating to the choice of data collection methods and instruments will be made with reference to the explanatory design and the organisational and logistical constraints impacting the collection of data. Further detail and justification for decisions regarding the sample, data collection methods, ethical considerations and other consultation that took place in order to conduct the study will be provided. Proposed methods of data analysis will be outlined.

3.10 The participants and eligibility criteria

Participants in this study were Registered or Enrolled Nurses at NZBS who met the following eligibility criteria:

1. Employed by NZBS (i.e., not temporary or agency nursing staff)

2. Eligible to participate in either the Registered Nurse or Enrolled Nurse pathway of the NZBS PDRP (i.e., not employed in a role that required completion of the 'Senior Nurse' PDRP)

3. Not employed in a NZBS designated senior nursing role.

Justification for the eligibility criteria and its consequent impact on the sampling strategy was based on the fact that all nurses are entitled to participate in the PDRP from the time that they begin their permanent employment with NZBS. Nurses who were in designated senior nurse roles were not eligible because they were required to use a different PDRP pathway from the Registered or Enrolled nurses. The 'Senior Nurse' pathway had a different set of requirements (e.g., there were fewer options to complete; there was no financial remuneration for PDRP completion, and Nursing Council's adapted competencies for particular roles like clinical management, managers, educators or policy and research focused nurses were used). Additionally, senior nurses were often directly involved in portfolio assessment and NZBS had the expectation that its senior nurses would actively champion PDRP. Furthermore, the literature review revealed that roles like those of the Charge Nurse or other nurse manager (which would be considered to be a senior nurse role at NZBS) were implicated in the creation of a supportive learning climate (Gillespie et al., 2011; Gould et al., 2007; Heath & Utiera, 2014a; Ogier & Barnet, 1986; Tennant & Field, 2004). These factors were thought likely to make the senior nurse PDRP experience quite different to that of the Registered or Enrolled nurses.

3.11 Role of the researcher

Creswell (2009) highlighted that in mixed methods research there should be clarity about the role of the researcher. Elaborating, Creswell (2009) identified that the background, history, values, experience of the setting, and culture of the researcher can all contribute to the challenges presented in accessing the sample, the interpretation of the data, and any ethical issues that might arise. Various other

authors (e.g., Beanland, Schneider, LoBiondo-Wood, and Haber (1999); Burns and Grove (1987); Costley, Eliot, and Gibbs (2010); Creswell (2009); McDermid, Peters, Jackson, and Daly (2014)) observed that far from being a convenient, easily accessed setting, researching in one's own institution was likely to be fraught with difficulties which could compromise the work. In this study, particular strategies were employed to safeguard the integrity of the research and promote the safety of participants and the researcher.

My role as the Nurse Advisor: Professional Development created the potential for an imbalance in the power relationship between me as researcher and the participants. The power imbalance stemmed both from my organisational role and as the PDRP co-coordinator. Here, Creswell (2009) offered specific strategies to ameliorate some of the issues identified and these were implemented in this research. One of the key strategies included asking senior nurses to recruit participants to the quantitative phase leaving the researcher at 'arm's length' reducing the risk of any perceived coercion to join the study.

Ensuring the integrity of the research and safety of the participants was also important where I collected data myself. This was especially relevant to interviews because of my implicit and explicit understanding of the workplace; its culture and history of PDRP; its implementation and specific programme details. This knowledge helped me to follow-up responses to maximise understanding of nurses' participation decisions. The research Information Sheet contained explicit reference to who would be conducting the interviews in the qualitative phase. This information provided eligible participants with the ability to self-select for each phase of the study on the basis that they knew who was carrying out the research and who would interview

them. This level of transparency facilitated a collaborative, purposeful discussion using questions based on the findings from the quantitative phase of the work.

3.12 Ethical considerations

3.12.1 Ethical approval

Massey University Human Ethics Committee approval was granted in March 2016 (Appendix C). As part of the ethical approval process, the NZBS senior leadership team and Maori Staff Advisory Group (MSAG) were invited to review the study proposal and to consider their support for its subsequent completion at NZBS. It was important that these groups understood the nature of the study and were able to consider any potential personnel or business impacts. Access to nursing staff and resources at NZBS was formally granted in conjunction with MUHEC approval (see Appendix D).

3.12.2 Consent

Participation in this study was voluntary for both the quantitative and qualitative phases. Consent to participate in the quantitative phase was inferred by return of the questionnaire to the researcher. Volunteers for the semi-structured interviews in the qualitative phase were asked to sign a consent form indicating that they understood the purpose of the work, the option for interviews to be transcribed by a third party and the possibility of audit and publications arising from the completed work. Participants were advised that they could withdraw from the qualitative phase of the study up until the start of the transcription of their interview.

3.12.3 Confidentiality and anonymity

All data collected electronically during the course of this work was stored in password protected documents. It was only accessible to the researcher and supervisors. Physical documents produced were kept in a locked cupboard (e.g.,

questionnaires, field notes, consent forms). Interview transcription was undertaken by a third party and therefore, a confidentiality agreement between the researcher and third party was required (See Appendix J). Participants remained anonymous during the quantitative phase. This was achieved by the allocation of a number to a completed questionnaire on its receipt and this assisted with data reconciliation only. It did not offer any means by which to identify participants. In the qualitative phase, participants self-selected to participate by providing the researcher with contact details. Interview transcripts were anonymised and are presented in the thesis as letters. The same level of anonymity will be provided in any subsequent publication.

Disposal of the information produced in the course of this work is planned within the relevant time-frames and guidelines indicated by the relevant ethics committees, educational institutions and the organisation accessed for the work.

3.13 Consultation: Maori Staff Advisory Group and Cultural Safety

As part of the development of the research, involvement of Maori nurses was actively sought. Referring to the NZBS Maori Staff Advisory Group for their support, the nature and purpose of the research was explained in a face to face meeting with the Executive Chair of the group. The philosophical location of the work, the research processes, the data collection processes and data analysis procedures were all discussed. The questionnaire was offered for review and an indication was made about the possible areas for discussion in the semi-structured interview questions in so far as this was possible. Amendments to the questionnaire schedule following ethics committee review and piloting were also offered for review and discussion. The research was supported by MSAG and the Executive Chair remained available for support and consultation throughout the project (see Appendix E).

3.14 Phase 1: Quantitative Data Collection

The choice of data collection instrument needed to account for both eligibility and accessibility to the sample given the widespread geographical locations of NZBS staff. NZBS has centres located as far apart as Auckland and Dunedin. Some nurses also work a significant proportion of their time on mobile collections reaching as far as Invercargill in the south and Kaitaia in the north. Many are also employed on a part-time basis. Access to electronic communication like email is compromised by the working habits of the population, the availability of computers on mobile collections and the opportunity to check electronic correspondence. Furthermore, the chosen method also needed to be able to account for the ethical context of the work and the relationship of the researcher with the population. Therefore, the chosen data collection method needed to be sufficiently flexible to accommodate this situation. The tool chosen because it met all of these terms was a directly mailed questionnaire.

3.14.1 Justification for using a questionnaire

A number of authors have described the flexibility of the questionnaire as a method of data collection (Gillham, 2000a; Oppenheim, 1992; Punch, 2003; Robson, 1993). Identifying that large amounts of information can be collected on a wide range of issues, Punch (2014) stated that a questionnaire allowed researchers to ask short questions easily and for questions to be standardised to address the same concerns with the whole population. Robson (1993) further identified the convenience of self-completion at a time to suit the individual respondent. In the context of this study, use of a directly mailed questionnaire was justified on the basis of the advantages indicated here and because it addressed the unique challenges presented by access to this particular population.

When using a questionnaire, there is potential to include scaled responses as in a rating scale or an attitude scale, sometimes referred to as a Likert Scale. With the inclusion of a rating scale for example, strongly agree to strongly disagree, comes the opportunity to provide participants with greater choice for their answer, from a little to a lot, or from strongly agree to strongly disagree. Quantitative data so yielded can be manipulated within available statistical packages to illuminate relationships (Boone & Boone, 2012; Carifio & Perla, 2007; Jamieson, 2004). Attitude scales were effective in Carryer's (2002, 2007) work where individual attitudes to PDRP were measured. The Chain of Response model also includes attitude to learning and therefore scaled response was deemed to be a good option to assist in the measurement of nurses' attitudes to PDRP and learning in general. A second rating scale provided the ability to measure nurses' opinions about factors affecting their participation in PDRP. These factors were developed from the available literature on CPD. Whilst questionnaires clearly made data collection a relatively easy process in this study, there are a number of instrument shortcomings that should not be overlooked.

3.14.2 Disadvantages of questionnaires

Harris and Brown (2010) identified that questionnaires are usually viewed as an objective research tool. Cohen et al. (2011) advised they can be time consuming in their development, yet more easily analysed. Tuckman (1978) expressed his pragmatic opinion, that their primary purpose is to allow researchers to ask about, rather than observe, behaviour. Gillham (2000a) simply stated that developing a questionnaire is a difficult occupation, and further suggested they are often used inappropriately.

Characteristically, the primary difficulty of questionnaire development is described as being the construction of questions, both for their interpretation by the

respondent and in planning their analysis at the outset (Punch, 2003). As a result, there

are a myriad of texts to support the process of questionnaire development. However,

the process described by Punch (2003) summarised the need for a logical approach

which determined the relationship between the questions being asked and the research

questions overall. Attention to detail at this stage of question development was

indicated as being more likely to produce a reliable and valid questionnaire.

Furthermore, it solved the issues related to reliability and validity identified by Gillham

(2000a), Punch (2003) and Robson (1993) as being critical to the production of quality

data.

3.14.3 Questionnaire Development

One strategy that can be used to assist in solving reliability and validity issues, is

to make use of a previously validated questionnaire. In the context of this research, a

previously validated questionnaire was investigated for use. It had been used in three

previous studies (Carryer et al., 2002; Carryer et al., 2007; Havill, 2010). Whilst the

previous use of the questionnaire and track record for its production of quality data

supported its validity, the questionnaire needed to be assessed for its suitability for use

in this study. To be valid, questions needed to be relevant to the population under

scrutiny. In other words, content validity was of concern. If the questions were not

representative of the research context, then the data produced would lack sufficient

quality, potentially compromising all subsequent steps. Other alternatives included

adapting questions from previously validated studies to assist in questionnaire

development. However, commentators like Robson (1993) and Punch (2003) cautioned

there were potentially more threats to quality data when questionnaires were adapted

than there might otherwise be if a new questionnaire was developed for the purpose.

Permission was sought and granted from Professor Jenny Carryer, Massey University, to use the PDRP Questionnaire developed for her previous studies (Carryer et al., 2002; Carryer et al., 2007) and in the work of Havill (2010) (see Appendix F). In order to assess whether the questionnaire was appropriate for use in this study, the hierarchy of concepts approach articulated by Punch (2003) was used. Punch (2003) argued that there should be a clear relationship between the higher order concepts used in a research study and the questions formulated for use in a questionnaire.

Evaluation of Carryer's (2002, 2007) questionnaire using the hierarchy of concepts approach showed that there was indeed connectedness between this study and those by Carryer at the levels of research area and research topic. Elements of similarity also existed at the level of the study aim. However, for the purposes of this study there was deemed to be insufficient connectedness at the level of specific research questions and the kind of data collection questions required when compared with those posed in Carryer's (2002, 2007) questionnaire. Straightforward adoption of the Carryer (2002, 2007) questionnaire was rejected. However, adaptation was possible because of the similarities between the respective studies, for example, regarding information requirements and attitude to PDRP. This made it possible to model the questionnaire for this study on a format tested by Carryer as being user friendly, as well as being able to adapt particular questions to reflect NZBS programme rules and specifications.

A four section questionnaire was developed (see Appendix L). Coverage included collection of demographic data in section 4. Response to key pieces of information about both the NZBS PDRP procedures and its connection to continuing competency requirements of Nursing Council made up section 1. Disposition to PDRP

and CPD in general, using a Likert-type scale and guided by the elements of Cross'

(1981) chain of response model was the subject of inquiry in section 2. Scaled response

questions to items found within the literature and developed through brainstorming

with colleagues about the most commonly cited reasons affecting nurses' decisions to

participate in PDRP were in section 3.

A pilot study was undertaken prior to the main data collection period (See page

108 for details). Pilot studies are important for a number of reasons in the context of

this work. First, the researcher is a novice; second, questionnaire development can be

fraught with difficulty and, given that the remainder of the study was dependent upon

it, it needed to be the best possible version available. Indeed, counsel from authorities

on the subject of instrument development recommended this as an essential activity

(Beanland et al., 1999; Fraenkel & Wallen, 2009; Oppenheim, 1992; Robson, 1993). The

value of undertaking a pilot study, although it may add several weeks to the completion

of the work, is an increased familiarity with all aspects of the study including data

analysis. On completion of the pilot study, lessons learned were reviewed with the

outcome that amendments were made to instrumentation and process so that mistakes

were avoided when the main study was conducted.

3.14.4 Participants (Phase 1: Quantitative data collection)

All Registered or Enrolled nurses who met the eligibility criteria on the day data

collection began were directly mailed an information and questionnaire package (see

Appendix H, L). This action ensured that all eligible participants were identified; that

they were contacted and informed about the study, and had the opportunity to

consider whether or not to participate. Prior to starting the work, the maximum sample

size assuming no vacancies and all participants were eligible was determined to be 145.

3.14.5 Sample size

The number of participants required in the quantitative phase of the study is worthy of discussion since the intended outcomes of the work did not need to be generalisable to the wider population. However, the number of participants did need to be sufficiently large to enable the data to be meaningful in this context. Fraenkel and Wallen (2009), Beanland et al. (1999) and Burns and Grove (1987) all argue that the answer to the actual numbers of participants required is not always definitive. Calculation of the sample size if generalisability was an intended outcome indicated that 60% or more participants would be sufficient. Justification for pursuing a 60% response from the sample arose from commentary provided by Cohen et al. (2011) on mixed methods research. These writers indicated that in sequential mixed methods designs, the quality of initial sampling procedures inevitably influences the next phase and likewise, the quality of the data collected. Ultimately, achievement of more than a 60% response rate from the questionnaire added to the validity of the research.

3.14.6 Quantitative data collection procedures

Discussion about the research took place at the national senior nurses meeting where an overview of the research, its purpose and procedures were provided. Clinical Nurse Leaders (CNLs) were asked to act as the local liaison for their sites, taking delivery of and distributing project packages to potential participants. CNLs were asked to provide time for completion of the participant materials at their respective staff meetings.

The packages provided included a letter of introduction outlining the purpose of the study and requesting participation, together with Massey University Human Ethics Committee (MUHEC) approved data collection material (see Appendix H, L, and P).

There was a six-week timeframe for return. Reminders were given by CNLs after three weeks, and a final reminder at my request one week prior to closing. These took the form of a general announcement at handover or staff meetings. Participants had the option to return their completed questionnaires via external mail in envelopes provided or to use the internal mail as they wished.

3.14.7 Data analysis

Punch (2003) identified that during the development of a questionnaire, the researcher should pay attention to how they will undertake analysis. The demographic information collected provided data so that descriptive statistics could be used to show frequencies or variations with the intention of identifying any patterns within the data. Examples of the kind of data for presentation included characteristics of the population like their length of time registered as a nurse, their age, gender and previous level of education engagement with PDRP. This information was used to examine discrete populations within the sample looking for similarities and differences.

Section one of the questionnaire (factual knowledge of PDRP) involved scoring individuals against pre-determined correct responses. Analysis was intended to highlight areas where more information might be needed. Results were planned to be presented as a tabulation of overall results showing clearly which questions were answered well and those that were not. The range, mode and mean scores were able to be identified. In real world studies like this one Robson (1993) indicated that the opportunity to solve problems as a result of the work is an expected outcome. Therefore, the relationship between total individual scores and demographic variables like age, length of practice experience or history of PDRP engagement were used to identify themes or patterns about particular groups of staff who responded to the

questionnaire. The sample size was likely to be small and generalisability was not intended because the focus was the NZBS PDRP. Therefore, provision for undertaking extensive statistical analysis was limited to the possibility of using two-sample unequal variance t-test where comparison was to be made between group means.

Section two focused on nurses' disposition or attitude to PDRP as a CPD activity. Further, the section acknowledged the factors affecting decision-making identified in Cross' (1981) model. The use of a scaled response (strongly disagree to strongly agree) meant that individual summated responses could be used to determine attitude towards each factor. Such analysis provided insight into particular participant attitudes which was relatable to demographic data (Bryman, 2006; Lovelace & Brickman, 2013). The individual scores were presented in graphs using a trendline that demonstrated any positive or negative tendency with the attitude grouping of the responses.

In section 3, nurses reported on their situational perspective by using a scaled response to show the extent to which each factor affected their decision to participate in PDRP. There was no intention to determine from the data whether the effect indicated was positive or negative. Rather, the factor described the extent to which the factor affected participation on the scaled response. Further, in having no tendency towards positive or negative affect, it afforded the opportunity to ask 'why' in the qualitative phase for factors for which a major affect was reported by the group. The responses were rank ordered by most number of responses indicating the factor had had a major effect. The topic stems of the statements were indicative of the areas that were most important to be addressed in the follow-up interviews.

At the end of section three, nurses were asked to make any additional comments. The intention was to ensure that there was adequate coverage of the

factors affecting a decision to participate which may not have appeared in the literature or which were peculiar to this group. Free text responses were analysed using the general inductive approach described by Braun and Clarke (2006).

3.14.8 Interim phase: interview question development

Development of the semi-structured interview schedule was based on analysis of the responses provided by participants in the quantitative phase of the study (a more detailed explanation of this process is provided in the chapter on quantitative findings - see page 135). Semi-structured interviews provided the opportunity for participants to explain and clarify notable findings that emerged from the quantitative phase of the study.

3.15 Phase 2: Qualitative Data Collection

Questionnaires produce large amounts of quantitative data. Their shortcoming however is found in the lack of explanation or rationale for the answer given by the participants. By contrast, interviewing allows participants to add detail and dimension to their response. Gillham (2000b) observed that interviewing as a data collection technique can have both structure and flexibility. This means that topic areas can be pre-determined, yet participants can be asked to clarify or illuminate their perspective. For the purposes of this research, semi-structured interviews were proposed to be the most useful data collection strategy. In this research, pre-determination of the topics came from analysis of the quantitative data and participants explained using their own words (Harris & Brown, 2010). Fraenkel and Wallen (2009) identified this as an interview format called the 'interview guide'.

3.15.1 Justification for the use of semi-structured Interviews

When the interview guide is used, topics are identified prior to the interview as in this study. During the interview, the order of questions is decided as the conversation unfolds. Fraenkel and Wallen (2009) urged caution with this particular type of interview because of the obvious question sequencing differences. These writers suggested that participant responses could be influenced. However, in this study, explanation of factors affecting participation in PDRP was the focus for the interview and, as many of the factors were potentially related, 'going with the flow' and using probes to assist participants to explain, was deemed an appropriate strategy. Given the interviewer's role within the organisation, putting participants at their ease was most important. This was more likely to be accomplished using a conversational approach rather than rigid adherence to a structured question schedule.

3.15.2 Disadvantages of semi-structured interviews

Robson (1993) maintained that interviews can be extremely time consuming. Together with the geographically widespread study population and the unknown location of the volunteers for interviews, time for data collection and travel was a major consideration during data collection. To ameliorate some of the issues related to time, interviews were limited to a maximum of one hour. This was stated early in the data collection phase, as nurses needed to request release from their duties in order to participate. Furthermore, issues of time and resourcing related to travel and completing data collection within the job of the researcher were also considered and negotiated within the decision to undertake interviews of any description with this population. Undertaking semi-structured interviews was supported by NZBS.

3.15.3 Participants (Phase 2: Qualitative data collection)

In the qualitative phase, the reliance on numbers of participants to contribute to the external validity of the study was not required (Fraenkel & Wallen, 2009). Instead, the focus was on the rich description of the volunteer participants. The total number of interviews was thus dependent on achieving the 'theoretical saturation' described by Guest, Bunce, and Johnson (2006) and meaning that interviews were undertaken until they yielded no new data or themes. Nurses volunteered to participate in phase two of this work during completion of the questionnaire as previously described. Using survey participants as interview informants in the same sequential study sat well with promoting the validity of mixed methods approach taken (Creswell, 2015b; Onwuegbuzi & Collins, 2007).

There were thirty-six volunteers to be interviewed. To avoid any unintentional bias when selecting individuals to follow-up, the researcher assigned each volunteer a number (1-36) on receipt of their contact details. The contact order for volunteer interviewees was made using a random number generation application. Volunteers were contacted in this order. If a volunteer changed their mind, the next volunteer was contacted and so on until 15 interviews were arranged. Appointments for interviews were made ahead of time and the researcher travelled within the context of her job role and conducted all interviews face to face.

3.15.4 Qualitative data collection procedures

Interviews were conducted by the researcher according to a semi-structured schedule derived from phase one findings of the study (see Appendix M). Information sheets and consent processes were undertaken by the researcher with each interviewee prior to the start of the interview (see Appendix P). The interviews were

digitally recorded and were transcribed by a third party transcription service recommended by Massey University. The director of the transcription service made an electronic declaration of the transcriber confidentiality agreement on behalf of the company and its employees (See Appendix J). Interviewees were provided with a copy of their interview transcription by email and were asked to sign a transcript release form prior to analysis.

3.15.5 Data analysis

The NVIVO software program (version 11) was used to manage and support analysis in this phase of this study. The principal technique used was a general inductive approach described by Clarke and Braun (2006) and Thomas (2006). The use of this strategy for analysis was intended to provide a systematic process for data reduction to enable the findings to be displayed and interpreted. However, because the interviews were semi-structured and related to notable responses from phase one, the main adaptation of the technique was to determine nurses' explanations in relation to each question posed. The data was validated by respondent validation of their transcripts and review of coding by the supervision team.

A systematic process was chosen because both Thomas (2006) and Braun and Clarke (2006) highlighted the tendency among researchers to overlook the need to be specific about the procedures used to analyse qualitative data. The consequences of using a robust process are found in the consequent trustworthiness of the work. Thomas (2006) further argued that researchers also require straightforward procedures to follow without the need for the technical details required by the adoption of a particular approach like phenomenology for example. Having taken a pragmatic stance

to this work and being a novice researcher, it is argued that the use of a relatively straightforward procedure was an advantage in this work too.

Thomas (2006) outlined that the 'general inductive approach' to qualitative data analysis is concerned with the close reading and interpretation of raw data from which concepts or themes are generated. Commonly used in health and social science research where there is a need to understand patient experiences or to evaluate service initiatives, the general inductive approach has been used in several well considered studies like that exploring end of life spiritual care by nurses in an Intensive Care Unit in the Netherlands (Noome, Kolmer, van Leeuwen, Dijkstra, & Vloet, 2016), and another examining women's changes in eating during pregnancy (Paterson, Hay-Smith, & Treharne, 2017). The procedures followed were those outlined by Braun and Clarke (2006) and are shown below in Table 3-3. (The code book is provided in Appendix Q).

Table 3-3 Phases of data analysis in the general inductive approach

Phase	Objective and process
Familiarisation	**Becoming familiar with the data** Achieved in this study by reading and re-reading transcripts with identification of initial topics related to each of the questions at interview. Where similar topics were raised in the same context in response to other questions, for example, when a respondent referred back to or added further description or commentary on something already mentioned, this was noted and cross-referenced for inclusion in coding and searching.
Generation	**Coding features of the data** Colour coding was used to identify topics in relation to each question within the transcripts using NVIVO. This created a systematic approach and visual reference across the transcripts. Data was then collated for each topic area for each interview question, including any outlying data generated as described above.
Searching	**Identification of themes within the coded data** The collated data was reviewed and initial themes were identified within the responses for each interview question.
Defining	**Definition of the themes identified within the data** Themes were refined until they were a coherent map of the data and there was clear separation between the themes identified
Reporting	The outcome of analysis using this process is reported in the qualitative findings chapter.

3.15.6 Data validation

The validity of semi-structured interviews can be increased by asking participants to review their own transcripts in processes described by Burnard, Gill, Stewart, Treasure, and Chadwick (2008). However, it was also noted by Burnard et al. (2008) that the process could add bias where participants were unable to see the relevance of their thoughts to the final outcomes and might seek to change their perspective to one that was more acceptable after reading. Creswell (2009) noted that as an alternative, an independent auditor could be helpful in reviewing not only transcripts, but the entire project to ensure that the level of data analysis from raw transcription to interpretation is cogent throughout.

For the purposes of this study, the former option was used. Participants were emailed a copy of the transcript of the interview with the researcher. They were asked to respond to the researcher within a three-week time frame if they wished to make any comments about the contents of the transcripts. The email also included a 'release of transcript' form which participants were asked to sign and return to the researcher (see Appendix K).

Supervisors also formed a significant part of ensuring the trustworthiness of the data analysis. Coding strategies were discussed at meetings and progress was reviewed to support the appropriateness of the themes as they were developed. The code book structure advocated by DeCuir-Gunby, Marshall, and McCulloch (2011) facilitated the documentary process. Unintentionally, the senior nurses at NZBS validated some of the emergent themes. In a planned feedback session about the research, the senior nurses indicated that the themes presented reflected some of the CPD practices they had observed among their nurses.

3.16 Pilot Study

The pilot study was undertaken following ethical approval and access permission was received from NZBS. The sample for the pilot study were 10 senior nurses. This group were not taken from CNLs who would be involved in the recruitment of the Registered or Enrolled nurses when data collection from the study sample began. The group comprised of Nurse Educators, Charge Nurses and Clinical Coaches. The rationale for choosing this group and this number of senior nurses was that they had familiarity with the NZBS PDRP programme, were already required to critique forms and other documentation as part of NZBS regulatory processes, and were not eligible to participate in the study.

The pilot sample were directly mailed the questionnaire (see Appendix G). The mailing contained an information pack and an additional request to review the material provided both for ease of understanding and any recommended editing. The pilot participants were asked to complete the questionnaire and to identify any instructions or questions that were not clear enough. Where questions did not seem to be relevant to their role, the senior nurses were asked to judge the question as if they were in the position of a Registered or Enrolled Nurse. The pilot participants were asked to return the questionnaires as instructed and to complete contact details if they were willing to complete a pilot interview. The feedback about the questionnaire and its instructions together with the data provided was reviewed and analysed. Pilot interviews were arranged and conducted with those who had indicated they were willing to participate.

Questionnaire feedback showed that one participant thought there was some repetition of questions between sections 2 and 3 relating to accessing assistance to develop a portfolio and evidence required for a portfolio. Another participant raised

whether English as a second language should be included as a factor influencing PDRP participation. A different participant suggested there should be further investigation related to organisational culture and expectation that PDRP would be completed since this had been her experience in prior employment. Three other participants indicated that the anchors used in the pilot study were difficult to use and that the instructions were confusing. They recommended that either the statements were changed to make this easier or that the instructions were made clearer. In the qualitative answer section, no additional fields for investigation were noted.

The analysis plan for data for both phases was trialled, and a range of ways of presenting information was tested. Three interviews were undertaken with volunteers which afforded me the opportunity to develop questions from the quantitative data and to practice the recruitment process for interviews and interviewing skills. NVIVO was used to enable me to develop skills in coding and analysing qualitative data. The outcome of this part of the pilot study was aimed at, and succeeded in, developing overall confidence with the data collection method.

Consideration of the feedback provided was followed through with amendments. The stem statement wording and anchors in section 3 were amended to their final format. This change was discussed with the senior nurses who supported the decision to change them to more adequately direct the nurses who would participate in the actual study. Other feedback was rejected on the basis that it either fell outside the scope of this study or had been considered and rejected previously.

3.17 Data Collection: Main study

Final versions of the information sheets, consent forms, questionnaire and other documentation required for the study were completed as per schedule provided in

Appendix B. The questionnaire and information pack was distributed as per the planned study processes to 129 eligible participants. On the closing date of the study, 82 had been returned. Contact details were supplied by 36 survey participants with a view to their being interviewed in the qualitative phase of the study. Data and its analysis from both the qualitative and qualitative phases of the study are presented in detail in the following chapters.

3.18 Summary

In this chapter, I have given an account of the underpinning epistemology and consequent methodological approach to be taken to answering the questions from my practice experience as a nurse teacher in a clinical setting. Having demonstrated how a mixed methods approach was likely to be genuinely useful in this situation because of both gaps in the literature and the type of information required about the PDRP, I have also justified the data collection tools chosen. The development of data collection tools has been related to the emergent specialist literature and to relevant key sources regarding research instrumentation. Issues of reliability and validity have been addressed. Ethical considerations, in particular those of the practitioner as researcher have been identified and accounted for within the data collection procedures. Strategies employed to ensure that care was taken to ensure that participants' contributions, information and narratives were handled sensitively and ethically have been highlighted and justified within the chapter.

In the next chapter, quantitative data will be presented including semi-structured interview question development. In the subsequent chapter, qualitative data will be presented following implementation of this study design at NZBS during 2016.

4. Quantitative Findings

4.1 Introduction

The results of the quantitative phase of this mixed methods study will be presented in this chapter. The organisation of the chapter will follow the structure of the questionnaire itself. However, as a starting point, the demographic information collected will be presented to enable appreciation of the participant characteristics. The results of each section of the questionnaire will then be presented including comments provided by the participants in the free comments section of the questionnaire. In the final section of the chapter, the process for developing the questions for the subsequent semi-structured interviews will be outlined.

The aim of this phase of the study was to explain the factors that affected New Zealand Blood Service (NZBS) nurses' decisions to participate in PDRP. A directly mailed questionnaire was chosen to gather data to answer the following questions:

1. What do NZBS nurses understand about PDRP?

2. What are NZBS nurses' attitudes to PDRP?

3. What affects NZBS nurses' decisions to participate in the PDRP programme?

The questionnaire was administered using the processes and data collection instruments previously developed and piloted (See Chapter 3). There was a 64% response rate on the closing day (n = 82). Follow-up with all eligible participants via their Charge Nurses added no additional responses. All questionnaires were usable, although not all questions were answered by all participants.

4.2 Demographic Data

Demographic data was collected from participants for the primary purpose of identifying population variables and characteristics (Punch, 2003). This information was used to support analysis and identification of any relationships between the population variables and the factors that affected decision-making about PDRP. Table 4.1 provides an overview of participants. Most frequent responses are highlighted in bold font.

Table 4-1 Demographic data

Scope of practice						
RN	EN	No answer				
78 (95%)	3 (5%)	1 (1%)				
Gender						
Male	**Female**	Gender diverse				
10 (13%)	**71 (87%)**	1 (1%)				
Initial Nursing Qualification						
Hospital Certificate	**Diploma in Nursing**	**Bachelor of Nursing**	**No answer**			
17 (21%)	17 (21%)	**47 (57%)**	1 (<1%)			
**Additional Qualifications **						
Specialist Nursing Certificate	**Postgraduate Certificate or Diploma**	**Non-nursing qualification**	**None**			
4 (5%)	18(22%)	14 (17%)	**48 (58%)**			
Currently undertaking professional study						
Yes	**No**					
3 (4%)	**79 (96%)**					
Currently studying (other than nursing)						
Postgraduate Diploma	**Other**		**None**			
1 (<1%)	**2 (2%)**		79 (97%)			
Already submitted a portfolio						
Yes	**No**	**No answer**				
23 (28%)	**57 (70%)**	2 (2%)				
Region of NZBS						
Northern	**Waikato**	**Central**	**Southern**	**No answer**		
25 (30%)	18 (22%)	20 (24%)	17(21%)	2 (2%)		
Years of nursing practice						
0-5	**6-10**	**11-15**	**16-20**	**21-25**	**>26**	**No answer**
17 (21%)	15 (18%)	7 (13%)	8 (10%)	5 (6%)	**27 (33%)**	3 (4%)
Age Group						
20-30	**31-40**	**41-50**	**51-60**	**61-70**	**No answer**	
17 (21%)	14 (17%)	**21 (26%)**	18(22%)	9 (11%)	3 (4%)	
Full or part-time working hours						
Full-time	**Part-time**	**No answer**				
37 (45%)	**44 (54%)**	1 (<1%)				
Years working for NZBS						
< 1	**2-5**	**6-10**	**10-15**	**>16**	**No answer**	
26 (32%)	21 (26%)	15 (18%)	12 (15%)	7 (13%)	1 (1%)	

*Percentages rounded to the nearest whole number. ** Participants reported more than one additional qualification*

The table shows 87% were female (*n* = 71), 95% were Registered Nurses (*n* = 78) and more than half (57%) had completed a Bachelor of Nursing programme as their initial qualification for entry into nursing (*n* = 47). Additional nursing qualifications were reported by 29% participants (*n* = 24), and a further 15% identified that they had other, non-nursing qualifications (*n* = 12). The table shows that 96% of participants were not currently studying (*n* = 79) and that 70% had not submitted a PDRP portfolio on the NZBS programme (*n* = 57). A very small percentage (3%, *n* = 3) appeared to be participating in education outside of nursing. The data also seemed to suggest that participants were not using formal nursing education like postgraduate study to achieve their CPD requirements with less than 5% engaged with these programmes. Participants reported being located across all four geographic regions of NZBS. There was a wide range of years of nursing practice with 33% (*n* = 27) having practised for 26 or more years. Almost half of the participants (46%, *n* = 34), reported working for NZBS for more than five years, whilst 32% (*n* = 26) had been with the organisation for less than one year. Almost a third of participants had worked for NZBS for more than 10 years. The majority of nurses (54%, *n* = 44) identified that they worked part-time with the remainder (45%, *n* = 37) in full time employment. Overall, the age characteristics of the participants were reflective of the wider national demographic of an aging nursing workforce (Nursing Council of New Zealand, 2013).

4.3 Knowledge of PDRP

Section 1 of the questionnaire (See Appendix L) examined participants' knowledge of 10 facts about NZBS PDRP. Knowledge about the relationship of PDRP to continuing competency requirements for Annual Practising Certificate (APC) renewal was also tested. Questions were further targeted on understanding about PDRP support

processes and resource availability. The survey also asked participants what they knew about financial and study leave allowances. The design of this section was as a multiple choice test. It resulted in a score out of 10 for each individual. Data is presented for the whole sample in Table 4.2 below.

Table 4-2 Knowledge about PDRP

PDRP facts	Correct answer	A	B	C	D	E	No answer
Minimum number of clinical practice hours	E	8	3	2	8	**60**	1
Minimum professional development hours	C	1	0	**76**	1	3	1
Availability of application and assessment forms	B	51	**58**	51	32	22	0
Professional requirements met by PDRP	D	42	32	10	**81**	17	1
Length of exemption from council audit	B	2	**69**	7	0	1	3
Which level provides financial allowance	E	12	3	3	2	**60**	3
How many days leave for preparation	C	4	8	**66**	2	1	1
With whom to agree level of portfolio	E	30	35	15	3	**26**	1
NZBS PDRP approved by	B	3	**75**	3	2	0	1
Recent audit equates with which level	B	9	**65**	5	0	0	3

*Most frequent answers highlighted in bold font
*Some answers do not equal n = 82 as participants indicated more than one response

The results showed that individual participant's scores ranged from 1 to 9. The sample mean was 5.8. Some participants made more than one response to some questions. These questions were marked incorrect since each question was designed to have one 'right' answer.

Related to professional issues, Table 4.2 shows that 73% of participants knew that 450 hours of clinical practice were required for continuing competence requirements (*n* = 60). Hours of CPD were well understood, with 93% identifying that 60 hours of CPD were required (*n* = 73). Overall, 72% (*n* = 59) identified both clinical practice and CPD hours correctly. However, 6% (*n* = 5) were unable to correctly identify either the number of practice or CPD hours. Most participants appeared to understand their obligation to achieve 60 hours of professional development within a three-year

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period. Contrastingly, there were gaps in knowledge about required practice hours and a small group were unable to identify either.

When asked about professional requirements met by engagement with PDRP, participants provided 182 responses across all available options. Single, correct answer responses were provided by 44% (*n* = 36) participants. For multiple response answers, the most frequently chosen combination of responses (a, b, d) included the NZBS specific annual key knowledge and skills assessments and annual performance review in conjunction with Nursing Council continuing competence requirements. Whilst it is true that an NZBS portfolio requires the inclusion of all of these elements, the data appears to show that 21% (*n* = 17) of the cohort could not distinguish their regulatory continuing competency requirements from those of their employer. The remaining 40% (*n* = 33) showed no clear understanding of continuing competency requirements, identifying various incorrect response combinations. Questions related to PDRP support and resources showed participants lacked information and process clarity.

When asked about access to application and assessment forms, participants made 214 responses. Of these, only 12% (*n* = 10) were a single, correct answer. The low response rate here is of interest since the inability to locate support resources could impact on the ability to take part. Similarly, when asked to identify the person with whom the level of portfolio should be agreed, only 24% (*n* = 20) of participants could correctly nominate their Charge Nurse. Other participants incorrectly identified the PDRP co-ordinator (37%, *n* = 30) or the Clinical Nurse Leader (43%, *n* = 35). PDRP processes state clearly the need for a Charge Nurse to support an application at the outset of any work.

Although it appeared that access, support and continuing competency details were not universally understood, participants appeared to have more knowledge about the range of benefits associated with PDRP completion. This was shown by the 84% (*n* = 69) who knew that participation would exempt them from Nursing Council audit. If a nurse had already been audited, 79% (*n* = 65) knew that material presented to Nursing Council could be used to meet PDRP requirements at competent level. Participants understood that successful achievement of the Proficient and Expert/Accomplished levels would result in a financial allowance (73%, *n* = 60). Knowledge of study leave support was indicated by 80% (*n* = 66). Familiarity with the programme also extended to knowing that Nursing Council had approved the NZBS PDRP (91%, *n* = 75).

Overall, participants showed they understood most benefits of PDRP. However, there were knowledge gaps about PDRP requirements, especially those that related to Nursing Council recertification and authorisation from a Charge Nurse prior to starting. Further, there were participants who appeared not to appreciate the detail of their professional accountability to meet continuing competency requirements for example, hours of clinical practice and CPD. Yet, participants did seem to know that completion of a PDRP portfolio would exempt them from a Nursing Council recertification audit as well as providing other benefits like financial allowances. It appeared that participants did not perceive the commonality between PDRP and continuing competence was completion of their mandatory professional requirements. Even when nurses had completed a portfolio, their overall factual recall about PDRP did not appear to improve. Mean scores for the knowledge section were compared between those who had submitted a portfolio and those who had not using a two-sample unequal variance t-test. Group A (submitted portfolio) had a mean score of 5.95 compared with Group B

who had not submitted (*M* = 5.77). There was no significant difference between the means of the two groups (*p* = 0.27*).

4.4 Chain of response model results

Section 2 was designed to identify participants' attitudes to elements of Cross' (1981) Chain of Response model. The Chain of Response model illustrated the multiple facets involved in the adult learners' decision to participate in continuing education. The variables considered by Cross (1981) included self-evaluation; attitude about education; expectation that participation would meet personal goals; life transitions; information about the learning activity; together with support from others. To investigate, a 5-point Likert scale measuring agreement from strongly disagree to strongly agree with stem statements was used (See Appendix L, Section 2).

4.4.1 Self-Evaluation

Cross (1981) observed that previous learning experiences significantly influenced whether an individual felt they were capable of undertaking future learning opportunities. Therefore, the purpose of this section was to ask participants about themselves as a learner.

Three statements addressed the element of self-evaluation in Cross' (1981) model. Participants were asked to consider previous learning experiences in nursing. They were also asked if they believed engagement with further learning would enhance their clinical skills, and whether they believed they were capable of completing PDRP. The results are shown overleaf in Table 4-3.

Table 4-3 Self-evaluation responses

Self-evaluation	SD	D	N	A	SA	No answer
My experience of continuing professional development in nursing has been positive	3	9	25	**35**	8	2
Further learning will enhance my clinical skills	0	2	11	**36**	32	1
I am capable of completing a PDRP portfolio	0	2	9	**38**	32	1

*Most frequent answers highlighted in bold font

As a group, participants most frequently agreed they had had positive experiences of professional development in nursing; that completion of a portfolio was something they were capable of doing and, that further learning would have benefits for their clinical skills (see Figure 4-1). Summation of individual responses to determine attitude score for self-evaluation, showed most participants viewed themselves positively.

Figure 4-1 Self-evaluation: Individual attitude measurement summated scores
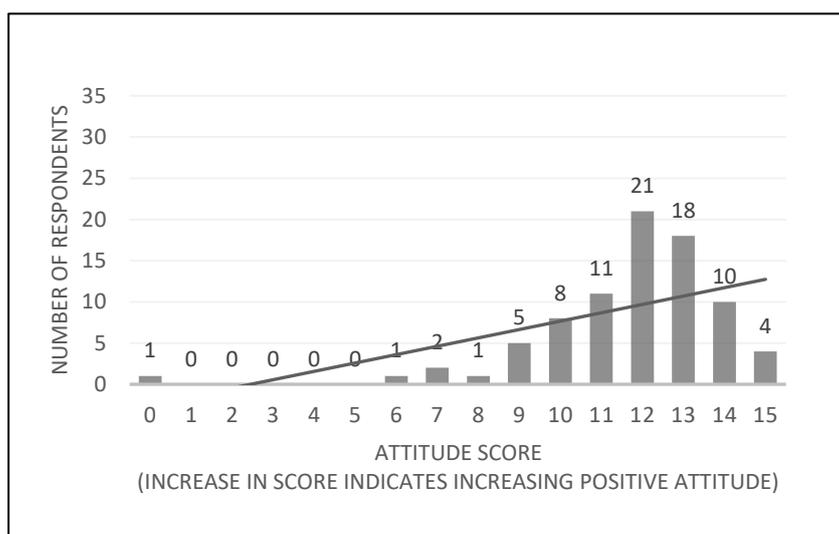
4.4.2 Attitude to PDRP completion (Education)

In the context of this study, PDRP portfolio completion was viewed as the education focus. Statements were designed to show participants' attitudes about whether they were motivated to complete a PDRP portfolio, if they believed engagement with PDRP had implications for their clinical practice and whether they felt

that PDRP was needed for continued development as a healthcare professional. The results are provided in Table 4-4.

Table 4-4 Attitude to PDRP responses

Attitude to PDRP completion	SD	D	N	A	SA	No answer
I am motivated to complete a PDRP portfolio	5	12	13	**35**	16	1
Completing a PDRP portfolio helps me to demonstrate my clinical capabilities	2	9	20	**34**	16	1
A PDRP portfolio is needed to evidence my continued development as a healthcare professional	4	6	15	**34**	20	3

*Most frequent answers highlighted in bold font

Of participants who responded, 63% agreed (*n* = 35) or strongly agreed (*n* = 16) that they were motivated to complete a PDRP portfolio whilst 21% of participants disagreed (*n* = 12) or strongly disagreed (*n* = 5) that they were motivated to complete a portfolio. A further 16% (*n* = 13) chose a neutral response. The majority of participants (61%) agreed (*n* = 34) or strongly agreed (*n* = 20) that portfolio completion was a means to demonstrate clinical capabilities and 65% agreed (*n* = 34) or strongly agreed (*n* = 20) that it was necessary to have a portfolio for evidence of continued development as a healthcare professional (*n* = 54). Yet, being motivated and feeling as though PDRP was purposeful had not translated into a large number of completed portfolio submissions. Furthermore, whilst the majority of answers appeared to be positive, summation of individual attitude scores illustrated that within the cohort, there were some who did not share the same view (See figure 4-2 overleaf).

Figure 4-2 Attitude to PDRP: Individual attitude measurement summated scores
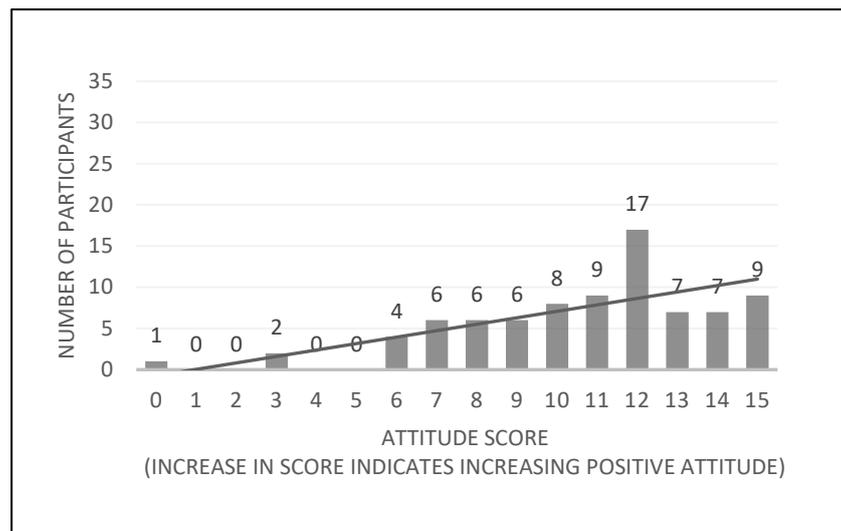
4.4.3   Expectation that participation will meet personal goals

Participants were asked how participation with ongoing learning would assist them in meeting personal goals. The statements shown in Table 4-5 were developed to obtain a perspective on the valency of PDRP as a means by which participants expected their personal goals could be achieved.

Table 4-5 Expectation that participation will meet personal goals responses

Expectation that participation will meet goals	SD	D	N	A	SA	No Answer
Producing a PDRP portfolio is useful for my career	2	7	15	**38**	19	1
I am confused about what PDRP helps me to achieve	7	**42**	16	11	5	1
Completing a PDRP portfolio is a relevant activity for me	2	8	22	**41**	8	1

*Most frequent answers highlighted in bold font

Participants either agreed (*n* = 38) or strongly agreed (*n* = 19) that PDRP was useful for their career. Most indicated they were not confused by what PDRP would help them to achieve indicating that they disagreed (*n* = 42) or strongly disagreed (*n* = 7) with the second statement about confusion with what PDRP helped to achieve. There was agreement also that completing a portfolio was a relevant activity for the 70% who either agreed (*n* = 41) or strongly agreed (*n* = 8). Yet again, summation of individual

data showed there were participants who did not have high expectations that they would meet their personal goals through PDRP (See Figure 4-3).

Figure 4-3 Expectation of meeting personal goals: Individual attitude measurement summated scores
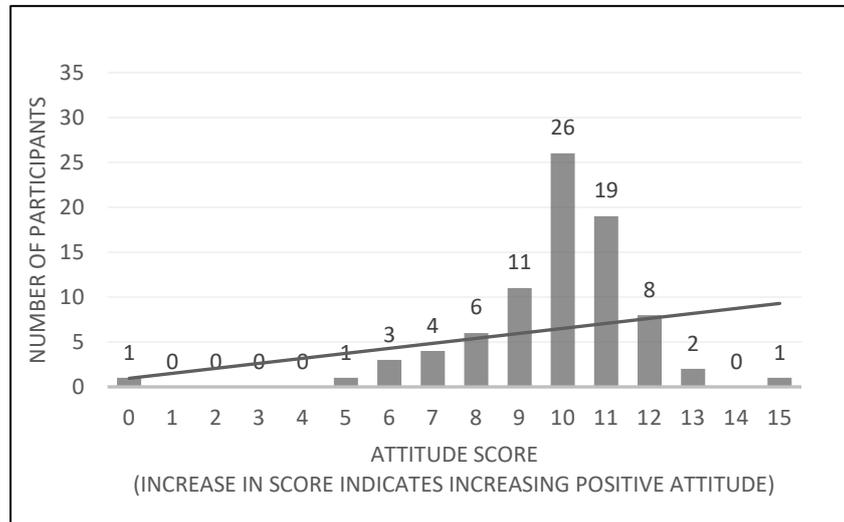
4.4.4 Life Transitions

The essence of Cross' (1981) discussion on life transitions in this questionnaire was considered as available time to spend on portfolio development. Thus, participants were asked to indicate their level of agreement with statements about time available at home or at work for completion of PDRP requirements. Results are shown in Table 4-6.

Table 4-6 Life transitions responses

Life transitions	SD	D	N	A	SA	No answer
I have sufficient time at home to complete the requirements for a PDRP portfolio	17	**31**	21	10	2	1
I have sufficient time at work to complete the requirements for a PDRP portfolio	22	**40**	12	6	1	1

*Most frequent answers highlighted in bold font

Time to complete PDRP requirements was clearly an issue for participants whether at home or at work. Here, 59% disagreed (*n* = 31) or strongly disagreed (*n* = 17) they had sufficient time at home and 78% disagreed *(n* = 40) or strongly disagreed (*n* = 22) that there was sufficient time available at work. This is an interesting perspective

since contractually, nurses are entitled to 2 days of study leave for portfolio preparation and in the knowledge section, 81% (*n* = 66) had indicated that this was understood. It appears that 2 days may not be considered to be sufficient. The individual summated scores, validated the observation that relatively few of the participants were positively disposed to the statements posed (See Figure 4-4).

Figure 4-4 Life transitions: Individual attitude measurement scores
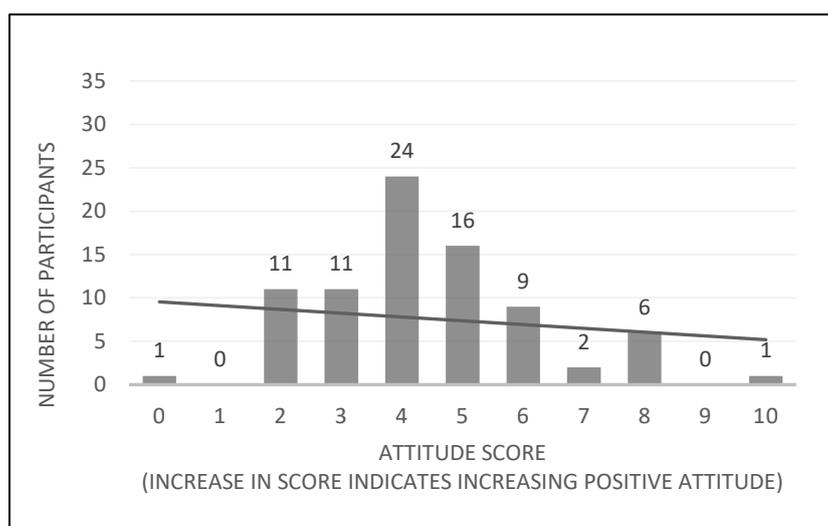
4.4.5   Information

In this case, information about PDRP programme requirements was needed in order to progress a portfolio. Therefore, this section intended to ascertain participants' attitudes to statements about information and available resources to support the development of a PDRP portfolio. The results are shown in Table 4.7.

Table 4-7 Information responses

Information	SD	D	N	A	SA	No answer
Information about getting started on the NZBS PDRP is readily available to me	0	3	17	**48**	14	0
My Professional Development Team is accessible to provide advice	1	7	17	**37**	20	0
Resources that help me to complete an NZBS PDRP portfolio are available to me	1	6	20	**42**	13	0

Most frequent answers highlighted in bold font

Information about getting started on PDRP appeared to be readily available to the participants. Of the participants, 76% agreed (*n* = 48) or strongly agreed (*n* = 14) that it was. Participants also agreed that the Professional Development Team was accessible to provide advice and that other resources to help complete a portfolio were available. Interestingly, participants had earlier indicated they were not clear about the location of information and other resources about the programme. The conflicting data appears to suggest that other sources of information might be more readily sought out than the electronic resources available via eLearn (NZBS elearning platform).

4.4.6   Participation

The final section drew on Cross' indication that reference groups like colleagues can have an influence on education uptake. Thus, participants were asked about the support they received from members of the clinical team. The results are shown in Table 4.8.

Table 4-8 Participation responses

Participation	SD	D	N	A	SA	No answer
My peers are supportive of me completing a PDRP portfolio	0	12	**38**	20	12	0
My Charge Nurse encourages me to participate in the NZBS PDRP programme	1	7	19	**44**	10	1
My Clinical Nurse Leader encourages me to participate in the NZBS PDRP programme	1	8	21	**37**	14	1
My Clinical Coach encourages me to participate in the NZBS PDRP programme	1	8	18	**38**	16	1

*Most frequent answers highlighted in bold font

Support from Charge Nurses, Clinical Nurse Leaders and Clinical Coaches was forthcoming with most frequent responses agreeing with the statements posed. However, participants were most frequently neutral about the support they received from their colleagues (46%, *n* = 38) although 40% agreed (*n* = 20) or strongly agreed (*n* =

12) that their peers were supportive. Charge Nurses, Clinical Nurse Leaders and Clinical Coaches appeared to be equally important in encouraging participation, suggesting that these roles are key to supporting nurses' PDRP.

4.5   Factors affecting the decision to participate

Section 3 focussed on factors that affected a decision to participate. The results are shown in Table 4.9.

Table 4-9 Factors affecting decision to participate

Factors affecting decision to participate	No	Minor	Neutral	Moderate	Major	No answer	Rank order
Understanding what I am required to prepare for my PDRP portfolio	4	7	4	32	**35**	0	**4**
Understanding how I am required to present my PDRP portfolio	2	9	10	**33**	28	0	9
Understanding what to write to validate Nursing Council competencies	2	7	6	32	**35**	0	**4**
Understanding how to write a reflection on my clinical practice to include in my PDRP portfolio	2	11	4	**35**	30	0	**4**
Understanding how to do a presentation to my colleagues to include in my PDRP portfolio	5	5	10	**31**	**31**	0	10
Knowing how to get started with putting a portfolio together	3	7	8	**34**	30	0	7
The encouragement I get from my workplace about completing PDRP	8	6	17	**28**	22	1	15
The links I can see between completing PDRP requirements and my clinical practice	8	6	17	**34**	16	1	7
Access to paid time off work to complete PDRP requirements	5	7	13	**28**	28	1	15
Getting support when I need it from the Professional Development Team	3	5	5	29	**38**	2	**3**
Being excluded from audit by Nursing Council if I participate in the NZBS PDRP programme	4	7	10	17	**43**	1	**2**
The amount of my own time I will have to spend on completing PDRP requirements	2	9	5	21	**44**	1	**1**
The allowance that is available for completing some levels of the NZBS PDRP	4	7	10	28	**31**	2	10
Thinking I can actually write about what is being asked	4	6	18	**29**	24	1	14
Feeling that developing a PDRP portfolio is a professional expectation	7	7	14	**30**	23	1	13
The personal financial costs associated with accessing professional development	4	13	**31**	17	16	1	10
Thinking I can achieve the required hours of professional development	12	13	14	**26**	16	1	17

Modes for each factor are highlighted in bold font

The purpose of asking about these factors was to determine the extent to which each one affected a decision to participate in the PDRP programme and whether there were any commonalities amongst NZBS nurses. The response scale was chosen specifically because it allowed response on the extent to which a particular factor affected their decision. It was not of interest at this stage whether the factors were perceived positively or negatively by an individual.

With the exception of one factor about which participants were most frequently neutral (the personal financial costs associated with accessing professional development), most participants indicated that each factor influenced their decision to a moderate or major extent. Therefore, to determine which appeared to be most important, the factors were rank-ordered by most frequently chosen response. Time, exclusion from Nursing Council audit, how to write Nursing Council competencies or a reflection, together with understanding what was required to be prepared for PDRP were the top factors. Clearly, having set these factors apart, further explanation was required.

4.6   Qualitative feedback

Additional written comments were invited in a free text section of the questionnaire. In this case, the purpose of inviting qualitative feedback was to add any factors that were particular to the participants and might not have appeared in the literature. Participants made 21 written responses covering a variety of topics. Their comments achieved the intended purpose and further, began to illustrate what it meant to be a PDRP participant. Four topics were identified as important to this small group. Free text responses were analysed using the inductive approach described by Braun and Clarke (2006). Themes are reported below, linked briefly to demographic

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variables. Miscellaneous individual comments are also reported because of the unique perspectives they provided.

4.6.1   The aging workforce

Insights into the issues facing older PDRP participants were provided by four respondents. Respondent 66 identified that she was in the over 50 age group and that she defined PDRP as being of little benefit because it would not help professionally when she was expecting to retire within a few years. Similarly, participants 33 and 28 who were also in the over 50 age group, felt that they too were coming to the end of their careers and would not be participating. These comments were echoed by respondent 38, a nurse in the same age group who had previously completed PDRP but reflected,

> *I found it so hard to complete and I am so close to retirement now I'm not going to bother.*

It appeared that reasons to complete PDRP were less compelling to older members of staff. Furthermore, there was a hint that for respondent 66 at least, the purposes of PDRP were disconnected from their professional or employment obligations.

4.6.2   Time

Although 'time available for completion of requirements' had been included as an attitude response in the survey, eight participants gave additional commentary on 'time'. It was clear that different contexts and definitions of time existed within the group. Three participants defined time as 'off duty' or 'personal time'. Here, they identified it was difficult to find time to complete a portfolio at home. Two participants did not elaborate on reasons why this was so, but respondent 82 showed the impact that time for PDRP completion had had on her personal life,

I can say that it takes a lot of my personal time to complete a PDRP. As a solo parent working full time this is a huge emotional stress that is not helpful in supporting my home and family life. It is a cost to my children and mental/emotional well-being that it is expected of me.

All three participants who referred to 'off duty' or 'personal time' had submitted portfolios on the NZBS PDRP programme. Participants 13 and 81 also indicated that the biggest issue with PDRP was the time it took to complete. These participants had not submitted a portfolio on the NZBS programme and it remained unknown whether they had completed a portfolio in a previous employment situation. Consequently, it was impossible to understand if this opinion was based on previous experience or on hearsay. However, further specific insights into how time had become an issue for PDRP completion were available.

Time was also defined as 'time to learn new skills' by two respondents. The skills involved appeared to make it possible to participate or to support others. Skills were listed as learning to type or to write a Nursing Council peer assessment. Paradoxically, 'time for writing Nursing Council peer assessments' was itself highlighted as a particular issue. One respondent indicated that it was hard to ask a colleague to complete a peer assessment as it was well known that these assessments could take time to do. The comment was validated by another respondent who explained how it could take a long time to complete a peer assessment. She had been approached by several staff to do so in the past and had found it a strain.

From the replies provided, it could be reasoned that the amount of time taken for PDRP completion at home was not welcomed. It seemed that attempting PDRP could also bring with it the need to learn additional skills which added to the overall time it took to complete. Moreover, for those who had persevered, their newly learned

skills became useful resources for other staff. Consequently, it seemed there was more pressure put on these individuals to make time to support others. Being successful with PDRP appeared to bring with it an unintended burden of committing even more time to support colleagues.

4.6.3 Accessing and using study leave

The Multi-Employer Collective Agreement (MECA) contract makes provision for two days study leave to support those who are preparing a PDRP portfolio. Interestingly, participants 40 and 41 stated that they had not known about their entitlement until they were completing the questionnaire. Both were from the same NZBS region. A respondent from a different region of NZBS had been able to access the study leave available, but commented,

> *Having the paid time given as 2 days spread out. This makes it difficult.*

Respondent 29 clearly also knew that study leave was available, but outlined that,

> *Staff have also started and not finished due to not being given the study time to do so.*

The responses appeared to show that information about and access to study leave had not reached all prospective PDRP participants and indicated that there was room for improvement in information provision. Further, when leave entitlement was understood, there appeared to be incompatibility between what was expected and granted when leave was applied for.

4.6.4 Valency of PDRP

Whilst the benefits of PDRP appeared to be well understood in the survey, the free text comments revealed the detail of portfolio requirements for each level might

not be. Respondent 68 called for more information and clearer expectations of what was actually required.

When PDRP was attempted, participants seemed to have little clarity about the relevance of requirements like a written reflection. Respondent 8 appeared to have started writing a reflection but had been hindered by the need to revise their work which left them feeling that what they had,

> *achieved so far [was] not on the right track at all.*

Another opinion was that PDRP was too hard to complete and academically focussed. Participant 38 thought the process was daunting and participant 71 had objected to receiving feedback about grammar and academic style. Yet another participant reported her focus had been directed towards getting the right academic language for Nursing Council competencies. Two other participants were concerned that PDRP was not an accurate reflection of work performance and capability and indicated that PDRP was more a 'paper exercise'. Another participant outlined that some people could write excellent portfolios but that these was not always reflective of their everyday contribution at work. Two others simply did not perceive that completing PDRP requirements would make them a better nurse.

Participants had not appreciated the educational value of PDRP in terms of being able to develop clinical practice. The impression of PDRP was that it had more academic, rather than practical, benefit. Therefore, for some of the participants, the valency of the learning activity on these terms appeared not to be a reasonable expectation or sufficient reward to warrant completion. Indeed, not even the prospect of receiving any associated benefits like exemption from recertification audit or financial reward, were sufficient leverage for the necessary valency to make it an option

for those 14 respondents who had not completed PDRP and who had provided free text responses.

4.6.5 Miscellaneous

Opinion on the financial rewards of PDRP were written about by three respondents. One comment provided insight into how this associated allowance became integral to the family budget.

> *The amount of time to complete versus the monetary gain is not worth the time or energy involved except that $74 per fortnight of one income would be missed if I didn't repeat my PDRP.*

Effectively, money had become the valency for this participant, rather than any of the intended professional development goals.

The predicament of those who had English as a second language was also described in the comments. One participant reported being reluctant to start PDRP as communicating in written English on the topics outlined in the application brochure was too difficult.

4.6.6 Answering the quantitative phase questions

The data from the survey gave significant insights into nurses' knowledge of NZBS PDRP, its associated processes, resources and support; their attitudes to it as a learning activity, and the factors that influenced their decision to participate. This data was gathered to answer the questions posed in this phase of the study. In the subsequent sections, each question is answered using that data. Areas for further explanation were identified and are used as justification for the questions to be posed in the second, qualitative phase of the study.

4.7 What do NZBS nurses understand about PDRP?

More than 75% of the survey participants were knowledgeable about the hours of professional development and clinical practice requirements that needed to be evidenced. Equally, benefits of the programme for example, exemption from recertification audit and allowances that became due were well understood. However, there remained a substantial number of participants who could not provide accurate answers to the PDRP basic fact questions. When asked to put PDRP requirements into a wider professional context (e.g., their relationship to continuing competence requirements for Nursing Council), less than half of the sample responded correctly. It was evident that their knowledge about the connection between PDRP and Nursing Council continuing competence requirements was lacking. Further, those who had participated in PDRP did not appear to assimilate any additional information about the wider perspective of PDRP through its completion. Yet, responses to the attitude statement about whether there was confusion about what PDRP achieved suggested participants were not at all confused. This insight might mean that participants have a different view of the role and purpose of PDRP than that intended by the Professional Development Team (see page 24). Therefore, it appeared that participants' understanding of the purpose of PDRP and its relationship to continuing competence requirements needed further explanation.

4.8 What are NZBS nurses' attitudes to PDRP?

Generally, the questionnaire responses created the impression that participants had a positive view of themselves as learners and PDRP as a learning activity relevant to nursing. These findings are perhaps not surprising since this group of adults are already

established as successful learners having achieved nursing qualifications. Furthermore, attitude to PDRP as an education option were also positive and participants indicated that PDRP was a relevant activity, useful to their careers and they knew what it would help them to achieve. As an activity, participants indicated PDRP met conditions for both expectancy and valency defined by Cross (1981). Motivation to engage was also observed to be high yet, engagement rates remained low and therefore, reasons why high motivation did not translate into a completed portfolio needed further explanation. However, the positive disposition to PDRP did not describe the perspective of all participants. A subset existed who did not appear to view themselves as being capable of completing PDRP, positive about the activity or believe that it would serve their interests. Unfortunately, given the design of this study it was not possible to follow-up with these particular participants because inclusion in the second phase was by self-selection.

The data also held conflicting accounts about the availability of information and PDRP resources between the knowledge and attitude sections of the questionnaire. The data appeared to suggest that other information sources might have been used since it seemed that digital resources were not well comprehended. Avenues sought and used by nurses for provision of PDRP information needed further explanation.

Promoting PDRP engagement seemed to come via encouragement from senior nurses. Here, participants most frequently identified Charge Nurses, Clinical Coaches and Clinical Nurse Leaders. Their encouragement however, had failed to translate into the submission of a high volume of completed portfolios and again, needed further explanation.

4.9   What affects NZBS nurses' decisions to participate in PDRP?

There appeared to be a number of factors that affected nurses' engagement with PDRP. No one factor was universally regarded as the most important by the group even though some appeared to be more important than others. As a naïve mechanism, rank-ordering gave perspective to those factors which were most important to the group. These factors reflected themes that were also encountered in the qualitative section of the questionnaire for example, time to complete PDRP. Having crudely identified the factors with the most meaning to the participants, the opportunity to explain why they were important needed to be followed through into the next phase of the work. Furthermore, the individuality of factors affecting participation needed to be explained. It was evident in data from the attitude scale that some nurses felt completely differently about the proposition of PDRP. It was possible that a personal landscape of factors affecting the decision to participate existed and could not be discounted without explanation.

Qualitative responses provided some context on factors that had not been documented in the literature. In particular, age had not been found as a feature of discussion in a large amount of literature and, given the aging workforce, the relevance of PDRP to this group is worthy of consideration. The qualitative data also gave the impression that issues had been identified in accessing study leave. Further, understanding the educational point of the requirements seemed problematic for some, and still others appeared not to have benefitted from the type of advice received on draft written work.

4.10 Development of questions for the qualitative phase

The previous analysis of the data revealed pertinent topics to be explored with nurses who volunteered to be interviews in Phase 2. The following tables indicate the questions to be asked and each is justified. The tables relate to questions developed from the knowledge, attitude and factors sections of the survey. Table 4-10 begins with those questions developed from insights in the information about PDRP section of the survey. Question 6 was intended to provide opportunity to explain overall reasons for engagement with PDRP.

Table 4-10 Semi-structured interview questions originating from section 1 of the questionnaire

Section 1: Questions for data explanation	
Questions	**Justification**
1. Continuing competence requirements are a relatively recent addition to APC renewal. What has been your experience of the process?	Comfortable, familiar experience to start the interview. Opportunity to relax into the interview and to build rapport.
2. What evidence do you have to provide? Probe: Why?	Opportunity for nurses to explain their understanding of Nursing Council recertification processes. Provides opportunity to explain understanding of interconnectedness of requirements and if the role of PDRP is explained.
3. What would Nursing Council consider to be appropriate evidence for continuing competence validation?	Gives nurses the opportunity to explain the activities and behaviours they undertake to meet continuing competence requirements and if the role of PDRP is explained.
4. Do you ever need help to complete your validation? Probe: What kind of help is required?	Nurses can explain if needed, what they have difficulty with during their recertification process. Options to explain how they might get around any issues and if the role of PDRP is explained.
5. What options do nurses have available to them to assist completion of continuing competence requirements?	Nurses can explain the options they see as being available and if the role of PDRP is explained.
6. Have you ever participated in PDRP? Yes: Probe for reasons why No: Probe for reasons why not	Nurses can explain their reasons for participation choice.

Participants had shown in section 2 of the survey that they viewed themselves as being capable of completing PDRP, positive about the activity or that it would serve their interests. Other data exposed in section 2 gave rise to the need to explain participants' high motivation but lack of follow through with portfolio completion. Further, access to supporting resources and information for PDRP could not be clearly understood from the quantitative data and required explanation. So too, the role of the Charge Nurse, Clinical Nurse Leader and Clinical Coach. Questions developed from section 2 data are shown in Table 4-11.

Table 4-11 Semi-structured interview questions originating from section 2 of the questionnaire

Section 2: Questions for data explanation	
Questions	**Justification**
7. In the survey, some nurses described themselves as being motivated to complete a PDRP portfolio, but only a few of them had chosen to do so. Why might nurses be motivated to complete PDRP? Probe: Do (reasons provided) apply to you?	Nurses able to explain motivational factors in third person and then consider application to themselves.
8. In the survey, some nurses strongly agreed that their Charge Nurse (more than any other senior nurse) encouraged them to participate in the NZBS PDRP. Why might nurses think it was important for the Charge Nurse to encourage participation? Probe: Do (reasons provided) apply to you?	Nurses able to explain how Charge Nurse encourages participation in third person and then consider application to themselves.
9. In the survey, some nurses indicated that factors related to available PDRP resources strongly affected their decision to participate in NZBS PDRP. Why might a nurse's decision to participate be affected by PDRP resources? Probe: Do (reasons provided) apply to you?	Nurses able to explain how available PDRP resources affected participation in third person and then consider application to themselves.

The remaining questions were based on Section 3 data and commentary provided by participants in the factors affecting participation section (See Table 4-12). Of all the factors the nurses were asked to make a response to, use of the participants' own time was most frequently indicated in the strongly agree option. Further comments were provided in the comments section and these responses illustrated a variety of perspectives. As such, 'time' was selected for inclusion at interview.

The additional free text comments had provided a perspective of factors that had not appeared in the literature. Age and financial allowances were highlighted by participants. Simply because of its relationship to future workforce predictions, 'age' was selected for further explanation. The comment related to financial allowance in the free text section, showed how it had become intrinsic to one family's functioning. Motivation and valency for this respondent were beyond the reach of professional or education objectives, it was purely personal. Given that allowances for PDRP are always part of negotiations at MECA bargaining, and the implication that financial allowance affected the decision to participate in PDRP to the least extent, it was worthy of further explanation. The final two questions in the interviews were designed to facilitate the opportunity for participants to offer their thoughts on PDRP to both NZBS and Nursing Council. It was a way to encourage interviewees to have their say.

Table 4-12 Semi-structured interview questions originating from section 3 of the questionnaire

Section 3: Questions for data explanation	
Questions	**Justification**
10. In the survey, some nurses indicated that factors related to time for completion strongly affected their decision to participate in NZBS PDRP. Why might a nurse's decision to participate in PDRP be affected by time? Do (reasons provided) apply to you?	Nurses able to explain 'time' in third person and then consider application to themselves.
11. In the survey, some nurses indicated that factors related to PDRP requirements strongly affected their decision to participate in the NZBS PDRP. Why might a nurse's participation be affected by the requirements? Do (reasons provided) apply to you?	Nurses able to explain how available PDRP requirements affected participation in third person and then consider application to themselves.
12. In the survey, some nurses indicated that factors related to Nursing Council competencies affected their decision to participate in the NZBS PDRP. Why might a nurse's participation be affected by Nursing Council competencies?	Nurses able to explain how Nursing Council competencies affected participation in third person and then consider application to themselves.
13. In the survey, some nurses indicated that factors related to age strongly affected their decision to participate in the NZBS PDRP. Why might a nurse's decision to participate be affected by age? Do (reasons provided) apply to you?	Nurses able to explain 'age' in third person and then consider application to themselves.

14. In the survey, some nurses indicated that factors related to the financial allowances available strongly affected their decision to participate in NZBS PDRP. Why might a nurse's decision to participate be affected by a financial allowance?	Nurses able to explain how available PDRP allowances affected participation in third person and then consider application to themselves.
15. The survey and interview may not have covered all commentary that an individual participant would like to acknowledge. This question invited additional comments about the NZBS PDRP	Nurses able to explain particular views on NZBS PDRP that might not have been adequately covered elsewhere.
16. The survey and interview may not have covered all commentary that an individual participant would like to acknowledge. This question invited additional comments about Nursing Council and PDRP.	Nurses able to explain particular views on Nursing Council' role in PDRP that might not have been adequately covered elsewhere.

4.11 Summary

This chapter has presented the results obtained from 64% of the 129 New Zealand Blood Service nurses who participated in the survey phase of this study during June 2016. Data presentation and analysis has largely followed the order of the questionnaire to provide structure and logical flow. The relationship of this phase to the next, explanatory phase has been identified and questions developed to enable explanation of key data findings. In the following chapter, data from the qualitative phase of the study will be presented using the questions developed here. Discussion of the data from both phases will be presented in Chapter 6 culminating in the achievement of the overall research aim which was to explain NZBS nurses' engagement with PDRP.

5. Qualitative Results

5.1 Introduction

In the previous chapter, data from the quantitative phase of the study was analysed, giving rise to the development of questions to be posed during the semi-structured interviews planned for the qualitative of the research. In this chapter, results from the qualitative phase of this mixed-methods study will be presented. As with all explanatory sequential mixed-methods designs, the intention of the qualitative phase is to add context to the quantitative findings and ultimately, to explain phenomena identified. For this study in particular, the purpose of doing so is to explain factors that, in the quantitative phase of the study, appeared to have most strongly affected nurses' decisions to participate in the New Zealand Blood Service (NZBS) Professional Development and Recognition Programme (PDRP). The semi-structured interview schedule is used to organise the remainder of the chapter and to support presentation of the subsequent data analysis. Verbatim quotations are used to illuminate themes that emerged from the explanatory data.

5.2 Process

Using the processes presented in Chapter three, 36 participants identified they could be contacted for interview. Interviews were arranged with 15 volunteers and 14 were completed owing to one late withdrawal due to family circumstances. Data analysis began immediately after transcription was completed. Vignettes in Table 5-1 are presented to give the reader some key facts about the nurses who participated in the interviews.

Table 5-1 Nurse Vignettes

Nurse A
Nurse A has never been audited and has submitted a PDRP portfolio.

Nurse B
Nurse B has never been audited and is working towards completion of a PDRP portfolio.

Nurse C
Nurse C has never been audited or submitted a portfolio.

Nurse D
Nurse D has never been audited or submitted a portfolio.

Nurse E
Nurse E has never been audited or submitted a portfolio.

Nurse F
Nurse F has never been audited but has submitted a PDRP portfolio.

Nurse G
Nurse G has never been audited or submitted a PDRP portfolio.

Nurse H
Nurse H is working towards completion of a PDRP portfolio.

Nurse J
Nurse J has never been audited but has completed a PDRP portfolio.

Nurse K
Nurse K has been audited and has never submitted a portfolio. Nurse

Nurse L
Nurse L has been audited and is working towards completion of a PDRP portfolio.

Nurse M
Nurse M has completed a PDRP portfolio and has been audited.

Nurse N
Nurse N has never completed PDRP and has never been audited.

Nurse O
Nurse O is working towards completion of a PDRP portfolio.

5.3   Meeting continuing competence requirements

The interview schedule began with a series of six questions. Participants talked about their experience of Annual Practising Certificate (APC) renewal; a process which

was expected to be familiar. As such, it was a topic likely to reduce any nervousness at the outset of the interview. Survey data had shown most nurses understood there were three components to Nursing Council's continuing competency requirements. However, less clarity was observed in answers about the relationship between continuing competency requirements and PDRP. Consequently, further explanation was needed.

Nurses explained how they had developed their understanding of the process and its requirements. Through analysis, four categories were identified which explained nurses' knowledge and perception of the processes and personal involvement required. The categories were labelled as, learning how, knowing what was needed; meeting what was being asked, and the value of the PDRP/continuing requirements relationship.

5.3.1 Learning how

Establishing the connection between continuing competence requirements and APC renewal appeared to come through first-hand experience of either selection for recertification audit or PDRP engagement. Engagement with either process appeared to add clarity about how to meet prescribed requirements and ways that competencies for the scope of practice could be validated.

Nurse K defined the process when she told of her Nursing Council audit within the last three years. She was preparing for PDRP at the time of her selection for audit and realised how she could use evidence already prepared to meet audit requirements. Nurses M and J showed how PDRP had a similar role for them, developing their appreciation of the depth required to validate Nursing Council competencies,

> *…until I did my PDRP I don't think I fully understood the [Nursing Council] competency requirements. (Nurse M)*

> *…unless you have a PDRP you don't actually have any way of backing up that you have met your [Nursing Council] competencies. (Nurse J)*

5.3.2 Knowing what was needed

Knowing what was needed also came from engagement with PDRP or selection for recertification audit. Nurse O had almost completed a PDRP portfolio and was able to define what would have been needed to meet continuing competency requirements,

> *I would have completed the domains and give[n an] example for each domain and also having another person reviewing my practice as well and to have all my practising hours on a written piece of paper so it can be seen and my training hours as well.*

Like Nurse O, others who had been through the relevant processes knew that Nursing Council competencies needed to be validated with examples from clinical practice and that peer assessment was also required. Furthermore, they identified similarities between the two sets of requirements including the individual's exemption from recertification audit for the next 3 years. Their insight further extended to knowing validation of continuing competence requirements was relevant to the integrity of their on-line application for renewal of an APC.

Among those who had not been audited or engaged with PDRP, knowing what was needed was not top of mind,

> *I would have to look it up, I know there is evidence of education hours. (Nurse N)*

> *400 hours' worth of working in an arena to do with nursing practice and that is all I know really to do with keeping up with my licence. (Nurse D)*

> *I'm just presuming that they just probably want 60 hours education…… I don't know the others. I'm looking into it. (Nurse C)*

APC renewal, recertification audit and PDRP processes were explained by this group as a series of separate, unrelated events. Nurses explained how APC renewal reminders and recertification audit requests came from Nursing Council. Random

selection could be made at any time. Recertification audit however, could be avoided

by undertaking PDRP. In other words, the extent of nurses' explanation of the

relationship between PDRP and continuing competence requirements was limited to

exemption from recertification audit. There was no evidence of their understanding of

the commonalities between recertification audit and PDRP or that completion of either

would mean continuing competence requirements had been met.

When exploring the evidence needed by Nursing Council if asked, there was

little recognition of what was acceptable. Nurses D and C for example, both proposed

that their annual 'key knowledge and skills' clinical assessments for the NZBS internal

regulatory cycle were sufficient. The lack of ability to distinguish between their

professional competencies and job related ones indicated they likely misunderstood the

purpose of both. The extent of their misunderstanding might also mean these nurses

are not clear about what is being asked during the on-line APC renewal process.

5.3.3   Meeting what was being asked

On-line APC renewal asks nurses to declare whether they meet the continuing

competence requirements. As it is, the process relies heavily on the veracity and

integrity of the nurse completing the form. It assumes nurses have sufficient

knowledge of validating continuing competence requirements and that they have done

so. The latter point was illustrated by Nurse M who had recently completed a PDRP

portfolio,

> … with the Practising Certificate you find it's pretty much just ticking
> off boxes … it kind of relies on the fact that you understand them and
> are doing the right things.

Nurse G, who had not completed a PDRP portfolio or been selected for recertification audit, echoed the sentiment,

> ...a lot of that is done on trust … that the RNs are completing them
> correctly and understanding them correctly.

There did not appear to be any distinction between the ideas of those who had or had not done PDRP. All nurses seemed to know that there was a need to be able to demonstrate APC requirements, even though evidence did not need to be physically produced for the on-line application. Not having to provide evidence on-line however seemed to equate with not doing anything for some. It appeared that unless PDRP or recertification audit had been completed, nurses did not collate evidence substantiating how they met continuing competence requirements. Nurse C explained it had not been done because,

> It's just a challenge of putting it into a formal document.

Nurse D elaborated,

> I do have it in the back of my mind that I would need to prove in a
> written form that I am able to meet the types of competencies that
> they [Nursing Council] are looking for.

Examples were found where nurses were 'caught out' having not completed the necessary information for APC renewal. Nurse L was selected for recertification audit having never completed PDRP or documented how she met APC requirements. She explained,

> ...you sort of dodge the bullet, don't you, for so many years?

The idea of 'bullet dodging' for Nurse L meant selection for recertification audit had been avoided. Consequently, she had never needed to document how she met requirements. In other words, non-selection for recertification audit excused evidence

preparation. More, this activity was postponed until the next APC renewal date when the cycle of 'bullet dodging' began again.

5.3.4 The value of the PDRP/Continuing requirements relationship

Nurses described their reasons for undertaking PDRP at all. Its valency was apparent to those who had seen PDRP and continuing competence requirements similarities. Consequently, expectation that participation would 'meet personal goals' anticipated in Cross' (1981) model, appeared in some narratives. The prospect of being excused from recertification audit had sufficient valency to encourage Nurse A among others. Whilst identifying that she didn't go into the process willingly, Nurse A shared,

> *I knew it was here to stay so there was no point fighting it, but I had to work through it myself to see the value between doing a PDRP and the correlation with the competencies for our Practicing Certificate.*

Yet, not all nurses who had made the connection between avoiding recertification audit and PDRP completion, had submitted a portfolio. Each offered a particular reason why this was so.

Nurse G had experienced several consecutive, unexpected lifestyle changes which had derailed her attempts to complete the work required; Nurse B had been prevented from submitting because her peer assessor had left the organisation unexpectedly at short notice and she had been unable to find a substitute at the time of interview. Nurse O had one mandatory NZBS training event to complete which was scheduled for the day after interview. These examples gave a window of explanation on how the life transitions predicted by Cross (1981) could impact the best of intentions to complete the work and, that institutional factors like training schedules and staff turnover, were not to be discounted from the participation equation.

Contrastingly, some nurses made no such connection. Nurse C suggested one

solution would be to link PDRP and Nursing Council requirements so as to avoid audit.

Nurse D indicated that PDRP and recertification audit requirements were a 'little

removed from each other'. When asked if there was a relationship been PDRP and an

APC, Nurse N said, 'To be honest no'.

Nurses E and K were a unique pair within the group. These nurses had either

undertaken PDRP prior to being employed by NZBS or had been selected for

recertification audit. They were familiar with continuing competence requirements and

PDRP connections. Yet, neither had opted to participate in the NZBS PDRP programme.

These nurses showed how significant perceived valency of the activity was to the

individual. Nurse K discussed her recertification audit. Indicating why she did not

transfer into the NZBS PDRP as she could have done she said,

> *…it is not that hard to be audited anyway, so, because I have already*
> *done it I know how that works. So in terms of just normal practice*
> *every day I don't know about the benefits of PDRP… [why] doing that*
> *would benefit my practice...*

For Nurse E, the picture seemed more complicated. The level of PDRP applied

for interfered with assessment of Nursing Council competencies,

> *I'm signing that certificate [on-line APC] to say that I am up to date*
> *and I don't necessarily need external validation for that…For a PDRP*
> *you need [an] external to say, yes, you are practising at that level.*
> *And that's where the disconnect happens. You've got to meet their*
> *expectations … at that level [PDRP and APC] … but they obviously*
> *thought, no, you're not achieving that level. It wasn't achievable.*

Evidently, professional development outcomes of PDRP were not considered part of the

valency of PDRP for Nurse K. For Nurse E, being held accountable to produce a higher

standard of validation evidence for recertification requirements within PDRP had

diminished any valency at all. Neither saw any benefits to completing PDRP to advance their own practice.

The inclusion of continuing competence requirements within PDRP was only helpful to those who recognised their intrinsic relationship. Appreciation of the relationship had given rise to the explanation by some, that PDRP engagement was a means to avoid recertification audit. Yet, the perspective of Nurses E and K had revealed that even where professional requirements were well understood, the valency of the PDRP activity remained a significant determinant of the individual participation outcome.

Unlike their progress in understanding the relevance of recertification requirements, engagement with PDRP did not appear to develop understanding of how PDRP related to professional growth. The reasons to complete PDRP at NZBS was to support nurses to develop expertise. Yet, whether or not PDRP had been completed, participants never explained engagement in terms of their professional development.

5.4 Factors affecting engagement

In the survey, nurses were asked to rate agreement with statements about factors affecting their decision to participate in PDRP. The factors had been highlighted in the literature as influencing nurses' participation in other forms of CPD. Responses were designed to elicit the level of agreement about which factors most strongly affected nurses' decisions to participate. Responses did not identify whether the affect was positive or negative, nor did the survey ask for explanation. Eight factors affecting participation were followed up for detailed explanation at interview (See Chapter 4 for detail of factor selection).

5.4.1 Time

The word frequency report generated in NVIVO showed that overall, 'time' appeared most often (1.1% coverage) in the interview transcripts. The category, 'time' had already been identified in analysis of the free responses given in the quantitative data. In that data, the sub-categories were defined as 'personal time', 'time for learning new skills' and 'time for writing Nursing Council assessments'. Similarly, interview data demonstrated the existence of the sub-theme 'personal time' which was defined in the same way as in the quantitative data. Additionally, 'having time' to complete PDRP also existed in the narratives. No evidence was found in the interviews to support continuation of the theme 'time for learning new skills'. Nursing Council competence assessment was a discrete question and is reported elsewhere in this chapter (See section 5.4.5).

Personal time

Personal time was defined as, 'the time spent outside normal working hours to complete PDRP' and did not include study leave available for portfolio preparation. Two new views of personal time were found, adding to the quantitative data findings. First, the belief that portfolio completion at home was an inevitability illustrated by Nurse E,

> *But it had to be like that. If I wanted to do it, I had to do it outside of work. I didn't have a chance to do any inside of work, it was just [an] impossibility.*

Second, the more common view, like that of Nurse G who explained,

> *…people are not wanting to go home and then spend hours and hours and hours doing work, which they're effectively not paid for.*

Nurse A thought nurses begrudged spending personal time on PDRP. Nurse J also acknowledged nurses did not like to do PDRP at home. She further proposed the

explanation that engagement with PDRP might actually depend on whether it was viewed as a work or personal activity. Yet, any resentment associated with using personal time on a work-related activity was not detected in the narratives of those still to submit.

Making time

Nurses who had not engaged with PDRP showed they were well aware that completion would require some of their own time. They explained how they felt uncomfortable to work on PDRP where time did become available at work. One interviewee explained that it 'didn't feel right' to be working on PDRP whilst colleagues were completing other clinical duties. Nurse N added it was also difficult to switch focus between clinical duties and portfolio requirements. Nurses L and B noted they took annual leave to progress with PDRP. Nurse O had opted to work on PDRP for two hours at a time at home to make progress. Nurse J provided yet another perspective.

For Nurse J, PDRP completion was a professional responsibility. As she saw it, PDRP was about her clinical practice and demonstrating she was competent regardless of where she worked. Nurse J stated that she was accountable for managing her PDRP process and for this reason, completion was an acceptable use of her personal time. Knowing the requirements for continuing competence, Nurse A also explained that individual nurses had to take responsibility for PDRP completion. This included making personal time available.

Nurses J and A illustrated how learners were more likely to be motivated to achieve where valence and expectancy were high for the individual (Cross 1981). In this case, these nurses explained their participation in terms of professional valency and expectation in terms of meeting professional goals. Like Nurses J and A, there were

more who saw time for PDRP completion as a professional responsibility. Other explanations of 'personal time' revealed an element of resentment about the use of personal time for PDRP completion. Yet, the apparent dichotomy of opinion on this issue might well have been facilitated by the nurses' contractual agreement (MECA) which required the employer to make provision for study leave for PDRP preparation. Yet, accessing that study leave was shown to be difficult.

Accessing and using study leave

From their different NZBS regions, Nurses L, E, A and G reported that they had each experienced difficulty in securing study leave or had observed others being recalled to work to backfill sickness and to staff clinics when the workload was unexpectedly high. The lack of commitment to honour study leave for PDRP appeared to give participants the unfortunate impression that managers did not view it as a priority. Whether participants believed the study leave provision was actually sufficient was not explained in the narratives even though it had seemed worthy of consideration following analysis of the phase 1 data (see section 4.4.4).

Having the time

'Having the time' to complete PDRP was based on the amount of time nurses thought completing a portfolio would take. Two nurses estimated it could be achieved in a matter of days (Nurses M, J), whilst three others (Nurses G, A, L) thought longer. Evidence from the data showed explanation for not 'having the time' included situational factors like family commitments and institutional factors such as information about how to access resources. One respondent (Nurse D) evaluated themselves as likely to be slow to achieve a portfolio because they were very thorough. This nurse's statement was important because of the inference that she would therefore, need to

have a lot of time for PDRP completion. Furthermore, Nurse D's statement was reflective of another aspect of Cross' (1981) model because it showed how self-evaluation for example, as slow to complete, might impact on starting or progressing with the endeavour. As Cross' (1981) suggested, self-evaluation might be the beginning of the chain of response leading to participation.

5.4.2   Role of the Charge Nurse or Direct Manager

The importance of the Charge Nurse as the gatekeeper of leave appeared in nurses' narratives about 'time'. Further analysis identified that their impact extended to whether they provided encouragement and endorsed the nurse's level of application. Evidently, a 'PDRP-friendly manager' was essential to overall progress. Nurses explained that the Charge Nurses' actions set the tone of expectation and ensured the appropriate conditions for completion were facilitated. Nurse E defined the importance of the Charge Nurse's role for those who had ever attempted PDRP,

> *you are more likely to do it [PDRP] because your boss is saying you are*
> *good enough. (Nurse E)*

Those who had not engaged with PDRP also explained their view of the Charge Nurse. They too saw encouragement and support as central to the role. Nurse D suggested,

> *If you are endorsed by your Charge Nurse, it gives you confidence*
> *because then there is someone there that believes that you can do it.*

For others, PDRP-friendliness of the line manager was explained in terms of leadership ability. Nurse O summarised,

> *Well, she's the person in charge and if she doesn't lead people to do it*
> *then how would you feel encouraged to do it?*

Conversely, nurses used the absence of any leadership stance to explain their non-participation. Nurse L related the following,

> It wasn't pushed…none of us had done one because it wasn't encouraged. It wasn't spoken about.

It appeared that for some, the culture of expectation of PDRP completion created by the Charge Nurse was instrumental to even getting started.

From the data it appeared that the 'nearness' of any encouragement was also relevant. For some staff at NZBS, the Charge Nurse was not on site each day. Instead, she managed a region which placed her in the main centre more frequently than at the sub-regional centre. For nurses in the sub-regional centres, the perspective of the 'next best' leadership influence (on-site Clinical Nurse Leader or Clinical Coach) appeared to be essential for those nurses geographically removed from their Charge Nurse. This was illustrated in the interviews with Nurses K and A who identified the 'next best' leader also needed to be knowledgeable about PDRP processes and requirements.

The Charge Nurse's role in PDRP participation appeared to go beyond that of simply being the gatekeeper of study leave. More, nurses explained that they needed ongoing support and encouragement from their leader. A PDRP friendly manager could act as both advisor and cheerleader and effectively, rubber stamp PDRP as a worthy activity. Yet, the need for constant external validation and support to enable individual progress was potentially a metaphor for lack of confidence. This is a critical finding in the light of quantitative data which appeared to show a positive disposition to the availability of resources and information required to support nurses' PDRP participation. It seemed that provision of resources was well received, but needed

enhancement from a 'knowledgeable guide' to assist navigation of the process. The latter point was illustrated in conversations about PDRP requirements.

5.4.3   PDRP Requirements

When nurses explained how PDRP requirements affected engagement with PDRP, they defined them as 'daunting' and initially difficult to 'get the hang' of. PDRP requirements extra to continuing competence requirements were designed to facilitate provision of evidence in support of developing expertise. Requirements included for example, a written case study, a teaching session or account of practice development. Nurses referred to these colloquially as the PDRP 'options work'. Whilst 'Competent Level' adds only NZBS mandatory training requirements like annual clinical procedure assessment, fire training or first aid for example, Proficient and Expert levels require additional written work like those previously outlined. These levels were singled out for further conversation and two key concerns were raised: nurses' understanding of the kind of evidence that would validate their practice at these levels and belief in their own capability to complete them. Nurse N summarised how what was required affected a decision to participate,

Some requirements … will definitely put you off.

Others explained what those specific requirements were. The presentation was the least liked especially where nurses were 'shy' or as Nurse H reported, did not believe that they had the relevant skills. It was a view also shared by Nurses J and O who had completed, or were at least part way though, their respective portfolios. Interestingly, the alternate option to a presentation, to reflect on being a preceptor for a new member of staff, did not feature in the narratives. Working alongside someone and sharing knowledge appeared to be a less daunting proposition than presenting.

Elsewhere, how PDRP requirements affected the decision to participate was explained by the amount of writing or volume of work. Nurse C indicated that the challenge was in the writing and putting it on paper. Nurse K suggested that anything higher than Competent would have a lot more work involved. The obvious message in the narratives appeared to relate to time to complete the work. However, it is also worthy of acknowledging that confidence to write or 'put it on paper' could just as easily be reflective of nurses' lack of confidence in the context of the interviews.

5.4.4   PDRP Resource availability

Nurse A summarised the group view when she said that she found the resources available to support the PDRP process to be excellent. Nurse F found that on-line resources made access even easier and meant they could be used at home. Having the information all in one place assisted participants in 'getting a feel' for PDRP. Where issues were explained, they were mainly in regard to resources being exclusively on-line. Here, Nurse N explained the idea of having to 'learn eLearn' (the NZBS e-learning platform used as a repository for PDRP material) as being an additional task in the process of PDRP completion. Nurse N's explanation was reminiscent of the quantitative data where nurses explained about 'time to learn new skills'. However, others commented on the practical problems of an on-line environment. Nurse E identified initial difficulties in locating e-resources and remembering where they were for later access. Nurse B contended that forgetting passwords could deter some staff members. It did not appear that there were insufficient resources rather, on-line access was problematic for a few. Greater diversity of opinion was evident however, in relation to allowances for proficient and expert levels.

5.4.5 PDRP allowances

Whether nurses had completed PDRP or not, explanation about whether PDRP allowance affected their decision to participate focussed on more than money. Those who had completed PDRP indicated that personal development and the challenge of learning new things had been their main motivation to complete PDRP. Nurse F seemed to suggest the amount of money was trivial, that it might buy a coffee a week. Nurse J however, viewed the allowance as a benefit for something she intrinsically believed was part of her professional accountability,

> *It would have been quite easy to stay at competent…but you think oh*
> *well it is not that much more work and I get a good bonus from it, so*
> *why not.*

Whilst Nurses H, N and L had not participated in the PDRP programme, they reported the financial allowance would not have been their primary motivator in any case. Nurse H considered,

> *It's not only that [allowance], it's about your career and your*
> *competency. It's not all about the money.*

Nurse D acknowledged that some might see a financial allowance as a bonus, but explained that more important, was being considered as a valuable team member. Nurse K concurred, adding that it was a reasonable allowance in any case. Furthermore, Nurse K acknowledged that even though she had not completed PDRP, she was becoming resigned to the idea that it was a basic requirement in the present healthcare climate with or without an associated allowance. Other interviewees explained how their perception of the allowance was because of their PDRP experience.

Nurse E explained the prospect of a financial allowance had initially motivated her to participate but,

> *The extra money wasn't a factor in the end…. Whether I was getting paid five, ten, fifteen thousand dollars extra – it wasn't worth the stress.*

Nurse E's view indicated there was a level at which the effort of completion exceeded the worth of the monetary reward. In later conversation, Nurse E would talk more about her experience of PDRP in previous employment, adding to the weight of evidence that began to show how the process of PDRP completion needed to be a supportive, affirming process.

For Nurses B and C, exclusion from Nursing Council recertification audit on successful completion of requirements was a more important benefit than an allowance. Nurse G also believed that the financial allowance was not the most important reason for participation. Instead, she suggested,

> *You should be doing it [PDRP] for your professional worth.*

All participants were able to offer personal explanation on how the allowance affected a decision to participate. Yet, there appeared to be some dissonance between participants' own explanations versus the ways they thought it might affect others. Two interviewees appeared to suggest that some nurses participated because they simply needed the money. Nurses M and D said,

> *Well I'm just part time so [money] probably isn't as necessary for me as it is for people working full time, but I guess it is quite a nice bulk sum.*

> *I can see how it [money] would definitely be a factor… because you … make two or three thousand dollars more a year.*

However, the explanation provided in the free text quantitative data provided a powerful counter to the apparent values-based decision making and opinions of some of those interviewed,

> *The amount of time to complete versus the monetary gain is not worth the time or energy involved except that $74 per fortnight of one income would be missed if I didn't repeat my PDRP.*

Survey participant 67 established that for some, the only factor affecting the decision to participate in PDRP was the ability to provide for a family.

Overall, most nurses explained they were inclined to see PDRP participation as part of their professional values and identity. For most, money was nice to have, but in itself had insufficient incentive to be the only driver for PDRP engagement. However, what was troublesome in the narratives was the spotlight on the importance of PDRP experience. It appeared that where PDRP was not a positive experience, all progress was halted. Future attempts to engage were also impacted, irrespective of professional values or personal financial gain. The only factor strong enough to overcome anything was providing for a family.

5.4.6   Nursing Council competencies

Analysis of earlier questioning had shown how nurses simply 'ticked the boxes' during on-line APC renewal. Further, nurses avoided documenting Nursing Council competencies unless they were selected for recertification audit. Direct questioning about the affect Nursing Council competencies had on the decision to participate in PDRP extended the previous explanation. Interviews revealed how nurses' interpretation of what was required, the perceived difficulty of the task and consequently the individual's ability to respond appropriately affected engagement. Nurse L defined the problem,

> *The categories are quite specific and our job is quite specific and it was putting your role into those categories… some of them were a bit twisty.*

5.4.7 Interpreting and responding

Nurses E, H and C had attempted to complete Nursing Council competencies at points in their past. They agreed that it could be difficult to interpret competency statements and to tell what evidence would be suitable to validate them. Nurse E explained,

> *Some of them [Nursing Council competencies] you have to read a couple of times to try to decipher to see what they are actually wanting. [A] lot of it is to do with that language thing of how do I answer that?*

Using the right kind of language to respond to the competencies had previously been highlighted in the quantitative data. In the interviews too, nurses explained that understanding how to write appropriate responses had caused them to doubt whether they were writing the right thing, and sometimes had deterred progress. Nurse K explained,

> *If you are not sure how to do it, it is actually quite hard to try and write that stuff down and so I know that some people are struggling with that and I think they just give up.*

However, Nurse H's explanation advanced understanding of what was most difficult. Pointing directly towards the clinical floor she said,

> *I would say for most people; it's like putting **that** into words.*

The problem seemed to be with writing about clinical practice and putting it in a way that validated Nursing Council competencies. Nurses were saying that they didn't think they had the writing skills to validate competency statements.

5.4.8 Perceived difficulty of the task

Interpreting and responding to the competencies was only part of the overall explanation. Those who had completed PDRP or a recertification audit added further

perspective. Their views showed how the task was perceived as being difficult from the outset.

Nurse J reflected that validating Nursing Council competencies could be difficult the first time. She summarised,

> *…for people who have never done it, it is quite hard to get your head around writing your competencies and what goes where and who you need to get to do your peer review and how it all works.*

Nurse J outlined subsequent attempts were easier. Nurses K and M supported Nurse J's view and shared how hard it had been to think of clinical examples they could use. Nurse B suggested that it was hard to relate the competencies to the work of the organisation. Nurse L stated that Nursing Council competencies were the only factor that significantly affected her ability to complete her PDRP portfolio. Consequently, nurses appeared to excuse themselves from persevering until there was another, more compelling, reason for completion. For Nurses L and K, it was selection for recertification audit. For Nurse E, it was the prospect of a financial allowance. For Nurses J and F, it was commitment to their respective personal professional standards. For Nurses A and M, it was to avoid selection for recertification audit.

Nurse O appeared to bypass all hardship by seeking assistance. This part of the process had not affected her decision to participate in PDRP,

> *I find that [Nursing Council competencies are] really easy…especially when you gave us a way to actually structure the way we write it. It's just been so much easier.*

5.4.9   Peer/Manager assessment

If self-assessment of Nursing Council competencies was problematic, peer assessment had greater difficulties since it required a third party (peer or manager) to make an independent assessment. Furthermore, the quantitative data had drawn

attention to the burden of success that came with PDRP completion and the consequent obligation to assist others with their required peer assessment.

The first issue for most nurses was finding someone to complete the peer assessment. This was illustrated in the narrative of Nurse B who had organised a colleague to undertake her peer assessment. Unfortunately, the colleague resigned at short notice without completing it, leaving Nurse B unable to submit a portfolio as intended. Nurse O concurred, explaining how it was imperative that a peer assessor understood what they had to do. There were too few who could assist. Nurse O found it difficult to keep 'asking and asking' her colleague to complete her assessment. Yet, Nurse O was sympathetic to those being asked to undertake peer assessment since she realised just how much commitment was needed to make the assessment at all. Nurses K and F gave the perspective of the peer assessor, and added to the voice heard in the quantitative data.

Nurse K emphasised the significant time commitment involved; completing a peer assessment for her colleague had taken a whole day at home. Nurse F shared her experience of spending several days completing a peer assessment for a colleague. She explained how disappointing it was to have put in such effort only for the colleague never to complete PDRP. She would now 'think twice' before agreeing to do a peer assessment again, further compounding the problem of finding a willing peer assessor.

Clearly, the responses raised the possibility that the small number who could do the assessments were being overwhelmed by the volume of requests. Nurses K and F had highlighted a practical consequence associated with low levels of PDRP uptake in a relatively small, but geographically widespread organisation. The pool of capable peer assessors was small, meaning that other PDRP participants might well have struggled to

find assistance. The lack of peer assessors might also contribute to explaining the slow expansion of the NZBS PDRP since its implementation.

5.4.10 Age

Nurses raised the relevance of PDRP completion for nurses who were near to retirement in the quantitative data. When asked about age during interviews, explanation showed no particular polarisation of opinion. More, each age group could see its value or advantage for others, although there was some sympathy from everyone for those in the older age groups doing PDRP. There was a general acknowledgement that whatever age the nurse, the continuing competence requirements remained applicable. The only caution provided was to ensure that learning remained relevant and was delivered in a way that was accessible and appropriate to all age groups.

5.5 Vicarious Experience

Making a decision to participate in PDRP or progressing requirements did not happen independently from the clinical environment. Narratives showed how nurses' interactions with others shaped their overall experience of PDRP participation. In some cases, this 'vicarious experience' provided additional challenges to overcome. These interactions were defined as 'any information or experience related by others about PDRP'. Nurse A defined it as, 'Second hand talk and hidden hurdles'.

Nurse A talked about how she had had to overcome several hidden hurdles before she contemplated how she would develop her own PDRP portfolio. She explained,

> *Everyone talks about the PDRP and those people say, oh gosh – it*
> *takes so long. Oh, you've got to do this. Even before you get to even*

> *seeing what PDRP involves so that can put you off … even [before you]*
> *see what the PDRP actually is.*

Nurse F concurred on the impact of others' views. In particular, Nurse F talked about the 'collective negativity' of those around her and how information in circulation was not always accurate. In her area, Nurse L gave an example of how misinformation had created the perception of restricted choices about the level that could be applied for. There was evidence to suggest that the circulation of information was not confined to single centres. Nurse J, who worked in a different centre, provided the same example. Others observed that confusion was the main outcome. Nurse A dealt with the second-hand information and confusion created by ignoring it,

> *Once I realised that I shouldn't be listening to the second hand*
> *information on everything and it was best to go to it and then I found*
> *it was easy … All these people giving out this second hand information*
> *were people who hadn't done PDRP at all … The reality is their*
> *perceptions were so wrong. And their information was so wrong and*
> *it was all derogatory and negative.*

The category of vicarious experience was extended by Nurse M who shared her situation. She had observed the behaviour of an early adopter of PDRP. Explaining how vicarious experience had impacted her own decision to participate in PDRP she related,

> *We saw [nurse's name] go through the process and she always put a*
> *lot of pressure on herself and was quite vocal with how difficult it was*
> *and I think people hear that.*

Nurse E shared a similar situation from previous employment,

> *She actually submitted her portfolio three times and had it sent back*
> *… it impacted on me because she … was an epitome of an expert and*
> *you sort of think – oh god. What else do you want from me? Do you*
> *want a pound of flesh as well?*

The difficulties of PDRP seemed to be magnified in the narratives of vicarious experience. Vicarious experience went some way to explaining how nurses formulated

an opinion on what the process of completing a PDRP portfolio might be like. How others related their experience or information appeared to be an important factor in affecting other nurses' participation in PDRP. Yet, first-hand experience was not to be ignored. Nurses M and E talked about their own experience and how this had also deeply impacted their decision to participate in PDRP.

Nurse M had supported a colleague at NZBS with peer assessment. She told about her first-hand experience,

> *So I did my peer assessment and thought this is really good and handed it in and it was sent back going, oh no – that's not right. You need to start again and I was just sort of completely lost. I ended up going back and forth a few times and then being accepted with very minor changes to what I had originally written and I think that was quite disheartening really.*

Nurse E had also attempted PDRP previously. She shared,

> *I got excellent feedback from teaching sessions that I had done …..I spent weeks and months researching COPD and the latest research and I had got dab hand at drawing lungs on the board. I had done all of that stuff, all of that hard work in my own time to just be like … how does that apply to our strategic planning for the hospital?*

Like vicarious experience, first-hand experience was a powerful factor affecting nurses' decisions to participate. Yet, this type of experience appeared to have greater personal reach. The examples of poor process described remained with respective participants. Nurse E has never engaged with PDRP again and Nurse M participated only to avoid recertification audit.

5.6 Valency of PDRP

Despite difficulties in finding a peer assessor or being unable to get study leave or encountering any of the myriad of other factors that could affect their decision to participate or the process of preparation, most of those who had completed PDRP took

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the view that the activity was a self-determined one; each had the willingness to overcome the obstacles presented. This discrete group also appeared to have a compelling reason for PDRP completion for example, to exclude themselves from recertification audit or because they felt that it was part of their professional value system.

For the remainder who had not completed the PDRP process, reasons for lack of participation were diverse. Nurse N explained that personal requirements for information about PDRP were not met and that the whole of PDRP portfolio development was simply an academic exercise. For Nurse G, a series of significant life events had overshadowed her ability to complete. For Nurse C, the thought of tackling the writing involved was demotivating. Nurse E explained herself by identifying the NZBS programme was not compulsory and wasn't actually needed to be a nurse. Nurse D identified herself as being slow and thorough so the process of portfolio development would take a long time and still other reasons included having to learn eLearn, the elearning platform of the organisation. Whilst it is important to note that the reasons cited for non-participation would sit well within Cross' (1981) Chain of Response model, it is worth considering a more radical analysis. That is, that the reasons provided are quite simply a 'polite and reasonable reasons not to' participate in PDRP. Far from being a reflection of past learning difficulty, or a lack of information or support as might be readily explained by Cross' (1981) model, the reasons actually provided by the nurses were eminently solvable. It seems that the educational propositions of the programme, that it will assist nurses to develop clinical expertise through its processes or that it will facilitate completion of mandatory regulatory requirements, may be insufficient valency to motivate engagement.

5.7 Creation of a personal PDRP landscape

There were many factors that could affect an individual's decision to participate in PDRP. It seemed, time and again and in response to different questions, the intrinsic worth of PDRP to the individual nurse came together with their self-belief, confidence, first-hand and vicarious experiences, and their own motivation to participate or reasonable reason not to. Labelled as the 'personal PDRP landscape' during data analysis, the individual factors came together for each of the nurses. Nurse A defined this PDRP landscape,

> *It's not to do with anybody else, if you've got a path you want to follow … you've got to create it. You can't rely on other people to clear the pathway totally; you've got to make it happen.*

The narratives explained just how fragile self-belief and confidence to make it happen could be. They also showed that the vicarious element to participation could undermine a decision to start any PDRP preparation. Nurses identified characteristics in their colleagues who they saw struggle to start,

> *from my angle … there's the confidence side of it that they want to do it … but they're just a bit too scared and don't have the confidence to start it. (Nurse A)*

Other interviewees provided commentary on the fragility of self-belief and receiving appropriate support from key individuals. It was important that a participant felt 'good enough' to complete a PDRP portfolio in the eyes of their line manager. Nurse E explained,

> *Nurse E: If you've got your boss saying you're good enough to do this portfolio please do it – you are more likely to do it because your boss is saying you are good enough to do it.*
>
> *Researcher: Good enough?*

> *Nurse E: mmm… because perhaps you sort of get that bit of a boost in confidence. So actually if your boss and your Charge Nurse is saying, 'you can do that,' then it's a bit of a boost to your confidence.*

Support from the education team and senior staff also appeared to be significantly important in the personal PDRP landscape and in maintaining a positive process once a nurse had chosen to participate in the programme. Nurse B explained,

> *I think the biggest things are ….. Yeah just that support and encouragement and you know, positive feedback yeah when you're doing it.*

There were other examples of where the positive process had created a landscape that supported PDRP completion. Nurse L explained how she had engaged the help of a Nurse Educator in a one on one situation. She regarded the support as having been helpful for her as she started out,

> *Like, I'd do some rubbish in the morning and she'd email back in the afternoon with suggestions on why it was rubbish and then I'd tinker and email it and we'd just email each other backwards and forwards.*

Similarly, Nurse J commented that she had sought assistance from the local Clinical Coach for assistance,

> *I did get some help from a Clinical Coach as to what examples our practice here fits with, rather than in the DHB.*

Nurse E was quick to suggest that people familiar with PDRP were the best options when direction was required. Nurse A considered her experience carefully and whilst she was able to point out parts that could be improved and was able to contribute to explaining how some factors might affect participation in PDRP, she shared the following advice on how a portfolio would ultimately come together,

> *My only advice to anyone doing PDRP is don't listen to anyone else and do what suits you. And if you want to have time in work time, it's up to you to liaise with your Charge Nurse, Clinical Nurse Leader to arrange it.*

In summary, the 'personal PDRP landscape' included not only the individual disposition to factors affecting engagement, but also the valency of the activity. Support was instrumental to confidence and key people created a positive, productive process. Self-determination relied on the arrangement of all of these factors and was intrinsic to the creation of a completed PDRP portfolio.

5.8   Shaping the future of the NZBS programme

In the final part of the interview, opinion was sought directly about the NZBS PDRP programme and Nursing Council's role in programme approval. Nurses were asked if there were any improvements they would like to see. Some shared their insights from their experience of undertaking the NZBS PDRP programme whilst others based their suggestions on observation of the requirements for other programmes.

Nurse J suggested that the organisation of the material could be pulled together in one document rather than separate ones for ease of use. This view was echoed by Nurse D who encouraged NZBS PDRP managers to 'pull it all together'. Nurse H wanted to see changes to the ways that deadlines for completion were set. Instead of being self-directed, this nurse wanted PDRP managers to set the timeframes for completion. She thought this would reduce staff procrastination. Nurse M called for a workshop to be held for interested parties and Nurse A indicated information-giving could be managed by one-on-one consultation with the Nurse Educators for new staff. Nurses also offered advice for Nursing Council. Yet, in doing so, they further explained the fragility of their understanding of the relationship between continuing competence requirements, annual practising certificates, audit and PDRP completion and approval.

5.9 Advice for Nursing Council

Nurse J suggested that Nursing Council could put forms on their website for PDRP so that everyone was doing the same thing. Other nurses felt that Nursing Council could do more to ameliorate confusion by being clear about what was needed for PDRP completion. Nurse C felt the amount of writing required for PDRP should be re-examined by Nursing Council because it presently put people off engaging with the process. Nurse L suggested that Nursing Council should reconsider the deadlines they set for PDRP completion and that administratively, they should ensure that all of the paperwork for recertification audit had actually been received. Nurse E provided more detailed advice about the competencies for each scope of practice,

> *I would say look at the language that you are using and look at your clientele and look at who is out there … wanting to do the portfolio.*

5.10 Summary

Building on the data provided from the survey in Chapter 4, the nurses who were interviewed provided explanation of the factors affecting the decision to participate in PDRP. They showed how there was not one single factor to be addressed that would change their decision-making. Rather, there were a number of factors, predicted by the Chain of Response model advanced by Cross (1981). It emerged that nurses needed to have support throughout the PDRP completion process and that it was important their direct manager was PDRP-friendly to support progress. Nurse's narratives showed the relevance of vicarious experience of PDRP and how this might deter even the most capable of participants. It appeared that the key elements of PDRP completion were to be found within a personal PDRP landscape. This landscape held the key to what was worth overcoming to complete PDRP. In the following chapter,

analysis of the data from both phases of the study will be discussed in the context of the explanatory-sequential mixed methods study design, current literature and the wider background of nursing education. Limitations of the study will be considered and recommendations made for NZBS PDRP and the wider profession regarding the ways in which PDRP might evolve.

6. Discussion, Conclusions and Recommendations

6.1 Introduction

Participation in adult education was described by Cross (1981) as the ultimate outcome of the connections between factors included in her Chain of Response model. Depending on how the individual responded to each of its discrete elements, motivation to participate was determined. In previous chapters, Cross' (1981) Chain of Response model has provided a useful conceptual framework within which to consider the factors affecting nurses' decision to participate in PDRP. Analysis of the data generated in this study has documented the knowledge and attitudes of New Zealand Blood Service (NZBS) nurses towards PDRP. The study has also identified the factors that were relevant to these nurses deciding to engage with PDRP. Cross' model has enabled development of the view that a personal landscape of factors existed for each nurse. These individual landscapes were found to be complex, dependent on the myriad of possibilities of responses that were based on life events and previous education experiences. Personal landscapes were intricate enough, but the professional and employment contexts in which completion took place added further complexity. The use of Cross' (1981) Chain of Response model further enabled observation of the difficulties created when reconciliation of tensions between factors that crossed the boundary between the personal and wider, collegial, employment and regulatory contexts. The decision to complete PDRP is a complicated one and it takes place within an array of mixed messages from the employer, the regulator and professional colleagues.

In this chapter, these findings will be the subject of discussion. The explanations provided by nurses about the factors affecting their decisions to participate in PDRP will be reflected upon. Using current literature and integrating the factors from the Chain of Response model, discussion will show how this study both validates what is known about nurses' decisions to access PDRP and where it adds to and extends current knowledge. The chapter is organised with reference to the elements of the Chain of Response model resulting in the production of a PDRP specific version of the conceptual framework. An adapted Chain of response model is used to show how its application to the PDRP context assists explanation of the factors affecting nurses' decisions to participate in PDRP.

6.2   Self-evaluation

Self-evaluation is concerned with the way in which each learner perceives their own ability to succeed. Here, Cross (1981) suggested that learners were unlikely to engage in activities that might pose a threat to their self-esteem, although she acknowledged there was a relationship between having successfully participated in further education and the tendency to do so again. Of importance in this study appeared to be capability related to the perceived difficulty of the task. PDRP requirements; interpreting and responding to Nursing Council competencies together with options work all provided unique challenges for prospective participants.

6.2.1   PDRP requirements

Nurses' explanations identified that general appreciation of portfolio requirements were a factor in decision-making about PDRP participation. Specific difficulties were highlighted in understanding what was required and consequently, nurses did not have great confidence in their ability to complete what was asked. These

difficulties affected perception of the entire task and validated any apprehension felt by an individual related to their perceived capability of achieving the outputs needed for a portfolio submission. If it was difficult to understand, it was difficult to write about. On this issue, Norman and Hyland (2003) also identified that this type of dispositional barrier was significant, showing that self-confidence was instrumental to success in a study of ongoing education for student teachers. Corley (1994) documented similar challenges reported by nurses when completing evidence for professional portfolios. For others, the relevance of written work to the development of their clinical practice was not immediately obvious. It became apparent that whilst the underpinning pedagogy had been carefully crafted, the intended outcomes were not evident to potential participants. Consequently, the activities designed to support development of expert practice (reflection on action through case studies and presentations) did not seem to be valued. This finding adds new knowledge by extending the outcomes articulated in the work of Vernon, Chiarella, Papps, et al. (2013) who found nurses were also confused between purpose and requirements of the recertification and PDRP processes.

6.2.2   Interpreting and responding

Nurses who had completed or who had experience of working on PDRP requirements added further detail to the difficulties experienced. They reasoned that Nursing Council competencies were a significant factor that affected their continuing engagement with PDRP. They identified that it was difficult to interpret the Nursing Council competency statements as well as difficult to tell what kind of evidence would be suitable to validate them. Havill (2010) had similar findings in her work, whereby respondents felt unsure about how they should demonstrate the competencies in

relation to increasingly complex levels of PDRP. Furthermore, Havill indicated that the wording of competencies seemed to be difficult to understand particularly for those for whom English was a second language.

For PDRP options work, some forms of assessment were more acceptable than others. Again, having confidence in oneself to be able to do what was required featured strongly in nurses' narratives. Nurses indicated that presentations were least favoured, although others were considered to be challenging because of the writing required or volume of work anticipated. These issues are similar to those raised in the study conducted by Corley et al. (1994).

As a consideration of PDRP requirements, their acceptability to participants sits within the wider context of PDRP. Requirements are not set at a local level, rather these are nationally agreed and are made to suit particular specialities by the nurse completing PDRP. Given the variable initial entry to practice qualifications of the nurses in this study, it is certainly worth considering whether the ability to interpret and respond to options requirements is hindered by what McCready (2007) and McMullan et al. (2003) describe as 'academic maturity'. The study by Carryer et al. (2007) provides further insight, suggesting that where nurses are not educated via the tertiary system, PDRP is a daunting process. The latter point is reinforced by Tisani (2008) who identifies the extent of the problem for the less practised writer. These difficulties, together with the low levels of engagement reported with NZBS PDRP might also reflect the need to consider whether the educational activity is appropriate for the particular educational purpose. Adjustment to requirements might positively impact on the role of the Charge Nurse who, it appeared, had multiple roles and responsibilities beyond management in supporting nurses to complete PDRP.

6.2.3   Role of the Charge Nurse or manager

The role of the Charge Nurses was revealed to be more than simply a gatekeeper of study leave or financial support for CPD; they were crucial to successful PDRP completion. The nurses in this study identified that Charge Nurse support was needed from initial decision-making until PDRP completion. Without a PDRP-friendly Charge Nurse, a culture of completion did not exist in the clinical area and engagement with PDRP at all was of low priority. The Charge Nurse was central to setting the educational tone and ultimately, PDRP completion. In many ways, the need for Charge Nurse support throughout the endeavour pointed once again to the fragility of nurses' self-confidence and lack of belief in their own capability. However, the Charge Nurse had a difficult path to tread since they also approved leave and supported the level of portfolio completion.

Granting study leave fairly, and with respect to the needs of each collection centre appeared to be an onerous task which was never fully understood by participants. A lack of support for study leave when requests were not honoured gave some respondents the unfortunate impression that mangers did not view PDRP as a high enough priority. This finding is similar to that of Gould et al. (2007) who undertook secondary analysis on data from a study on continuing professional education for nurses. Here, the role of the nurse manager was found to be fundamental to the completion of CPD activities that needed approval. Carryer et al. (2007) also made this observation in relation to the underutilisation of study leave to complete PDRP portfolios where the nursing workload was substantial and prevented leave being supported. However, this study goes further, validating that there are gatekeeping aspects within the Charge Nurse role, but also in identifying the direct manager as a

substantial part of the support network needed to complete a portfolio. Their encouragement clearly impacted on participants' self-esteem and self-belief that a portfolio could actually be achieved. The role of the direct manager was intrinsic to the whole endeavour. Like the seminal work of Ogier and Barnet (1986) and Gould et al. (2007), this work adds yet another facet to the role of the direct manager. It underscores the importance of making appropriate decisions during recruitment and selection. The kind of educational experience this role creates is certainly included amongst the extrinsic factors that impact attitudes to education.

6.3   Attitudes about education

In Cross' (1981) model, attitude to learning was viewed as a direct outcome of previous experience. As she explained, learners are, "unlikely to return to the scene of their former embarrassment" (Cross, 1981, p. 126). Moreover, she advised that attitudes about education could also arise from significant reference groups such as those in the same situation or workplace. In other words, she suggested that individual attitudes to education are formed intrinsically and extrinsically. These attitudes endure over time and continue to affect learner engagement with further education. In this context, it might have been expected that nurses would likely be positive adopters of ongoing education having already been educationally successful by completing their initial preparation for nurse registration. However, this was not how the situation unfolded. In this study, the relevance of exposure to vicarious learning was underscored in the narratives of several nurses who had encountered others facing difficulty with their portfolio submissions. The role of the Charge Nurse was also highlighted as being instrumental in nurses' maintaining a positive disposition to the work involved with

PDRP. In many cases the Charge Nurse was not only the gatekeeper of study leave, but also acted as the main supporter of the nurse completing PDRP.

6.3.1 Vicarious learning

Nurses paid close attention to the behaviour of others both before and during PDRP participation. Crucially, how participation was role-modelled set some of the tone for a culture of PDRP completion within each centre. Even in centres where a PDRP friendly manager was in place, it was possible to track how nurses who had experienced a difficult process, talked about their difficulties to their peers. As this experience was retold it became another nurse's vicarious experience ultimately impacting on the decision of others to participate. It was possible to see that vicarious experiences came from watching others attempt to navigate the PDRP process. This new understanding showed the importance of the local PDRP climate but also that vicarious engagement with PDRP was cumulative. Furthermore, this study has also documented where vicarious experience was less than satisfactory, so too was the shared involvement.

The interview data showed how nurses held on to and talked about experiences from one employment to another. The experience of seeing someone else going through what appeared to be a tough submission process in one organisation could be brought to bear in the next even though the PDRP might have different goals or requirements. The effects were seen years later. In one case, a nurse had never engaged with PDRP as a consequence of her vicarious experience. It appeared that the vicarious experience to which she was exposed had been too overwhelming for her to even begin. Yet, in another perspective of vicarious experience, a different nurse outlined the strength of character it took to overcome the 'second hand information' she had gathered even before starting her PDRP submission process. These findings are

unique in the context of PDRP. However, they are relatable to the work of Bandura (1977).

Bandura (1977) argued that in everyday situations people observe what happens to others. In particular, individuals observe the rewards or punishments that follow a particular behaviour or action. These aspects strongly influence their own behaviour, creating the incentive to either copy the behaviour or not. For those nurses in this study who had observed others experience a difficult pathway to PDRP completion, it is possible to suggest that their observations did not reinforce PDRP to be a rewarding activity. Furthermore, there was evidence that some nurses had attempted to complete PDRP, but that their direct experience had been little better than those which they had observed. These nurses then, might never attempt PDRP voluntarily. Others however, like the nurse who had overcome the poor reputation of PDRP in her clinical area, could call on their more positive direct experiences to counter observation of PDRP as a non-rewarding activity. This situation is also reminiscent of the work of Lave (1996) who considered that social interaction and collaboration create components of situated learning in which unintentional learning can take place. It does so because as it normally occurs, learning is embedded within the activity, context and culture of the workplace. This latter point might also underscore the relevance of the culture of completion and support created by the Charge Nurse as previously discussed. Further, the powerful way in which nurses appeared to be persuaded by others might add additional meaning to the polite and reasonable reasons offered for non-participation where it appeared seemingly small hurdles were insurmountable. The attractiveness of the PDRP proposition was further highlighted when the valency and expectancy of the activity was considered.

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6.4 Goals and expectations

Cross (1981) considered 'valence' and 'expectancy' to be equally important. She suggested that learners were more likely to be motivated to achieve where valence and expectancy were high for the individual. To have sufficient valency and expectancy, the learning proposition needed to provide the learner with the reasonable expectation that engagement would meet their learning needs or aspirations.

6.4.1 Valency

In Phase 1 of the study nurses indicated that they knew what they would get from engagement with PDRP. Their responses at this stage appeared to support the idea that the programme had sufficient valency. Yet, despite their suggestion, participation rates were known to be low. Explanations drawn from the data revealed that valency and expectancy were not related to PDRP pedagogy or becoming an expert practitioner. More, valency and expectancy were related to the avoidance of recertification audit. Given the number of nurses who understood PDRP in this way, this insight might be used in additional research to determine whether there is any relationship between actual PDRP completion and expectation of being subjected to recertification audit.

As a reason to engage with PDRP, the development of expertise was conspicuous by its absence. This was not the basis upon which nurses felt compelled to engage with PDRP. PDRP appeared to be viewed as another task to be completed and occasionally as a means by which mandatory professional development could be achieved. The reason to complete it was external to the nurse. In focussing on PDRP as a means to avoid recertification, it was noticeable that nurses did not appear to have considered that their engagement with PDRP or any other form of CPD could positively

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benefit patients/donors. The lack of consideration afforded to the wider impact of engagement adds further weight to the observation that the valency of PDRP for nurses at NZBS is connected to completion of regulatory requirements. At best, the lack of balance in such a view is inconsistent with international findings where researchers like Koch (1990), Roedel and Nystrom (1987) and Krugman et al. (2000) who showed the valency of career ladder programmes was related to job satisfaction and recognition of nurses' important contribution to healthcare. However, the significant difference between New Zealand PDRPs and career ladders is that career ladders do not contain mandatory regulatory requirements and are accomplished on the basis that they contribute to the development of the quality of nursing.

6.4.2   PDRP allowances

A fairly casual attitude towards the financial allowance was noted across this study where only one nurse made a case for the significance of the financial award. The low priority of the PDRP allowance is an interesting finding since professional wisdom is such that money motivates engagement. The New Zealand Nurses Organisation (NZNO) include renegotiation of PDRP allowances at each iteration of the MECA agreement and these have been steadily increasing over the last decade. Yet, it was certainly not the view of nurses in this study that the allowances were sufficiently motivating that they would encourage engagement in their own right. Havill (2010) and Corley (1994) showed a similarly low key response about associated remuneration. In Havill's study, significant leverage came from the availability of time for completion whereas in this study, leverage was seen in the potential for PDRP to exclude the nurse from recertification audit. For most, the financial reward was a nice benefit for effort. Notwithstanding the bonus of financial reward however, there was a limit to what

nurses would endure for such a reward. The prospect of a financial reward lost its attractiveness for one nurse who had returned her portfolio numerous times for review with apparently no progress. In both the studies by Havill (2010) and Corley (2012), some nurses felt the financial incentives did not equate to the effort involved in PDRP/portfolio completion.

6.5   Life transitions

Life transitions concerned learners in different stages of their life cycle that meant that adjustments had to be made. Cross (1981) indicated that life transitions might positively promote engagement where new education is required perhaps following redundancy. Conversely, Cross considered the possibility that life transitions might also deter engagement where the life cycle phase adjustment excludes the possibility of taking on education (e.g., when raising a family or caring for an elderly or sick parent). The life transitions element of Cross' model acknowledged that individuals may have other life priorities that impact their ability to engage with ongoing learning.

6.5.1   Age

Commentary about the relevance of the nurse's age in conjunction with PDRP was received in the Phase 1 survey and followed up in Phase 2 interviews. Across the age range, older nurses considered that PDRP might not be useful with accumulating years, but their suggestion was for the need to consider how this group could continue to meet continuing competence requirements without it. They had seen immediately, the disadvantage of not undertaking PDRP would be that they could no longer be excused from recertification audit. Yet, older nurses were unable to identify what they needed that was so different. Potentially, age was yet another polite and reasonable reason not to participate rather than a genuine difficulty for the age-group. However,

the important issue raised through interviews was that there might be a point at which PDRP is no longer the most useful CPD activity.

Such a perspective necessarily invites a profession-wide conversation that acknowledges the need for ongoing CPD within the context of an aging workforce. This is especially so in the light of Nursing Council's publication that provides predictions about the way in which the workforce will transform in the coming years (Nursing Council of New Zealand, 2013). Nursing Council's publication shows how the workforce is rapidly heading to the point where most nurses will be nearer to the end than the beginning of their careers. The findings about nurses' responses to age are comparable within Havill's (2010) work where respondents suggested that some nurses were too old to make the effort.

The respondents in this research offered little commentary on more general themes related to life transitions like availability of childcare to support attendance at CPD events or conferences; significant family commitments or the hidden costs of CPD. This is different to the view contained in the plethora of literature available on the impact of mandatory CPD on healthcare professionals where all manner of life events were identified as barriers to engagement (Cleary et al., 2011; Dowswell et al., 2000; Moore et al., 2000).

6.6   Opportunities and barriers

Opportunities and barriers related to learners in the context of what they were prepared to overcome to engage with the learning. Cross (1981) indicated that a highly motivated learner might overcome many seemingly difficult situations whilst less motivated learners might be discouraged by more modest barriers. In this research, participants spoke favorably about the resources available to them, giving rise to the

expectation that participation would somehow have been made easier. However, despite all manner of opportunity being available, polite and reasonable reasons not to participate prevailed.

6.6.1 Support for completion

Financial support for CPD did not emerge as a reason why nurses did not engage with PDRP. One tentative explanation for this view is that NZBS provides a significant amount of specific work based learning on entry to the organisation for example, orientation for new staff takes up to three months. The large amount of education includes 'off the floor' classes where nurses learn about blood and blood product collection procedures in both simulated and supervised contexts; it encompasses the development of new, highly technical clinical skills. NZBS is also generous in its commitment to a range of professional development courses like nurse-led clinic preparation and preceptor development for example, for those who have completed initial work based competencies. Courses like these and others, are all offered in the static regional centres where staff are able to use leased vehicles for transport and where necessary, accommodation and travel is purchased in advance. In other words, the nurses are unlikely to be out of pocket if they choose internal education options. This finding is significantly different to other research where the associated costs of CPD were mentioned as being of particular issue. In a number of other works, the scope of the hidden costs included items like travel expenses, child care, course materials and other incidental expenses (Gould et al., 2007; Ross et al., 2013; Schweitzer & Krassa, 2010). Whilst nurses in this study were relatively silent on the issue of associated costs of participation, they were more vocal on the subject of study leave.

Nurses at NZBS are subject to a favourable employment contract regarding study leave. Up to two days study leave allowance for portfolio development and maintenance sits within the MECA. On the issue of accessing study leave, however, nurses shared many accounts about the difficulties they had experienced in engaging their manager to follow through on leave requests. Here, nurses indicated that unexpectedly busy clinics together with high levels of sick leave calls perpetuated the problem. This finding is not dissimilar to that of Carryer et al. (2007) who observed that research participants had been denied study leave due to variables like high workload and patient acuity. Internationally too, study leave was an ongoing issue where release from duty to undertake study for CPD put direct managers in the position of being gatekeepers (Gould et al., 2007). In another perspective on financial support, Havill (2010) proposed that nurses actually valued time off with study leave more than the remuneration for their CPD expenses. In answers to other questions, nurses expanded understanding about time for completion of PDRP.

6.6.2 Time

Time was viewed as if it 'belonged' either to a person or an organisation and could be classified in one of three ways: personal time, work time, or having time. 'Owners' could be recognised and judgements made about the appropriateness of the use of a particular type of time. How the use of time was viewed seemed to be related to whether the individual had an interest in completing PDRP or not. Some participants identified PDRP as a purposeful use of their time whilst others used time as a reason not to engage.

The conceptualisation of time having an owner extends previous work, suggesting that completing PDRP was more than a matter of resistance to spending

time on a work activity outside of employment as indicated in Havill's (2010) study. Indeed, several of those who had completed their portfolio explained they were not unhappy about the personal time involvement. In fact, they saw completing a portfolio as an investment in their careers; personal time for completion was an expectation. Others explained they were uncomfortable when using work time for completion. They articulated that it was simply not acceptable to undertake PDRP activities at work when others were busy attending to operational requirements. These findings are in contrast to other work where Ross et al. (2013) summarised that professional learning was seen as belonging within work-life and Cleary et al. (2011) submitted that their participants rated 'time off' as a significant commodity in being able to engage with CPD. Further, Havill (2010) provided discussion in her research where participants appeared to resent the prospect of spending personal time on PDRP development. Yet, there were participants in this study too, who like Havill's respondents, saw PDRP as a wholly work-related activity. Such a perspective is worthy of discussion since it reappeared in relation to accountability and responsibility for meeting continuing competence requirements.

The notion of ownership of time meant there were commensurate responsibilities. If personal time was used, there was the inference that the activity was the nurse's responsibility. Contrastingly, where the activity was undertaken during work time, it was an employer responsibility. Adding to this situation was the allocation of time for study leave in the then, current MECA. Potentially, inclusion of a stipulated amount of study leave within the contractual arrangement has inferred a level of employer responsibility. Consequently, it creates the expectation that PDRP should be completed in the employer's time and that completion is an employment matter.

Adding further complexity is the observation that PDRP also contains mandatory regulatory requirements for which the employer is not responsible. This reflection expands the detail of the extent to which there is ongoing confusion in terms of the roles and responsibilities of the regulator, employer and the health professional, originally outlined by Vernon, Chiarella, Papps, et al. (2013).

As well as having an owner, narratives connected time with novel perspectives on PDRP. Time was used as a polite and reasonable reason why PDRP engagement was not possible. Different to other studies, this one has shown how time was not simply about the 'use of time' but that it was also about how time could be used to explain non-engagement. It helped nurses to redefine themselves for example, as a slow learner, so PDRP would take too long, or as a nurse with high moral standards because it was not justifiable to complete PDRP whilst others were attending to the clinical workload.

A hidden curriculum was also observed. Here, there was a need for development of additional skills before PDRP activity could begin. Skills included writing self-assessment or peer assessment competencies for nursing council. Other skills were typing and word processing skills. Time for learning these new skills had to be taken into account when making the decision to participate in PDRP. Also revealed was an unexpected consequence of PDRP completion. In this new finding, nurses illustrated how, after completing their own portfolio, their colleagues expected them to be able to assist them by undertaking peer assessment for example. This consequence was not universally welcomed because of the significant time involved.

6.7 Accurate information

Cross (1981) argued that accurate information was the educational 'broker' for recruitment to a learning opportunity. She further outlined how failure to provide sufficient information resulted in lost opportunities to link learners with appropriate opportunities even in the presence of other motivating factors. This research showed how the complexity of understanding of continuing competence requirements impacted on nurses' decisions to participate in PDRP.

6.7.1 Meeting continuing competence requirements

Most nurses showed they could accurately identify the three basic requirements for continuing competence (i.e., the number of continuing professional development (CPD) hours, clinical practice hours and validation of Nursing Council competencies for their scope of practice). Their knowledge began to unravel however, when they were asked to explain the connections between these requirements and Annual Practising Certificates (APC), PDRP requirements and employer competencies. At interview, confusion between the NZBS internal quality assurance competencies and Nursing Council competencies became apparent. Secure knowledge links between continuing competence requirements and APC renewal were also difficult to establish. Further, it appeared that nurses viewed payment for APC renewal as a completely separate activity and there was no surety that the regulatory significance of the on-line payment was understood. Nurses did appreciate that Nursing Council may conduct random recertification audits to determine compliance with continuing competence requirements. However, avoiding selection was described as 'dodging a bullet' meaning that the effort of validating competencies was evaded until the next audit cycle. The issues related to recertification audits were narrowed down to the difficulties of

providing evidence for validation of Nursing Council competencies. It included both interpreting and responding appropriately to demonstrate what was required.

When explained in this way, a picture emerged of the complex structure of requirements which nurses must navigate and the depth of knowledge required to do so. Further complexity was added by the mixture of mandatory and voluntary requirements for each system and its links to another. Inevitably, there were mixed messages and subsequent confusion in explaining the relationship between continuing competence requirements and APC or PDRP. In the absence of clarity, nurses appear to have made the systems work for themselves linking PDRP and Nursing Council requirements at the most pragmatic level. Nurses do not engage with NZBS PDRP as a professional development activity. Rather, the primary educational purpose of PDRP is overshadowed by the more pressing need of this nursing community to avoid recertification audit. Consequently, the difficulties of reconciling pedagogical, regulatory and employment objectives within one professional development programme are well illustrated.

The complexities of situations where several groups of apparently similar objectives are to be met have been noted by others. In accounting for multiple needs, Fleet et al. (2008) and Collin et al. (2012) observed the considerable challenges involved when CPD was expected to account for the needs of several parties including the worker, organisation and profession. McColgan (2008) however, took the opposing view, suggesting that the goals of both lifelong learning and regulatory requirements could be merged. McColgan (2008) and others argued for the use of professional portfolios as a suitable strategy for the concurrent collection of evidence to support lifelong learning, competency and workplace goals (Byrne et al., 2009; Ng, 2010). The

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latter view of portfolio completion was not the experience of the majority of nurses in this study. Very few identified PDRP as their preferred method of documenting their ongoing learning. However, there was at least one nurse in this study who was able to show it was possible. It would be interesting to canvas the opinion of others like her, who had completed her initial registration via undergraduate degree, completed an entry to practice programme and who 'knew no different.'

6.7.2   Nursing Council competencies

Mandated to deliver on initial and recertification processes in the interests of public safety, Nursing Council has chosen, like many other international nursing regulatory bodies, to require its registrants to demonstrate their continuing competence using a variety of measures that can be audited. Validation of nursing council competencies are one such requirement. For the first time in this research, consternation caused during competency completion was detailed. Both self and peer assessments appeared to be problematic. Various examples were provided about the associated difficulties of writing competency responses these are detailed elsewhere (see page 157). A further area of issue related to the commitment required to complete a peer competency assessment within the required time frame and to the appropriate standard.

Understanding how competencies should be completed and the quality of the evidence to be provided, concerned nurses. Perceptions were that the activity was too hard, it took too long and many did not know what was needed. Nurses appeared to struggle to translate practical work into words that would make sense and usefully validate their professional competencies. These findings show different thinking about competency completion when compared with that related by Carryer et al. (2007). In

their study, one group of nurses felt that years of experience alone should account for the required evidence. Further, Vernon, Chiarella, Papps, and Dignam (2013) identified nurses' confusion about recertification and PDRP processes in their evaluation of the Nursing Council of New Zealand continuing competence framework. As with the current study, Havill (2010) and Carryer et al. (2007) identified that there was little difference in understanding between those who had and who had not completed PDRP. It seems that levels of confusion about what counts and how to present evidence is a perpetual issue. That it endures, is problematic.

The terminal objectives of courses leading to registration require that initial competencies for registration are met for the relevant scope of practice. Nurses returning to practice after a career break are also educated about regulatory requirements. So too, those nurses who are admitted to the New Zealand register from overseas. Whether the conversation is clear enough about recertification requirements being an annual requirement related to APC renewal is outside the scope of this study, but it is also worthy of consideration in context. The continuing level of confusion has been consistently reported over the past decade and raises the spectre of wider issues about professional accountability for upkeep of registration. Given their obligation to the maintenance of public safety, this recurring theme should be sufficient warning for Nursing Council to consider the support it provides to new and already registered nurses to properly achieve their recertification requirements.

6.8 Participation

It is fitting that the final section of this discussion section relates to participation. Cross (1981) described participation as the ultimate outcome of all of the factors included in the Chain of Response model and it was the lack of participation that

alerted to the need for this research to be conducted at all. The work set out to explain

NZBS nurses' decisions to participate in PDRP.

In its completion, this research has provided insight that there is an opportunity

to advance NZBS nurses' understanding about PDRP as a professional development

framework in its own right. Whilst there are benefits of completion in relation to

recertification requirements, these are not its main purpose. Consequently, PDRP has

yet to recoup the benefits identified by research like Benner (1984), Benner and Tanner

(1987) and Manley et al. (2005) who all showed clear and present practice impacts for

patients.

NZBS nurses showed how they were generally positively disposed to ongoing

learning and to the availability of resources, people and information required to

support their participation in PDRP. That they were so is attributable to their success via

initial education for registration. As Cross (1981) herself indicated, adults who had

already experienced success in the post-16 arena were more likely to return to study.

Yet, her statement did not completely explain participation in PDRP.

The situation uncovered by this research showed more of the complexities that

came to bear on the decision to participate. These complexities were well illustrated by

those who offered polite and reasonable reasons to decline. Here nurses cited time,

money, nursing council competencies and programme requirements as important

explanations about ways of crossing the divide between simply liking the idea and

submitting a portfolio. Some observed that the rollercoaster of life was often sufficient

reason why they did not have time. Yet more, showed how time could be wasted

waiting for education events and for those who had committed to assist them with

activities like peer assessments. It appeared that reasons not to, were often a metaphor

for lack of confidence. This critical finding is suggestive of the need to address accessibility related to participation. It is a view that is supported by the work of Norman and Hyland (2003) who concluded that confidence in oneself as a learner was a primary factor affecting engagement in post-16 education. These writers further argued for programme adaptation to improve social interaction as they viewed relationships in a learning context as a method to improve low self-confidence where it existed. There was evidence to support that self-evaluation was not the only factor that influenced participation.

For most nurses, financial costs were not the drivers of participation. Acknowledgement of this finding gives rise to the idea that cost/benefit analysis could be shaped on criteria that do not directly involve financial reward. This suggestion sits well with the work of Boeren et al. (2010) who, in developing their integrated model of participation in general adult education, describe it as being part of a personal 'cost benefit' analysis. Evidence of healthcare professionals being similarly influenced has been reported (Boeren et al., 2010; Gould et al., 2007; Murphy et al., 2006; Ross et al., 2013).

There was evidence that intention to participate was not static and that whilst one view could be held at one time, it was possible that this could change. Illustrations of this were found in both directions from intending to complete to not and vice versa. This is different to the view offered by Gorard and Smith (2007). These writers contended that for those individuals that do choose to participate, engagement is part of a deeply rooted lifetime pattern of behaviour. Further, Gorard and Smith suggested that a particular attitude to oneself as a learner was likely permanent. Overwhelmingly however, the response provided by the nurses in this study showed how the latter view

was unlikely to be so. Reflecting on each interview as it was conducted, it was possible

to propose that individually developed educational objectives might be needed to

address the personal PDRP landscapes that were illustrated in the nurses' narratives.

6.8.1 Personal PDRP landscape

PDRP landscapes were personal responses to factors appearing in the Chain of

Response model. Where all of the elements of participation are positively addressed,

Cross (1981) suggested that the opportunity for participating in learning activities was

maximised. However, this work has highlighted the importance of the context in which

the learning activity takes place. For example, reference groups including peers and

managers as well as family members were identified as having a strong influence on a

decision to participate. In the context of this research, individual understanding of the

purposes and relationships of PDRP to employer and regulatory requirements was also

significant. The PDRP landscape was clearly different for all of the nurses. It showed

that there were individual factors that were sometimes common, but not wholly

repeated for each person and reinforced the need for consideration to be made to the

range of factors that affect NZBS nurses' decisions to participate in PDRP. A

representation of the personal landscape is shown in Figure 6-1. This figure shows how

Cross' (1981) factors affecting engagement are still relevant, but that there are some

important factors influencing nurses' decisions to engage with PDRP within their

professional situations. These factors, the culture of completion lead by the Charge

Nurse; the support networks provided by Nurse Educators among others, create a

narrative of encouragement within the employment and regulatory context of the

moment. The additions to the model acknowledge the importance and enduring effect

of previous personal and vicarious experience on any decision to participate in PDRP.

Figure 6-1: Updated Chain of Response Model
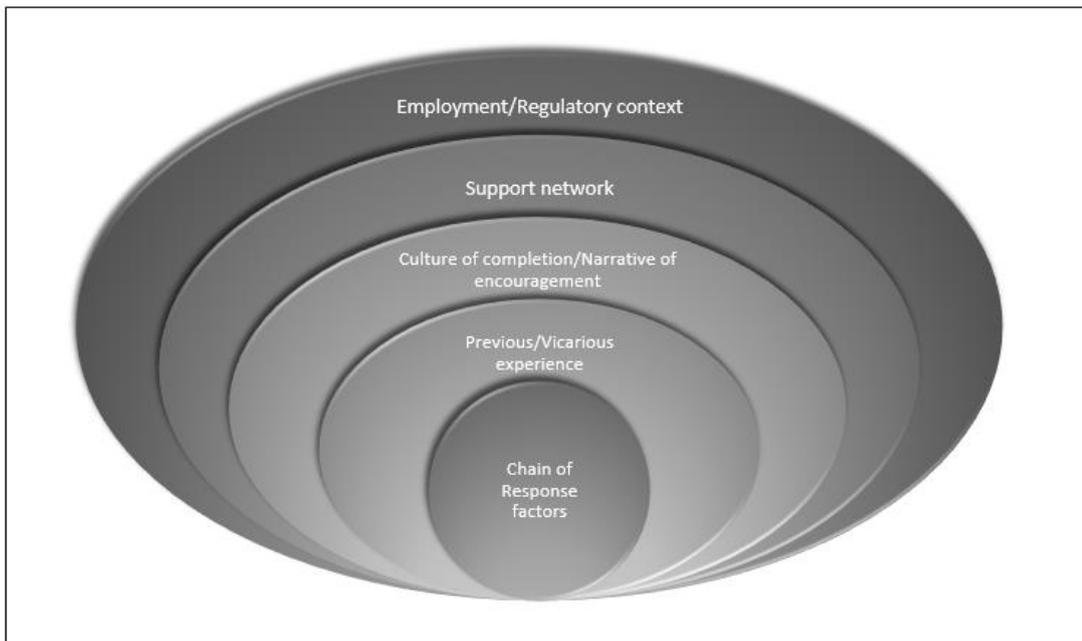
6.9 Limitations

The organisation within which the research took place is small when compared with large District Health Boards who run PDRPs for several hundred nurses. The PDRP itself is small and bespoke because of the highly specialised nature of work undertaken at NZBS. Further, the NZBS PDRP is crafted with the development of expertise in mind. As previously explained, the development of experts in this environment is a desirable business objective. However, this terminal objective might differ from other PDRPs where say, the development of practical skills to support nurses to become fit for purpose is a more useful outcome. This context may affect the generalisability of findings to other PDRPs, despite the fact that good response rates were a feature of this work. It is also worthy of consideration that those who chose to respond to both the survey and interview might be a particularly motivated group of people either because of their positive or unfortunate experiences with PDRP. Polarised responses have the ability to alter the overall impression of the data.

The data collection instrument used in Phase 1 of this research was adapted from a previously validated questionnaire. Whilst the process used to assess the suitability of the adaptations was robust, revalidation of the new format of the questionnaire did not occur beyond the scope of the pilot study. This leaves open the possibility that weak aspects of the questionnaire remain which might impinge on the trustworthiness of the data. Furthermore, questions for the semi-structured interviews were derived from the data produced in the questionnaire and as such, it can be argued that any flaws found could impact not only Phase 1 data, but also Phase 2.

I am also mindful that as practitioner-researcher my understanding of NZBS PDRP was intimate. The nuances and inferences within the conversations at interview might well have been missed by a more independent researcher. Yet, there was the possibility that because of my role I would over emphasise or ignore aspects of the data. It is certainly possible that another person would interpret the transcription data differently or perhaps would have thought to have followed-up in a different way during questioning. This gives rise to the potential that there were other voices to be heard within the data and that another person might analyse the data and see different themes and categories to those presented here.

6.10 Further research

Future research could include replication of this study in another organisation where PDRP remains voluntary or across several organisations with which a larger sample could be generated. It would be also interesting to undertake the same research in an organisation where PDRP is established and where participation is compulsory. Moreover, it would be valuable to conduct international comparative research where PDRP and clinical ladders were investigated and compared for their contribution to the

development of expertise. Further, development of Cross' (1981) Chain of Response model into an assessment tool might prove useful in personalising education plans for nurses. Insight into the factors affecting engagement at the end of such an assessment might enable provision of suitable information, assistance with accessing appropriate types of education including those most likely to fit in with an individual's culture and lifestyle to provide a pathway for achieving goals and aspirations.

6.11 Conclusions and implications for practice

Cross' (1981) model looked specifically at the factors and characteristics that would influence an individual to participate in ongoing education. This research has shown, that whilst factors affecting participation can be expressed well conceptually, the decision to participate in PDRP is made within a framework that includes the specific nature of the activity, the context in which it is happening and the culture of the place within which it happens. This work makes the following contributions to the discipline:

Contribution 1

Nurses' perspectives of PDRP participation are now explained as a legitimate group of factors affecting individual participation.

These findings mean that a 'PDRP ecology' exists for each nurse. This is an important development in understanding because it moves from current thinking about nurses as a group and responding to group concerns to the perspective of the individual and their learning needs. An individual PDRP ecology also explains how a personal landscape of factors can create either the opportunity to participate or provide a 'polite and reasonable reason not to'. Consequently, the boundaries created between

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participation and not can be interpreted. There is an opportunity for educators to use this information to support engagement with PDRP.

Contribution 2

Vicarious learning significantly impacts nurses' decision-making about PDRP engagement.

This study uncovered the close attention nurses paid to the behaviour of those who were completing PDRP. Crucially, these findings developed understanding that the ways in which PDRP participation is role-modelled sets a tone for the culture of completion within each centre. The type of vicarious participation experience to which nurses are exposed, strongly influences decision-making. Not always the most accurate or inspiring, these sources help to shape the culture and context in which nurses consider PDRP. The messages they provide are arguably some of the most powerful even in centres where a PDRP friendly manager supports the participation process. This adds meaning to the need to create a positive experience for participants; the narrative of encouragement is not always reflective of recent experience and poor experiences endure between employers and across careers.

Nurse educators have a significant role to play in ensuring that the processes they use are clear and useful in supporting nurses to achieve a positive and purposeful experience in their ongoing professional development. This will likely ensure that vicarious experiences are also positive and potentially contribute to the uptake of the programme by others.

Contribution 3

PDRP is not seen as a legitimate tool for professional development at NZBS.

This study showed that the NZBS PDRP's educational proposition, the development of expert clinical practitioners, was not the principal reason for nurses to engage with the programme. Intended as a practical outcome, NZBS PDRP included continuing competence requirements as part of portfolio production and was approved by Nursing Council. However, nurses appeared not to place emphasis on the connection between completing PDRP and meeting Nursing Council continuing competence requirements. Paradoxically, the reason to participate in PDRP was to avoid the regulatory scrutiny of recertification audit. This means that the purpose of PDRP as a professional development activity may not be well understood and that unfortunately, the altruistic action of embedding of regulatory requirements within a voluntary programme has obscured its primary educational purpose. Nurse Educators have a role in beginning a conversation about the future evolution of PDRP especially in the light of the mandate from Nurse Executives of New Zealand that PDRP become a national programme.

6.12 Recommendations

Recommendations following from this research are proposed for NZBS as the host of the PDRP being researched, national PDRP stakeholders and the regulatory body.

For NZBS to consider:

1. Ways of ensuring that nurses provide evidence of meeting their mandatory regulatory requirements on a three yearly basis outside of PDRP.

2. How re-shaping PDRP to use the newest evidential requirements can enable the development of expertise among staff.

3. Presenting mandatory regulatory and options requirements as separate activities internally so that the educational pathway and regulatory pathway are distinct and only come together at portfolio submission.

4. Ensuring that all new and current staff who manage nurses directly are well appraised of resources and expectations regarding PDRP.

5. Rebranding the current version of PDRP to account for the simple and effective adaptations identified by research participants in this work.

6. Including the development of a PDRP champion within the workforce at each centre.

For PDRP stakeholders to:

1. Support all programmes nationally becoming compulsory at Competent Level

2. Act quickly to develop PDRP in order to maintain its relevance for an aging workforce.

3. Consider how PDRP strengthens Māori and Pasifika nurses in their post registration years.

4. Consider refocussing PDRP on the needs of the nurse and their employer by removing continuing competence from evidential requirements.

5. Review other areas of incongruence between the needs of the regulator, the employer and the nurse for example, payment for APC; validation of completion of APC requirements so that relationships are clear and easily understood.

6. Collaborate on the implementation of personalised education assessment for PDRP participants.

For the regulator, Nursing Council, to consider:

1. Refreshing the advice and resources available via its website to assist nurses' understanding of the professional and regulatory accountabilities as a matter of urgency since this is the fifth piece of work that has raised issues about nurses' level of understanding of continuing competence requirements.

2. Whether the approval of PDRP programmes by Nursing Council remains a relevant activity when not all programmes are compulsory and there is now evidence that the occupational objectives of the employer together with the ongoing professional development needs of the nurse are overshadowed in the resulting situation.

6.13 Final words

There is no doubt that the work of the expert practitioner is essential to the future of healthcare. Growing nurses' practice to the level of an expert practitioner ought to be at the forefront of the continuing professional development agenda and top of mind for those who educate nurses. PDRP is one educational option through which the development of expertise might be accomplished. Yet, collaboration between those who teach nurses formally and informally, together with those who regulate might yet yield other, more innovative ways of reconciling the multiple outcomes required of CPD. Finding ways to easily engage nurses and trying a variety of strategies with which to do so is certainly worthy of consideration. Assessment of the personal landscape and consequent readiness to engage might be a starting point.

It is insufficient in the 21st century for nurses not to be vested in their own career and development. However, there are clear challenges for the profession in developing post-registration education sufficiently that it is appealing to the cross

section of women and men that choose nursing as a career. Professional development

needs to be manageable whilst positively impacting health outcomes. Patient's lives

depend on getting the balance right. The endeavour to achieve such a balance should

be relentless.

References

Aitken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association, 290*, 1617-1623.

Allen, J., & Dennis, M. (2012). Who's fit to practise? *Nursing Management-UK, 19*(1), 11.

Austin, Z., Marini, A., & Desroches, B. (2005). Use of a learning portfolio for continuous professional development: A study of pharmacists in Ontario (Canada). *Pharmacy Education, 5*(3/4), 175-181. doi: 10.1080/15602210500282434

Baeten, M., Dochy, F., & Struyven, K. (2008). Students' approaches to learning and assessment preferences in a portfolio-based learning environment. *Instr Sci, 36*, 359-374. doi: 10.1007/s11251-008-9060-y

Bandura, A. (1977). *Social learning theory*. Engelwood Cliffs, NJ: Prentice Hall.

Barnhill, D., McKillop, A., & Aspinall, C. (2012). The impact of postgraduate education on registered nurses working in acute care. *Nursing Praxis in New Zealand, 28*(2), 27-36.

Barriball, K. L., While, A. E. (1995). Participation in continuing professional education in nursing: Findings of an interview study. *Journal of Advanced Nursing, 23*, 999-1007.

Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (1999). *Nursing research methods: Critical appraisal and utilisation*. Artarmon, CA: Mosby.

Begle, M., & Johnson, S. H. (1991). Completing a cost benefit anlaysis for a clinical ladder project. *Recruitment and Retention, 4*(8), 1-4.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

Benner, P., & Tanner, C. (1987). Clinical Judgment: How expert nurses use intuition. *The American Journal of Nursing, 87*(1), 23-31.

Bhoyrub, J., Hurley, J., Neilson, G. R., Ramsay, M., & Smith, M. (2010). Heutagogy: An alternative practice based learning approach. *Nurse Educ Pract, 10*(6), 322-326. doi: 10.1016/j.nepr.2010.05.001

Boeren, E., Nicaise, I., & Baert, H. (2010). Theoretical models of participation in adult education: The need for an integrated model. *International Journal of Lifelong Education, 29*(1), 45-61. doi: 10.1080/0201370903471270

Boltz, M., Capezuti, E., Wagner, L., Rosenberg, M., & Secic, M. (2013). Patient safety in medical-surgical units: Can nurse certification make a difference? *MEDSURG Nursing, 22*(1), 26-37.

Bond, S. E., Crowther, S. P., Adhikari, S., Chubaty, A. J., Yu, P., Borchard, J. P., . . . Miyakis, S. (2017). Design and implementation of a novel web-based eLearning tool for education of health professionals on the antibiotic vancomycin. *Journal of Medical Internet Research, 19*(3), 1-1. doi: 10.2196/jmir.6971

Boone, H. N., & Boone, D. A. (2012). Analyzing likert data. *Journal of Extension,* (April). Retrieved from Journal of extension sharing knowledge, enriching extension website: http://www.joe.org/2012april/tt2.php

Boote, D. N., & Beile, P. (2005). Scholars before researchers: On the centrality of the dissertation literature review in research preparation. *American Journal of Educational Research, 35*(6), 28-31.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi: 10.1191/1478088706qp063oa

Brekelmans, G., Poell, R. F., & van Wijk, K. (2013). Factors influencing continuing professional development: A delphi study among nursing experts. *European Journal of Training and Development, 37*(3), 313-325.

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research 6*(1). doi: https://doi.org/10.1177/1468794106058877

Buchan, J. (1999). Evaluating the benefits of a clinical ladder for nursing staff: An international review. *International Journal of Nursing Studies, 36*(2), 137-144.

Buchan, J., & Thompson, M. (1997). *Recruiting, retaining and motivating nursing staff: The use of clinical ladders*. Brighton: The Institute for Employment Studies.

Burket, T. L., Felmlee, M., Greider, P. J., Hippensteel, D. M., Rohrer, E. A., & Shay, M. L. (2010). Clinical ladder program evolution: Journey from novice to expert to enhancing outcomes. *Journal of Continuing Education in Nursing, 41*(8), 369-374. doi: 10.3928/00220124-20100503-07

Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal, 204*(8), 429-432. doi: 10.1038/sj.bdj.2008.292

Burns, N., & Grove, S. K. (1987). *The practice of nursing research: Conduct, critique and utilisation*. Philadelphia, PA: W.B. Saunders and Company.

Byrne, M., Schroeter, K., Carter, S., & Mower, J. (2009). The professional portfolio: an evidence-based assessment method. *Journal of Continuing Education in Nursing, 40*(12), 545-552. doi: 10.3928/00220124-20091119-07

Carifio, J., & Perla, R. J. (2007). Ten common misunderstandings, misconceptions, persistent myths and urban legends about likert scales and likert response formats and their antidotes. *Journal of Social Sciences, 3*(3), 106-116.

Carlson, L., Crawford, N., & Contrades, S. (1989). Nursing student novice to expert: Benner's research applied to education. *Journal of Nursing Education, 28*(4), 188-190.

Carr, W. (1986). Theories of theory and practice. *Journal of Philosophy of Education, 20*(2), 177-186.

Carryer, J., Budge, C., & Russell, A. (2002). Measuring perceptions of the clinical career pathway in a New Zealand hospital. *Nursing Praxis in New Zealand, 18*(3), 18-29.

Carryer, J., Russell, A., & Budge, C. (2007). Nurses' understandings of the Professional Development Recognition Programme. *Nursing Praxis in New Zealand, 23*(2), 5-13.

Carter, L., Hanna, M., & Warry, W. (2016). Perceptions of the impact of online learning as a distance-based Learning model on the professional practices of working nurses in northern Ontario. *Canadian Journal of Learning & Technology, 42*(3), 1-15.

Casey, D. C., & Egan, D. (2010). The use of professional portfolios and profiles for career enhancement. *British Journal of Community Nursing, 15*(11), 547-552.

Casey, M., Cooney, A., O' Connell, R., Hegarty, J.-M., Brady, A.-M., O' Reilly, P., . . . O' Connor, L. (2017). Nurses', midwives' and key stakeholders' experiences and perceptions on requirements to demonstrate the maintenance of professional competence. *Journal of Advanced Nursing, 73*(3), 653.

Clarke, T., Abbenbroek, B., & Hardy, L. (1996). The impact of a high dependency unit continuing education program on nursing practice and patient outcomes. *Australian Critical Care, 9*(4), 138.

Cleary, M., Horsfall, J., O'Hara-Aarons, M., Jackson, D., & Hunt, G. (2011). The views of mental health nurses on continuing professional development. *Journal of Clinical Nursing, 20*(23-24), 3561-3566. doi: 10.1111/j.1365-2702.2011.03745.x

Cohen, L., Manion, L., & Morrison, K. (2011). *Research methods in education* (7th ed.). London: Routledge.

Cole, K. E., & Johnson, L. M. (2014). Improving patient access time: Arterial cannulation. *Intensive & Critical Care Nursing, 30*(3), 167-174. doi: 10.1016/j.iccn.2013.11.005

Coleman, E., Coon, S., Lockhart, K., Kennedy, R., Montgomery, R., Copeland, N., . . . Stewart, C. (2009). Effect of certification in oncology nursing on nursing-sensitive outcomes. *Clinical Journal of Oncology Nursing, 13*(2), 165-172. doi: 10.1188/09.CJON.165-172

Coleman, H., Rogers, G., & King, J. (2002). Using portfolios to stimulate critical thinking in social work education. *Social Work Education, 21*(5), 583-595. doi: 10.1080/0261547022000015258

Collin, K., Van der Heijden, B., & Lewis, P. (2012). Continuing professional development. *International Journal of Training and Development, 16*(3), 155-163. doi: 10.1111/j.1468-2419.2012.00410x

Collins, K., Onwuegbuzie, A., & Sutton, I. (2006). A model incorporating the rationale and purpose for conducting mixed methods research in special education and beyond. *Learning Disabilities: A Contemporary Journal, 4*, 67-100.

Committee, U. J. (2013). *Common Guidelines for Education Research and Development: A report from the Institute of Education Sciences, U.S Department of Education and the National Science Foundation* United States: Institute of Education Sciences, U.S Department of Education and the National Science Foundation. Retrieved from http://www.nsf.gov/pubs/2013/nsf13126/nsf13126.pdf

Considine, J., Botti, M., & Thomas, S. (2005). Effect of a self-directed learning package on emeregency nurses' knowledge of assessment of oxygenation and use of supplemental oxygen. *Nursing and Health Sciences, 7*(3), 199-208.

Considine, J., Ung, L., & Thomas, S. (2001). Clinical decisions using the national triage scale: How important in postgraduate education? *Accident and Emergency Nursing, 9*(2), 101-108.

Corley, M. C., Farley, B., Geddes, N., Goodloe, L., & Green, P. (1994). The clinical ladder: Impact on nurse satisfaction and turnover. *Journal of Nursing Administration, 24*(2), 42-48.

Costa, L. A. (1990). *The effect of nursing clinical ladder programs on patient care and the role of the nurse.* (PH.D.), WRIGHT INSTITUTE. Retrieved from http://ezproxy.massey.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=ccm&AN=1991133536&site=ehost-live Available from EBSCOhost ccm database.

Costley, C., Eliot, G., & Gibbs, P. (2010). *Doing work based research approaches to enquiry for insider-researchers*. Los Angeles, CA: Sage.

Cotterill-Walker, S. (2012). Where is the evidence that master's level nursing education makes a difference to patient care? A literature review. *Nurse Education Today, 32*(1), 57-64. doi: https://doi-org.ezproxy.massey.ac.nz/10.1016/j.nedt.2011.02.001

CPD4Nurses. (2018). CPD4Nurses continuing professional development for nurses. Retrieved April 11, 2018, from http://www.cpd4nurses.co.nz/

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3rd ed.). London: Sage.

Creswell, J. W. (2015a). *A concise introduction to mixed methods research*. Los Angeles, CA: Sage.

Creswell, J. W. (2015b, December 2015). [Mixed Methods consultation and workshop].

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Los Angeles, CA: Sage.

Cross, P. (1977). *A critical review of the state and national studies of the needs and interests of adult learners*. Paper presented at the National Institute of Education Invitation Conference Washington, D.C.

Cross, P. (1981). *Adults as learners*. San Francisco, CA: Jossey-Bass.

Crotty, M. (1998). *The foundations of social research meaning and perspective in the research process*. St Leonards: Allen and Unwin.

Curzon, L. B. (2003). *Teaching in further education: An outline of principles and practice* (6th ed.): London: Continuum.

DeCuir-Gunby, J. T., Marshall, P. L., & McCulloch, A. W. (2011). Developing and using a codebook for the analysis of interview data: An example from a professional development research project. *Field Methods, 23*(2), 136-155. doi: 10.1177/152822X10388468

Detroyer, E., Dobbels, F., Teodorczuk, A., Deschodt, M., Depaifve, Y., Joosten, E., & Milisen, K. (2018). Effect of an interactive eLearning tool for delirium on patient and nursing

outcomes in a geriatric hospital setting: Findings of a before-after study. *BMC Geriatrics, 18*, 1.

Donyai, P., Herbert, R. Z., Denicolo, P. M., & Alexander, A. M. (2011). British pharmacy professionals' beliefs and participation in continuing professional development: A review of the literature. *International Journal of Pharmacy Practice, 19*(5), 290-317. doi: 10.1111/j.2042-7174.2011.00128.x

Doughty, L., McKIllop, A., Dixon, R., & Sinnema, S. (2018). Educating new graduate nurses in their first year of practice: The perspective and experiences of the new graduate nurses and the director of nursing. *Nurse Education in Practice, in press* doi: 10.1016/j.nepr.2018.03.006

Dowswell, T., Bradshaw, G., & Hewison, J. (2000). Child care responsibilities and participation in continuing education and traning: Issues relating to motivation, funding and domestic roles. *Journal of Advanced Nursing, 32*(2), 445-453.

Duff, B., Gardner, G., & Osborne, S. (2014). An integrated educational model for continuing nurse education. *Nurse Education Today, 34*(1), 104-111. doi: 10.1016/j.nedt.2012.11.022

Ekmekci, O. (2013). Promoting collaboration in health care teams through interprofessional education: A simulation case study. *International Journal of Higher Education, 2*(1), 78-83.

Ellis, L. B. (1996). Evaluating the effects of continuing nurse education on practice: Researching for impact. *Journal of Research in Nursing, 1*(4), 296.

Endacott, R., Gray, M. A., Jasper, M. A., McMullan, M., Miller, C., Scholes, J., & Webb, C. (2004). Using portfolios in the assessment of learning and competence: The impact of four models. *Nurse Education in Practice, 4*(4), 250-257.

Evidential Requirements Working Party. (2009). *Professional development and recognition programme (PDRP) evidential requirements working party report*. New Zealand: Nurse Executives of New Zealand Inc., New Zealand Nurses Organisation.

Fleet, L. J., Fox, G., Kirby, F., Whitton, C., & McIvor, A. (2011). Evaluation outcomes resulting from an internet-based continuing professional development (CPD) asthma program: Its impact on participants' knowledge and satisfaction. *Journal of Asthma, 48*(4), 400-404. doi: 10.3109/02770903.2011.563811

Fleet, L. J., Kirby, F., Cutler, S., Dunikowski, L., Nasmith, L., & Shaughnessy, R. (2008). Continuing professional development and social accountability: A review of the literature. *Journal of Interprofessional Care, 22*, 15-29. doi: 10.1080/13561820802028360

Fraenkel, J. R., & Wallen, N. E. (2009). *How to design and evaluate research in education* (7th ed.). New York, NY: McGraw-Hill.

Gallagher, L. (2007). Continuing education in nursing: A concept analysis. *Nurse Education Today, 27*(5), 466-473.

Gerrish, K., McManus, M., & Ashworth, P. (2003). Creating what sort of professional? Master's level nurse education as a professionalising strategy. *Nursing Inquiry, 10*(2), 103-112.

Gillespie, B. M., Chaboyer, W., Wallis, M., & Werder, H. (2011). Education and experience make a difference: Results of a predictor study. *AORN Journal, 94*(1), 78-90. doi: 10.1016/j.aorn.2010.11.037

Gillham, B. (2000a). *Developing a questionnaire*. London: Continuum.

Gillham, B. (2000b). *The research interview* New York: Continuum.

Goodloe, L. R., Sampson, R. C., Munjas, B., Whitworth, T. R., Lantz, C. D., Tangley, E., & Miller, W. (1996). Clinical ladder to professional advancement program: An evolutionary process. *Journal of Nursing Administration, 26*(6), 58-64.

Goodrich, C. A., & Ward, C. W. (2004). Professional issues. Evaluation and revision of a clinical advancement program. *MEDSURG Nursing, 13*(6), 391-398.

Gorard, S., & Smith, E. (2007). Do barriers get in the way? A review pf the determinants of post-16 participation. *Research in Post-Compulsory Education, 12*(2), 141-158. doi: 10.1080/13596740701387437

Gould, D., Drey, N., & Berridge, E. (2007). Nurses' experiences of continuing professional development. *Nurse Education Today, 27*(6), 602-609.

Grix, J. (2002). Introducing students to the generic terminology of social research. *Politics, 22*(3), 175-186.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-52. doi: 10.1177/1525822x05279903

Gustin, T. J., Semler, J. E., Holcomb, M. W., Gmeiner, J. L., Brumberg, A. E., Martin, P. A., & Lupo, T. C. (1998). A clinical advancement program: Creating an environment for professional growth. *Journal of Nursing Administration, 28*(10), 33-39.

Hardwick, S., & Jordan, S. (2002). The impact of part-time post-registration degrees on practice. *Journal of Advanced Nursing, 38*(5), 524.

Harris, L. R., & Brown, G. T. L. (2010). Mixing interview and questionnare methods: Practical problems in aligning data. *Practical assessment, research and evaluation, 15*(1), 1-19. http://pareonline.net/getvn.asp?v=15&n=1

Harrison, B. S. (1993). *Continuing nursing education: an analysis of the relationship between benefits, participation and socialization of registered nurse in Southeastern Virginia.* (ED.D.), COLLEGE OF WILLIAM AND MARY. Retrieved from http://ezproxy.massey.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=ccm&AN=1997051248&site=ehost-live Available from EBSCOhost ccm database.

Havill, L. M. (2010). *Careering into the future: Nurses' opinions of the professional development and recognition programme* (Master of Health Sciences (Nursing)), Otago, Christchurch. Retrieved from https://ourarchive.otago.ac.nz/handle/10523/370

Haywood, H., Pain, H., Ryan, S., & Adams, J. (2012). Engagement with continuing professional development. *Journal of Allied Health, 41*(2), 83-89.

Heath, S., & Utiera, O. (2014a). *Evaluation of a training programme for registered nurses to undertake nurse led clinics for therapeutic venesection patients*. New Zealand Blood Service. Auckland.

Heath, S., & Utiera, O. (2014b). *Report on the collections training needs analysis*. Auckland: New Zealand Blood Service.

Hespenheide, M., Cottingham, T., & Mueller, G. (2011). Portfolio use as a tool to demonstrate professional development in advanced nursing practice. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 25*(6), 312-320.

Higgins, N., Keogh, S., & Rickard, C. (2015). Original article: evaluation of a pilot educational program on safe and effective insertion and management of peripheral intravenous catheters. *Journal of the Association for Vascular Access, 20*, 37-42. doi: 10.1016/j.java.2014.12.001

Hinchliff, S. (1998). Lifelong learning in context. In F. Quinn (Ed.), *Continuing professional development in nursing: A guide for practitioners and educators*. Cheltenham: Stanley Thorne.

Hoffmann, T. (2013). Reflecting on the importance of reflection and critical analysis in prior learning portfolios: Instructional materials designed to enhance and guide the portfolio development and evaluation process. *Journal of Continuing Higher Education, 61*(2), 116-121. doi: 10.1080/07377363.2013.796841

Imenda, S. (2014). Is there a conceptual difference between theoretical and conceptuial frameworks? *J. Soc. Sci, 38*(2), 185-195.

Ingram, R. (1991). Why does nursing need theory? *Journal of Advanced Nursing, 16*, 350-353.

Institute of Education Sciences., U.S. Department of Education., & Foundation., N. S. (2013). *Common guidelines for education research and development: A report from the Institute of Education Sciences, U.S Department of Education and the National Science Foundation*. Institute of Education Sciences. U.S. Department of Education, National Science Foundation. Retrieved from http://www.nsf.gov/pubs/2013/nsf13126/nsf13126.pdf

Jamieson, S. (2004). Likert scales: How to (ab)use them. *Medical Education, 38*, 1217-1218. doi: 10.1111/j.1365-2929.2004.02012.x

Jasper, M. A. (1995). The potential of the professional portfolio for nursing. *Journal of Clinical Nursing, 4*(4), 249-255. doi: 10.1111/1365-2702.ep11545524

Johnson, B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14-26.

Jones, S. (1989). Is unity possible? *Nursing Standard 18*(3), 22-23.

Jones, W. J., Jenkins, J., & Johnson, J. A. (1988). Clinical career ladder development in nursing: Concepts and issues. *Journal of Health and Human Resources Administration, 10*(4), 361-377.

Jordan, S., Coleman, M., Hardy, B., & Hughes, D. (1999). Assessing educational effectiveness: The impact of a specialist course on the delivery of care. *Journal of Advanced Nursing, 30*(4), 796-807. doi: 10.1046/j.1365-2648.1999.01176.x

Joyce, P., & Cowman, S. (2007). Continuing professional development: Investment or expectation? *Journal of Nursing Management, 15*(6), 626-633 628p. doi: 10.1111/j.1365-2834.2007.00683.x

Jukkala, A. M., Henly, S. J., & Lindeke, L. L. (2008). Rural perceptions of continuing professional education. *Journal of Continuing Education in Nursing, 39*(12), 555-563. doi: 10.3928/00220124-20081201-08

Kao, S.-H., Hsu, L.-L., Hsieh, S.-I., & Huang, T.-H. (2013). The effects of two educational interventions on knowledge and competence of nurses with regard to conveying gastroscopy-related information to patients. *Journal of Advanced Nursing, 69*(4), 793-804. doi: 10.1111/j.1365-2648.2012.06062.x

Khatony, A., Nayery, N. D., Ahmadi, F., Haghani, H., & Vehvilainen-Julkunen, K. (2009). The effectiveness of web-based and face-to-face continuing education methods on nurses' knowledge about AIDS: A comparative study. *BMC Medical Education, 9*, 41-41. doi: 10.1186/1472-6920-9-41

Klenowski, V., Askew, S., & Carnell, E. (2006). Portfolios for learning, assessment and professional development in higher education. *Assessment & Evaluation in Higher Education, 31*(3), 267-286.

Koch, T. (1990). A new clinical career structure for nurses: trial and evaluation. The South Australian experience. *Journal of Advanced Nursing, 15*(8), 869-876. doi: 10.1111/j.1365-2648.1990.tb01941.x

Korman, C., & Eliades, A. B. (2010). Evaluation through research of a three-track career ladder program for registered nurses. *Journal for Nurses in Staff Development, 26*(6), 260-266. doi: 10.1097/NND.0b013e31819b5c25

Krugman, M., Smith, K., & Goode, C. J. (2000). A clinical advancement program: Evaluating 10 years of progressive change. *Journal of Nursing Administration, 30*(5), 215-225.

Kruijver, I. P. M., Kerkstra, A., Francke, A. L., Bensing, J. M., & van de Wiel, H. B. M. (2000). Evaluation of communication traning programs in nursing care: A review of the literature *Patient Education and Counseling, 39*, 129-145.

Lave, J. (1996). Teaching, as learning, in practice. *Mind, Culture, and Activity, 3*(3), 149-164. doi: 10.1207/s15327884mca0303_2

Lee, A. C. K., Tiwari, A. F. Y., Choi, E. W. H., Yuen, K. H., & Wong, A. (2005). Hong Kong nurses' perceptions of and participation in continuing nursing education. *Journal of Continuing Education in Nursing, 36*(5), 205-212 208p.

Lovelace, M., & Brickman, P. (2013). Best practices for measuring students' attitudes toward learning science. *CBE Life Sciences Education, 12*(4), 606-617. doi: 10.1187/cbe.12-11-0197

Lusk, B., Russell, L., Rodgers, J., & WIlson-Barnett, J. (2001). Pre-registration nursing education in Australia, New Zealand , the United Kingdom and the United States of America. *Journal of Nursing Education, 40*(5), 197-202.

Malik, D. M. (1992). Job satisfaction related to use of career ladder. *Journal of Nursing Administration, 22*(3), 7.

Manley, K., Hardy, S., Tichen, A., Garbett, R., & McCormack, B. (2005). *Changing patients' worlds through nursing practice expertise: Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation*. London: Royal College of Nursing. Retrieved from
http://www.rcn.org.uk/__data/assets/pdf_file/0005/78647/002512.pdf

Manley, K., Martin, A., Jackson, C., & Wright, T. (2018). A realist synthesis of effective continuing professional development (CPD): A case study of healthcare practitioners' CPD. *Nurse Education Today, 69*, 134-141. doi: 10.1016/j.nedt.2018.07.010

Manning, L. (2015). Tips for a top nurse portfolio.   Retrieved May 2016, from nursingreview.co.nz/tips-for-a-top-nurse-portfolio/

Marshall, A. P., Currey, J., Aitken, L. M., & Elliott, D. (2007). Key stakeholders' expectations of educational outcomes from Australian critical care nursing courses: A delphi study. *Australian Critical Care, 20*(3), 89-99.

Mathers, N. J., Challis, M. C., Howe, A. C., & Field, N. J. (1999). Portfolios in continuing medical education: Effective and efficient? *Medical Education, 33*(7), 521-530.

McClure, M. L., Poulin, M. A., Sovie, M. D., & Wandelt, A. (1983). *Magnet Hospitals: Attraction and Retention of Professional Nurses. American Academy of Nursing. Task Force on Nursing Practice in Hospitals*. Kansas CIty: American Academy of Nursing. American Nurses' Association.

McColgan, K. (2008). The value of portfolio building and the registered nurse: A review of the literature. *Journal of Perioperative Practice, 18*(2), 64-69.

McCready, T. (2007). Portfolios and the assessment of competence in nursing: A literature review. *International Journal of Nursing Studies, 44*(1), 143-151.

McDermid, F., Peters, K., Jackson, D., & Daly, J. (2014). Conducting qualitative research in the context of pre-existing peer and colleagial relationships. *Nurse Researcher, 21*(5), 28-33.

McKillop, A., Doughty, L., Atherfold, C., & Shaw, K. (2016). Reaching their potential: Perceived impact of a collaborative academic--clinical partnership programme for early career nurses in New Zealand. *Nurse Education Today*. doi: 10.1016/j.nedt.2015.09.005

McMullan, M., Endacott, R., Gray, M. A., Jasper, M., Miller, C. M. L., Scholes, J., & Webb, C. (2003). Portfolios and assessment of competence: A review of the literature. *Journal of Advanced Nursing, 41*(3), 283-294. doi: 10.1046/j.1365-2648.2003.02528.x

Miller, A. (1985). The relationship between nursing theory and nursing practice. *Journal of Advanced Nursing, 10*, 417-424.

Minick, P., & Harvey, S. (2003). The early recognition of patient problems among medical-surgical nurses. *MEDSURG Nursing, 12*(5), 291-297.

Ministry of Health. (1988). *Nursing education in transition: The transfer of nursing education to the general system of education 1973-1988: The Department of Health's perspective*. Wellington: Department of Health

Ministry of Health. (2009). *Clinical Training Agency purchase intentions: 2009/10*. Wellington: Ministry of Health. Retrieved from http://www.moh.govt.nz

Moore, D. A., Klingborg, D. J., Brenner, J. S., & Gotz, A. (2000). Motivations for and barriers to engaging in contiuing vetinary medical education *Journal of the American Vetinary Medicine Association, 217*(7), 1001-1006.

Morrison, S. M., & Symes, L. (2011). An integrative review of expert nursing practice. *Journal of Nursing Scholarship, 43*(2), 163-170. doi: 10.1111/j.1547-5069.2011.01398.x

Murphy, C., Cross, C., & McGuire, D. (2006). The motivation of nurses to participate in continuing professional education in Ireland. *Journal of European Industrial Training, 30*(5), 365-384.

National Council of State Boards of Nursing. (1996). Assuring competence. A regulatory responsibility position paper. from http://www.ncsbn.org/resources/complimentary_ncsbn_competence.asp.

National PDRP Co-ordinators. (2014). *Minutes of the Annual meeting 2014*. Auckland: National PDRP Co-ordinators.

National PDRP Co-ordinators. (2015). *Minutes of the annual meeting 2015*. Auckland National PDRP Co-ordinators.

National PDRP Co-ordinators. (2016). *Minutes of the annual meeting 2016*. Auckland: National PDRP Co-ordinators.

New Zealand Government. (1988). *State Sector Act*. Wellington: New Zealand Government.

New Zealand Government. (2003). *Health Practitioners Competence Assurance Act*. Wellington: New Zealand Government.

New Zealand Nurses' Organisation. (2018). Continuing professional development for nurses. Retrieved April 11, 2018, from https://www.nzno.org.nz/support/education/nz_education_websites

Ng, C. (2010). Portfolios: An affordable and effective means to pursue lifelong learning. In M. P. Caltone (Ed.), *Handbook of Lifelong Learning Development* (pp. 347-360). Melbourne, VIC: Nova Science Publishers Inc.

Ng, C., White, P., & McKay, J. C. (2007). A review of the development of electronic portfolios in education and health discplines: Supporting students' learning and continuing professional development. *The Radiographer, 54*(3), 24-29.

Noome, M., Kolmer, D. M., van Leeuwen, E., Dijkstra, B. M., & Vloet, C. M. (2016). The nursing role during end-of-life care in the intensive care unit related to the interaction between patient, family and professional: An integrative review. *Scandanavian Journal of Caring Sciences, 30*(4), 645-661. doi: 10.1111/scs.12315

Norman, M., & Hyland, T. (2003). The role of confidence in lifelong learning. *Educational Studies June*, 1-16. doi: 10.1080/03055690303275

Nurse Executives of New Zealand. (2017). *National framework and evidential requirements for New Zealand Nursing Professional Development and Recognition Programmes (PDRP)*. Wellington: Nurse Executives of New Zealand. Retrieved from https://www.nzno.org.nz/support/professional_development

Nursing and Midwifery Board of Australia. (2017). Registration renewal.   Retrieved July 2016, from http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Registration-Renewal.aspx

Nursing and Midwifery Council. (2014). Library of Standards.   Retrieved September 18, 2014, from http://standards.nmc-uk.org/PreRegNursing/statutory/competencies/Pages/context.aspx

Nursing and Midwifery Council. (2016). Revalidation: Dispelling the myths.   Retrieved September 2016, 2016, from https://www.nmc.org.uk/news/press-releases/revalidation-dispelling-the-myths/

Nursing and Midwifery Council. (2018). Revalidation.   Retrieved April 6 2018, from http://revalidation.nmc.org.uk/

Nursing Council of New Zealand. (2004). *Continuing Competence Framework*. Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. (2013). *Fact Sheet -The future nursing workforce: Supply projections 2010-2035*. Wellington: Nursing Council of New Zealand

Nursing Council of New Zealand. (2016a). *Approved professional development and recognition programmes*. Retrieved from file:///C:/Users/heath/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8b bwe/TempState/Downloads/Approved%20professional%20development%20and%20re cognition%20programmes%203%20November%202016.pdf

Nursing Council of New Zealand. (2016b). Continuing Competence.   Retrieved March 2, 2016, from http://www.nursingcouncil.org.nz/Nurses/Continuing-competence

Ogier, M. E., & Barnet, D. E. (1986). Sister/staff nurse and the nurse learner. *Nurse Education Today, 6*(1), 16-22. doi: http://dx.doi.org/10.1016/0260-6917(86)90057-2

Onwuegbuzi, A. J., & Collins, K. M. T. (2007). A typology of mixed methods sampling designs in social science research. *The Qualitative Report, 12*(2), 281-316.

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issue in mixed methods research. *Research in Schools, 13*(1), 48-63.

Onwuegbuzie, A. J., Johnson, R. B., & Collins, K. M. T. (2009). Call for mixed analysis: A philosophical framework for combining qualitative and quantitative approaches. *International Journal of Multiple Research Approaches, 3*(2), 114-139.

Oppenheim, A. N. (1992). *Questionnaire design, interviewing and attitude measurement*. New York: Cassell

Paterson, H., Hay-Smith, E. J. C., & Treharne, G. J. (2017). Women's experiences of changes in eating during pregnancy: A qualitative study in Dunedin, New Zealand. *New Zealand College of Midwives Journal*(52), 5-11. doi: http://dx.doi.org/10.12784/nzcomjnl52.2016.1.5-11

Peach, J. (2013). First PDRP fast-tracked in response to decade of discontent. *Nursing Review, 13*(6), 16-17.

Pelletier, D., Donoghue, J., & Duffield, C. (2003). Australian nurses' perception of the impact of their postgraduate studies on their patient care activities. *Nurse Education Today 23*, 434-442.

Pena, Y. F., & Castillo, M. A. (2006). Factors influencing staff members' participation in continuing education. *Rev Latino-Am Enfermagem, 14*(3), 309-315.

Phillips, J. L., Heneka, N., Hickman, L., Lam, L., & Shaw, T. (2014). Impact of a novel online learning module on specialist palliative care nurses' pain assessment competencies and patients' reports of pain: Results from a quasi-experimental pilot study. *Palliative Medicine, 28*(6), 521-529. doi: 10.1177/0269216314527780

Pool, I., Poell, R., & Cate, O. t. (2013). Nurses' and managers' perceptions of continuing professional development for older and younger nurses: A focus group study. *International Journal of Nursing Studies, 50*(1), 34-43. doi: 10.1016/j.ijnurstu.2012.08.009

Powers, K. A. (2016). Family presence during resuscitation: impact of online learning on nurses' perception and self-confidence *American Journal of Critical Care, 25*(4), 302.

Punch, K. (2003). *Survey research: The basics*. London: Sage.

Punch, K. (2014). *Introduction to social research quantitative and qualitative approaches*. London: Sage.

Richards, L., & Potgieter, E. (2010). Perceptions of registered nurses in four state health insititutions on continuing formal education. *Curationis, 33*(2), 41-50 10p.

Riley, J. K., Rolband, D. H., James, D., & Norton, H. J. (2009). Clinical ladder: Nurses' perceptions and satisfiers. *Journal of Nursing Administration, 39*(4), 182-188. doi: 10.1097/NNA.0b013e31819c9cc0

Robson, C. (1993). *Real world research a resource for social scientists and practitioner-researchers*. Oxford: Blackwell.

Roedel, R. R., & Nystrom, P. C. (1987). Clinical ladders and job enrichment. *Hospital Topics, 65*(2), 22-24. doi: 10.1080/00185868.1987.10543587

Ross, K., Barr, J., & Stevens, J. (2013). Mandatory continuing professional development requirements: What does this mean for Australian nurses? *BMC Nursing, 12*(1), 9-15. doi: 10.1186/1472-6955-12-9

Samy, A. A. (2008). Use of portfolios by medical students: Significance of critical thinking. *Kaohsiung Journal of Medical Sciences, 24*(7), 361-366. doi: 10.1016/S1607-551X(08)70133-5

Sanford, R. C. (1987). Clinical ladders: Do they serve their purpose? *Journal of Nursing Administration, 17*(5), 34-37.

Schmidt, L. A., Nelson, D., & Godfrey, L. (2003). A clinical ladder program based on Carper's fundamental patterns of knowing in nursing. *Journal of Nursing Administration, 33*(3), 146-152.

Schon, D. A. (1983). *The reflective practitioner: How professionals think in action*. London: Maurice Temple Smith Ltd.

Schultz, A. W. (1993). Evaluation of a clinical advancement system. *Journal of Nursing Administration, 23*(2), 13-19.

Schweitzer, D. J., & Krassa, T. J. (2010). Deterrents to nurses' participation in continuing professional development: An integrative literature review. *Journal of Continuing Education in Nursing, 41*(10), 441-447. doi: 10.3928/00220124-20101001-04

Shaw, T., McGregor, D., Sinclair, S., Sutherland, R., Munro, A., & Ross, J. (2014). E-learning portal for professional development in cancer care. *Education + Training, 56*(2/3), 165-178. doi: 10.1108/ET-11-2012-0113

Shin, J. Y., Issenberg, S. B., & Roh, Y. S. (2017). The effects of neurologic assessment elearning on nurses. *Nurse Education Today*. doi: 10.1016/j.nedt.2017.07.007

Spence, W., & El-Ansari, W. (2004). Portfolio assessment: Practice teachers' early experience. *Nurse Education Today, 24*(5), 388-401.

Spiva, L., Johnson, K., Robertson, B., Barrett, D. T., Jarrell, N. M., Hunter, D., & Mendoza, I. (2012). The effectiveness of nurses' ability to interpret basic electrocardiogram strips accurately using different learning modalities. *Journal of Continuing Education in Nursing, 43*(2), 81-89. doi: 10.3928/00220124-20111011-02

Spurr, P. G. (1996). *Perceived deterrents to participation in professional development of hospital-based registered nurses.* (ED.D.), UNIVERSITY OF LOUISVILLE. Retrieved from http://ezproxy.massey.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=ccm&AN=1999070541&site=ehost-live Available from EBSCOhost ccm database.

Stout, L. (2013). Nurses' perceptions of transfusion training: An evaluation. *British Journal of Nursing*, 22-28.

Tariq, S., & Woodman, J. (2010). Using mixed methods in health research. *Journal of the Royal Society of Medicine short reports*, 1-8. doi: 10.1177/2042533313479197

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research integrating quantitative and qualitative approaches in the social and behavioural sciences*. Thousand Oaks, CA: Sage.

Tennant, S., & Field, R. (2004). Continuing professional development: Does it make a difference? *Nursing in Critical Care, 9*(4), 167-172.

Thomas, H., & Qiu, T. (2013). Continuing professional development: Accountability, autonomy, efficiency and equity in five professions. *British Journal of Educational Studies, 61*(2), 161-186. doi: 10.1080/00071005.2012.756445

Thornhill, S. K. (1994). Hospital clinical career advancement programs: Comparing perceptions of nurse participants and nonparticipants. *Health Care Supervisor, 13*(1), 16-25.

Tisani, N. (2008). Challenges in producing a portfolio for assessment: In search of underpinning educational theories. *Teaching in Higher Education, 13*(5), 549-557. doi: 10.1080/13562510802334830

Tiwari, A., & Tang, C. (2003). From process to outcome: The effect of portfolio assessment on student learning. *Nurse Education Today, 23*(4), 269-277.

Tofade, T. S., Hedrick, J. N., Dedrick, S. C., & Caiola, S. M. (2013). Evaluation of pharmacist continuing professional development portfolios. *Journal of Pharmacy Practice, 26*(3), 237-247. doi: 10.1177/0897190012452311

Tuckman, B. W. (1978). *Conducting educational research* (5th ed.). New York, NY: Harcourt Brace Jovanovich.

UKCC. (1986). *Project 2000: A new preparation for practice*. London: UKCC.

Urbano, M. T., & Jahns, I. R. (1988). A conceptual framework for nurses' participation in continuing education. *The Journal of Continuing Education in Nursing, 19*(4), 182-186.

Vernon, R., Chiarella, M., & Papps, E. (2013). Assessing the continuing competence of nurses in New Zealand. *Journal of Nursing Regulation, 3*(4), 19-24.

Vernon, R., Chiarella, M., Papps, E., & Dignam, D. (2013). New Zealand nurses' perceptions of the continuing competence framework. *International Nursing Review, 60*(1), 59-66. doi: 10.1111/inr.12001

Waring, M. (2012). Finding your theoretical position. In J. Arthur, M. Waring, R. Coe, & L. V. Hedges (Eds.), *Research methods and methodologies in education*. London: Sage.

Warr, T. (1994). Safeguarding your career: Clinical career pathway. *Nursing New Zealand, 2*(9), 11-11.

Weaver-Hightower, M. B. (2008). An ecology metaphor for educational policy analysis: A call to complexity. *Educational Researcher*(3), 153. doi: 10.2307/30137956

Weddle, D. O., Himburg, S. P., Collins, N., & Lewis, R. (2002). The professional development portfolio process: Setting goals for credentialing. *Journal of the American Dietetic Association, 102*(10), 1439.

Wenghofer, E. F., Campbell, C., Marlow, B., Kam, S. M., Carter, L., & McCauley, W. (2015). The effect of contiuing professional development on public complaints: A case control study. *Medical Education, 49*, 264-275. doi: 10.1111/medu.12633

Williams, M., & Jordan, K. (2007). The nursing professional portfolio: A pathway to career development. *Journal for Nurses in Staff Development, 23*(3), 125-131.

Appendices

Appendix A: PDRP requirements

The levels used at New Zealand Blood Service are designated as Competent, Proficient and Expert reflecting the underpinning model of professional development (Benner's Novice to Expert model); (Benner 1984). Nurses must be supported by their direct manager for the level chosen for validation. Nurse Managers are expected to be able to identify the clinical behaviours of their nurses which show characteristics of the level applied for. Manager support is documented by signature when evidence is submitted for review by the assessment team.

Competent Level
Characteristics of practice: *Conscious and deliberate planning is a feature of performance by the competent RN. A developing sense of mastery of a range of situations is evident along with increasing levels of efficiency. The competent RN can balance priorities and options within situations and critical thinking is emerging. At this level, the competent RN demonstrates competence in clinical skills related to their area of practice. The competent RN is able to comprehend the value, meaning and purpose of the therapeutic relationship with the donor/patient and appreciates the social, economic, regulatory and political influences on their clinical nursing practice.*

Requirements	
1. Completion of all mandatory training for NZBS (e.g. Fire training, resuscitation training)	
2. Evidence of completing 60 hours of professional development activities within the last three years	Required by Nursing Council, these hours are documented including the type of activity undertaken with a brief outline of the learning objectives achieved and the impact of information brought back and used in the clinical setting
3. Evidence of completing 450 hours of clinical practice in the last three years	Required by Nursing Council, this evidence can be supplied from payslips or by letter from payroll departments
4. Self-assessment against Nursing Council competencies	This evidence must meet the requirements of Nursing Council showing an example of how the nurse evidences meeting the competency in their everyday clinical practice
5. Peer/Manager assessment against Nursing Council competencies	Required by Nursing Council, this evidence is completed as third party evidence effectively validating the self-assessment offered by the PDRP participant. However, examples of everyday practice must be largely different to those supplied by the nurse
6. A learning development plan	The purpose of including this activity is to demonstrate to Nursing Council that the nurse remains focussed and interested in their ongoing professional development

At **proficient** level, nurse must also meet Nursing Council continuing competence requirements and mandatory training requirements for NZBS. However, the level of practice is expected to be reflected in the practice vignettes supplied as evidence to validate meeting Nursing Council competencies for the relevant scope of practice. Additionally, at this level the NZBS programme requires the submission of the following written work:

Proficient Level
Characteristics of practice: *The proficient RN perceives the clinical situation as whole rather than as discreet aspects and demonstrates a broad knowledge base and grasp of varied situations. The proficient RN has a developing repertoire of options that are available to them and demonstrates an increased confidence in clinical ability. Relationships with donors/patients are intentionally therapeutic with the proficient RN being responsive to the donor's/patient's unique context. Through nursing action, the proficient RN demonstrates conscious awareness of social, cultural, economic, regulatory and political influences, and recognises the impact of personal views and behaviours on the situation. Able to share experience and knowledge with others, the proficient EN accepts responsibility and leadership within scope of practice, actively participating as a member of the team.*

Requirements	
1. Completion of all mandatory training for NZBS (e.g. Fire training, resuscitation training)	
2. Completion of continuing competence requirements prescribed by Nursing Council	
3. A case study, exemplar **OR** reflection on practice	Written work submitted demonstrates the characteristics of the Proficient practitioner provided in the definition for the level (see above). Guidance is provided for the format to use to enable inclusion of the appropriate aspects of reflection and demonstrating use of Kolb's experiential learning cycle
4. Evidence of completing a teaching session **OR** preceptoring a member of staff who is new to the organisation or learning a new procedure.	In this option it is necessary to provide a lesson plan and teaching resources for example if the first option is presented, or notes from meetings or progress reports, completion of initial training sufficient that the new staff member is able to meet the required standard at final skills assessment and evaluation of experience by the new staff member for the second option
5. Evidence of participating in a practice development **OR** quality initiative.	This option requires nurse to demonstrate that they are active at their local centre in promoting or identifying areas for practice improvement or alternatively, that they are positive, active participants in the implementation of new innovation

At **expert** level, programme participants must meet the same criteria as the proficient practitioners. However, experts must ensure that they supply evidence in their practice vignettes that is reflective of the definition of an expert practitioner. Additionally, this level of practitioner is required to provide evidence of two further written options:

Expert Level	
Characteristics of practice: *Guided by well-developed professional values, the expert practitioner is supported by extensive knowledge and clinical ability that contribute to the sense of salience of a range of alternatives within their specialty practice area. In addition to their considerable experience, the expert practitioner also demonstrates leadership in professional practice and contributes to the professional development of colleagues. They understand contemporary issues in nursing and the potential for impact on their practice area.*	
Requirements	
1. Completion of all mandatory training for NZBS (e.g. Fire training, resuscitation training)	
2. Completion of continuing competence requirements prescribed by Nursing Council	
3. Completion of a written case study, exemplar or reflection; Evidence of completing a teaching session or preceptoring a new member of staff; Evidence of participating in a practice development or quality initiative **AND:**	
4. Showcase how s/he is a resource to the organisation	Examples are varied but the kind of examples most frequently included are usually linked to extension of their everyday Registered Nursing role to undertake activities like providing a nurse-led clinic for therapeutic venesection patients. Evidence provided shows how individuals use their critical thinking to make decisions about patient treatment using the organisation's guidelines and normally, nurses will include how they guide and support other nurses to make the appropriate blood collections.
5. Completion of a postgraduate qualification or evidence of study at level 8 in the last three years	Transcript of university marks or copy of certificate awarded.

Appendix B: Timeline of research completion

March 2016	Ethical approval granted NZBS access granted Pilot study starts: Questionnaires distributed to pilot group Pilot questionnaires analysed
April 2016	Semi-structured interview questions developed Pilot interviews completed Data analysis procedures tested
May 2016	Completion of final draft of questionnaire
June 2016	Attendance at senior nurses meeting for briefing Questionnaire mailed to all eligible participants
July 2016	Return deadline 29 July
August 2016	Questionnaire analysis
September 2016	Questionnaire analysis
October 2016	Semi-structured interview schedule developed and tested
November 2016	Interviews
December 2016	Interviews
January 2017	Interviews complete Data analysis
To present date	Data analysis and write-up

Appendix C: Ethical approval confirmation

MASSEY UNIVERSITY

ALBANY

14 March 2016

Samantha Heath

Dear Samantha

HUMAN ETHICS APPROVAL APPLICATION – NOR 16/03
Enablers of nurses' engagement with continuing professional learning programmes

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a re-approval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Andrew Chrystall
Chair
Human Ethics Committee: Northern

cc Associate Professor Helen Southwood   Professor John O'Neill
    Institute of Education   Director of Education
    Albany Campus   **Palmerston North Campus**

Appendix D: Access approval letter

NZBLOOD
Te Ratonga Toto O Aotearoa

New Zealand Blood Service
National Office
11 Great South Road
Auckland
Private Bag 92071
Auckland 1142

Tel. (09) 523 5733
Fax. (09) 523 5754

March 3, 2016

Samantha Heath

█████████████

Dear Samantha

RE: Enablers of nurses' engagement with continuing professional learning programmes
Application: NOR 16/03

I am able to confirm that in my role as the National Manager of Donor Services and Head Nurse for NZBS, you have approval to conduct the required interviews with staff during work time as part of your research study. You are also given approval to access the PDRP database to assist with this research.

NZBS has funded you to undertake this advanced study as they foresee the outcome of this research will provide future benefits for the organisation.

Yours Sincerely,

Olive Utiera
National Manager Donor Services

Appendix E: Letter of cultural support

New Zealand Blood Service
National Office
11 Great South Road
Auckland
Private Bag 92071
Auckland 1142

Tel.   (09) 523 5733
Fax.   (09) 523 5754

February 2, 2016

To the Ethics Committee,

Re: Enablers of nurses' engagement with continuing professional learning programmes

I have had the opportunity to review the above research proposal by Samantha Heath, Doctor of Education Candidate at Massey University. I am available to provide Samantha with any cultural guidance and support she may need during the conduct of her research.

Yours Sincerely,

Olive Utiera
Chair, Maori Staff Advisory Group, NZBS
National Manager Donor Services

Appendix F: Permission to use previously validated questionnaire

On 29/06/2015, at 6:18 pm, Heath, Samantha <████████████████████> wrote:

Dear Professor Carryer,
My name is Samantha and I'm a year 2 Ed.D student at the Institute of Education at Massey.
As I go into semester 2 this year I will be preparing my full proposal for confirmation oral in November. My intention is to investigate participation in PDRP at New Zealand Blood Service as part of this work and to this end, I wonder if I may seek permission to use the questionnaire developed for the 2002 and 2007 studies published in Nursing Praxis in New Zealand?
If this is possible, please can you let me know any associated costs, acknowledgements and whether an electronic copy would be available?
Thank-you for your consideration.
Kind regards
Samantha

Samantha Heath
Nurse Advisor: Professional Development
New Zealand Blood Service

One blood donation can save the lives of up to three people.
Save Lives, Give Blood.
www.nzblood.co.nz

From: "Carryer, Jenny" <J.B.Carryer@massey.ac.nz>
Date: June 30, 2015 at 1:48:12 PM GMT+12
To: "Heath, Samantha" <Samantha.Heath@nzblood.co.nz>
Subject: Re: PDRP questionnaire

Dear Samantha

Please find attached an electronic copy of the survey we developed.
You are welcome to use it for no charge but with full acknowledgement please.

Kind regards
Jenny Carryer

Professor Jenny Carryer RN PhD FCNA(NZ) MNZM

School of Nursing   College of Health

Phone	+64 6 356 9099 extension 85343
	DDI 9518343
Email	J.B.Carryer@massey.ac.nz
Address	Office 6.17 Social Sciences Tower, Massey University, Palmerston North, New Zealand 4442
Mail	Private Bag 11-222, Palmerston North, New Zealand 4442
Internal	School of Nursing
Mobile	
0274491302	

Appendix G: Questionnaire pre-pilot study

**Enablers of nurses' engagement with
Continuing professional learning programmes**

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MĀTAURANGA

A questionnaire to survey nurses about their engagement with the Professional
Development and Recognition Programme at New Zealand Blood Service

**Please read the study information sheet and accompanying letter before
completing this questionnaire. Return of the completed questionnaire implies
your consent to participate.
Could you please return the questionnaire in the pre-addressed envelope within
two weeks.**

SECTION 1: Information about PDRP

**In this section, the researcher is trying to discover whether facts about PDRP
requirements are well known across NZBS. Please tick the box next to the
answer you think is correct:**

1. What is the minimum number of clinical practice hours are you required to complete in a 3 year period on the RN/EN PDRP pathway?
a)   120   ☐
b)   250   ☐
c)   340   ☐
d)   350   ☐
e)   450   ☐

2. What is the minimum number of hours of continuing professional development (ongoing education) you are required to complete in a 3 year period on the RN/EN PDRP pathway?
a)   20   ☐
b)   40   ☐
c)   60   ☐
d)   100   ☐
e)   120   ☐

3. All the required application and assessment forms for NZBS PDRP are available from which of the following sources? (Tick all that apply)	
a) Cornerstone (the intranet)	☐
b) NZBS eLearn site	☐
c) The PDRP co-ordinator by request	☐
d) Nursing Council	☐
e) My Charge Nurse	☐

4.	Completion of any level on the RN or EN NZBS PDRP pathway ensures that you have completed which of the following requirements? (Tick all that apply)	
a)	NZBS annual Key Knowledge and Skills assessments	☐
b)	An annual performance review	☐
c)	NZNO membership renewal	☐
d)	An Annual Practising Certificate from Nursing Council	☐
e)	Employment at NZBS	☐

5.	Completion of any level on the RN or EN NZBS PDRP pathway exempts you from Nursing Council audit for how long?	
a)	5 years	☐
b)	3 years	☐
c)	2 years	☐
d)	18 months	☐
e)	12 months	☐

6.	Which levels provide a financial allowance on your NZBS PDRP pathway?	
a)	Competent, Proficient, Expert/Accomplished	☐
b)	Expert/Accomplished level only	☐
c)	Proficient level only	☐
d)	Competent level only	☐
e)	Proficient and Expert/Accomplished levels	☐

7.	How many days of paid leave are available to you to complete the initial preparation of a portfolio for the NZBS PDRP programme?	
a)	0	☐
b)	1	☐
c)	2	☐
d)	3	☐
e)	4	☐

8.	With whom should you agree the level of portfolio you will apply for before you begin any work on your portfolio?	
a)	PDRP Co-ordinator	☐
b)	Clinical Nurse Leader	☐
c)	Clinical Coach	☐
d)	Area Manager	☐
e)	Charge Nurse	☐

9.	The NZBS PDRP programme achieved a 5 year period of approval from:	
New Zealand Nurses Organisation		☐
Nursing Council of New Zealand		☐
NZBS Executive		☐
New Zealand Qualifications Authority		☐
The University of Auckland		☐

10. If you have recently been audited by Nursing Council, you are most likely to meet the criteria for which level NZBS PDRP?

None of them	☐
Competent	☐
Proficient	☐
Expert	☐
Accomplished	☐

SECTION 2: Attitude to PDRP

In this section you will read a number of statements. Please indicate your level of agreement with each statement by ticking the appropriate box.

Self-evaluation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. My experience of continuing professional development in nursing has been positive	☐	☐	☐	☐	☐
2. Further learning will enhance my clinical skills	☐	☐	☐	☐	☐
3. I am capable of completing a PDRP portfolio	☐	☐	☐	☐	☐

Attitude to PDRP	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
4. I am motivated to complete a PDRP portfolio	☐	☐	☐	☐	☐
5. Completing a PDRP portfolio helps me to demonstrate my clinical capabilities	☐	☐	☐	☐	☐
6. A PDRP portfolio is needed to evidence my continued development as a healthcare professional	☐	☐	☐	☐	☐

Expectation that participation will meet personal goals	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. Producing a PDRP portfolio is useful for my career	☐	☐	☐	☐	☐
8. I am confused about what PDRP helps me to achieve	☐	☐	☐	☐	☐

Life transitions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
9. Completing a PDRP portfolio suits my learning style	☐	☐	☐	☐	☐
10. I have sufficient time at home to complete the requirements for a PDRP portfolio	☐	☐	☐	☐	☐
11. I have sufficient time at work to complete the requirements for a PDRP portfolio	☐	☐	☐	☐	☐

Information	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
12. Information about getting started on the NZBS PDRP is readily available to me	☐	☐	☐	☐	☐
13. My Professional Development Team is accessible to provide advice	☐	☐	☐	☐	☐
14. Resources that help me to complete an NZBS PDRP portfolio are \available to me	☐	☐	☐	☐	☐

Participation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
15. My peers are supportive of me completing a PDRP portfolio	☐	☐	☐	☐	☐
16. My Charge Nurse encourages me to participate in the NZBS PDRP programme	☐	☐	☐	☐	☐
17. My Clinical Nurse Leader encourages me to participate in the NZBS PDRP programme	☐	☐	☐	☐	☐
18. My Clinical Coach encourages me to participate in the NZBS PDRP programme	☐	☐	☐	☐	☐

SECTION 3: Factors influencing decisions to participate in PDRP

In this section, use the scale provided to indicate the extent to which each factor affects your decision to participate in PDRP for example,

If you thought that "PDRP assessors are members of the professional development team and know about New Zealand Blood Service" contributed 'Quite a bit' to your decision to participate, you would answer like this:

	Not at all	Very little	somewhat	Quite a bit	A great deal
PDRP assessors are members of the professional development team and know about New Zealand Blood Service	☐	☐	☐	✓	☐

Indicate the extent to which each factor affects your decision to participate in PDRP	Not at all	Very little	somewhat	Quite a bit	A great deal
1. Understanding the evidence that I am required to prepare for my PDRP portfolio	☐	☐	☐	☐	☐
2. Understanding the evidence that I am required to include in my PDRP portfolio	☐	☐	☐	☐	☐
3. Understanding Nursing Council competencies	☐	☐	☐	☐	☐
4. Understanding how to write a reflection on my clinical practice to include in my PDRP portfolio	☐	☐	☐	☐	☐
5. Understanding how to do a presentation to my colleagues to include in my PDRP portfolio	☐	☐	☐	☐	☐
6. Knowing how to get started with putting a portfolio together	☐	☐	☐	☐	☐
7. The encouragement I get from my workplace about completing PDRP	☐	☐	☐	☐	☐
8. The links I can see between completing PDRP requirements and my clinical practice	☐	☐	☐	☐	☐
9. Access to paid time off work to complete PDRP requirements	☐	☐	☐	☐	☐
10. Getting support when I need it from the Professional Development Team	☐	☐	☐	☐	☐
11. Being excluded from audit by Nursing Council if I participate in the NZBS PDRP programme	☐	☐	☐	☐	☐
12. The amount of my own time I will have to spend on completing PDRP requirements	☐	☐	☐	☐	☐
13. The allowance that is available for completing some levels of the NZBS PDRP	☐	☐	☐	☐	☐

14. Thinking I can actually write about what is being asked	☐	☐	☐	☐	☐
15. Feeling that developing a PDRP portfolio is a professional expectation	☐	☐	☐	☐	☐

Please use the space below to highlight any other factors you think affect participation in PDRP that you don't think have been covered in the list above.

SECTION 4: Demographics

1.	Please indicate your scope of practice by ticking the appropriate box below:

Enrolled Nurse   ☐
Registered Nurse   ☐

2.	Are you:

Male?   ☐
Female?   ☐

3.	Which of the following **initial** nursing qualifications do you hold?

Hospital Certificate in Nursing   ☐
Diploma in Nursing   ☐
Bachelor of Nursing   ☐

4.	Please indicate any other qualifications you may hold from the list below:

Specialist nursing certificate   ☐
Non-nursing Bachelor Degree   ☐
Postgraduate Certificate   ☐
Postgraduate Diploma   ☐
Masters Degree   ☐
Other   ☐   Please list _____

5.	Are you currently undertaking any professional study?

Yes   ☐   Go to next question
No   ☐   Skip to question 7

6.	What are you currently studying?

_____

7.	How many years have you been practising as a nurse?

0-5 years   ☐
6-10 years   ☐
11-15 years   ☐
16-20 years   ☐
21-25 years   ☐
26 or more years   ☐

8.	To which age-group do you belong?
20-30 years	☐
31-40 years	☐
41-50 years	☐
51-60 years	☐
61-70 years	☐

9.	I have already submitted (or transferred) a portfolio to the NZBS PDRP
Yes	☐
No	☐

10.	Do you work:
Full time?	☐
Part time (for example, 0.8 or 0.5 FTE)	☐

11.	How many years have you worked for NZBS?
0-1 years	☐
2-5 years	☐
6-10 years	☐
10-15 years	☐
16 or more years	☐

12.	In which NZBS region do you work?
Northern	☐
Waikato	☐
Central	☐
Southern	☐

Thank-you for completing this questionnaire. Please look out for a summary of the key findings on the intranet in the next few months

Would you be interested in participating in the interview phase of this study? If you answered yes, please use the contact details form attached to this questionnaire to contact Samantha Heath

Appendix H: Participant information sheet

Enablers of nurses' engagement with
Continuing professional learning programmes
INFORMATION SHEET: WHOLE PROJECT

Researcher Introduction

This project is being carried out by Samantha Heath, Nurse Advisor: Professional Development at New Zealand Blood Service. Samantha is carrying out this research as part of her work as a Doctor of Education Candidate at the Institute of Education, Massey University. The research being undertaken is linked to study for this degree and participation in it is voluntary and confidential. The project is being supervised by Associate Professor Helen Southwood PhD, Director, Speech and Language Therapy and Dr. Mark Jones, Associate Head of School of Nursing, Massey University.

Project Description and Invitation

The aim of this study is to understand New Zealand Blood Service nurses' level of engagement with the Professional Development and Recognition Programme (PDRP). The first part of the study will involve completion of a questionnaire which takes around 20-30 minutes to complete. I will analyse the questionnaire answers which will provide a profile of the factors that influence participation in PDRP. Once these factors have been identified, I will ask for volunteers to be interviewed to find out more from you about your experiences with PDRP and the reasons why the factors identified in the survey influence your participation in PDRP.

I would be very grateful if you would consider participating in both the questionnaire and interview phases of this project.

Participant Identification and Recruitment

I am inviting Registered and Enrolled nurses who are eligible to participate in the NZBS PDRP programme to participate in this study. You are eligible to participate whether you have completed a PDRP portfolio or not. If you transferred your current PDRP portfolio onto the NZBS programme, you are also eligible to participate. You are not eligible to participate if your role is linked to the senior nurse pathway on PDRP.

Project Procedures

Information sheets about the project will be provided in your area by your Charge Nurse or Clinical Nurse Leader. Shortly afterwards, you will receive a named package in the internal mail which will contain project information and a questionnaire for you to complete. You will be invited to complete the questionnaire which should take no more than 20-30 minutes. You will be asked to return your completed questionnaire in the empty envelope provided in your package. At the end of the questionnaire you will be asked if you wish to volunteer for the interview phase of the study. If this is something you would like to do, you will be asked to make contact with the researcher.
The next stage of the research is to interview volunteers from the people who completed the questionnaire. The interviews will be conducted privately at a convenient time and location either face to face or using electronic media like skype for example. The interviews will last for up to 60 minutes. They will be recorded and transcribed at a later date and you will be asked to review this transcription of our conversation. There will be a list of questions to guide the interview. These questions will be based on the factors influencing participation in PDRP that were profiled from analysing the questionnaire.

You will be asked to talk about how and why the factors can influence nurses' participation in PDRP. If you wish, you may bring a support person with you to the interview. The interviews will be conducted by Samantha Heath.

The information I gather from the questionnaire will help to develop a profile of the factors that influence participation in PDRP programmes. The follow-up interviews will provide more information about your experiences and will help to illustrate how and why the factors profiled are important. Ultimately, it may be possible to identify programme adaptations to support nurses' involvement in PDRP.

There is no conflict of financial interest and the role of the research has been considered by the Ethics Committee (see below).

Data Management

The returned questionnaires will be stored in a locked cupboard in a locked room at Massey University, Albany. All electronic documents will be saved on the researcher's password protected computer. Once the voice recordings from interview have been transcribed they will immediately be deleted from the recording device. However, they will be kept as a digital file which will be password protected and accessed only by the researcher or her supervisors. The information will be kept up to five years. The consent forms, questionnaires and any other confidential written material relating to the research will be stored in a locked cabinet in Samantha's supervisor's office at Massey University for five years. After five years the data will be shredded using the University's confidential shredding system.

A summary of the findings of the research will be made available for everyone via the NZBS intranet, although if you participated in the interview phase you will receive this directly.

In any publication or conference presentation, your identity will remain confidential. All the information we obtain from you will be given a code. When the information is presented at conferences or published in journal articles your identity remains confidential.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used
- Be given access to a summary of the project findings when it finishes
- Withdraw from the interview phase up until the start of the analysis of the information you provided
- If at any time you feel uncomfortable during recording of any session you can ask for the recorder to be turned off
- Not answer any of the questions posed
- You may bring a support person with you to the interview phase of the study

Project Contacts

If you have any questions about the research, please feel free to contact Samantha Heath on the following phone number ███████████ or by email ████████████████████████████

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 16/03. If you have any concerns about the conduct of this research, please contact Dr. Andrew Chrystall, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43317, email humanethicsnorth@massey.ac.nz

Appendix J: Signed transcription confidentiality agreement

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MATĀURANGA

Enablers of nurses' engagement with continuing professional learning programmes

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I .... Lydia le Gros .... (Full Name - printed)

agree to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: _____ Date: 28/11

Appendix K: Interview participant release of transcript

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MATĀURANGA

Enablers of nurses' engagement with
Continuing professional learning programmes

AUTHORITY FOR THE RELEASE OF TRANSCRIPT

I confirm that I have had the opportunity to read and amend the transcript of the interview conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: .... Date: ....

Full Name - printed ....

Appendix L: Questionnaire final version

Enablers of nurses' engagement with
Continuing professional learning programmes

A questionnaire to survey nurses about their engagement with the Professional Development and Recognition Programme at New Zealand Blood Service
Please read the study information sheet and accompanying letter before completing this questionnaire. Return of the completed questionnaire implies your consent to participate.
Could you please return the questionnaire in the stamped, pre-addressed envelope before 29th July 2016.

SECTION 1: Information about PDRP

In this section, the researcher is trying to discover whether facts about PDRP requirements are well known across NZBS. Please tick the box next to the answer you think is correct:

1. What is the minimum number of clinical practice hours are you required to complete in a 3 year period on the RN/EN PDRP pathway?
a) 120 ☐
b) 250 ☐
c) 340 ☐
d) 350 ☐
e) 450 ☐

2. What is the minimum number of hours of continuing professional development (ongoing education) you are required to complete in a 3 year period on the RN/EN PDRP pathway?
a) 20 ☐
b) 40 ☐
c) 60 ☐
d) 100 ☐
e) 120 ☐

3. All the required application and assessment forms for NZBS PDRP are available from which of the following sources? (Tick all that apply)
a) Cornerstone (the intranet) ☐
b) NZBS eLearn site ☐
c) The PDRP co-ordinator by request ☐
d) Nursing Council ☐
e) My Charge Nurse ☐

4. Completion of any level on the RN or EN NZBS PDRP pathway ensures that you have completed which of the following requirements? (Tick all that apply)

a)	NZBS annual Key Knowledge and Skills assessments	☐
b)	An annual performance review	☐
c)	NZNO membership renewal	☐
d)	An Annual Practising Certificate from Nursing Council	☐
e)	Employment at NZBS	☐

5. Completion of any level on the RN or EN NZBS PDRP pathway exempts you from Nursing Council audit for how long?

a)	5 years	☐
b)	3 years	☐
c)	2 years	☐
d)	18months	☐
e)	12months	☐

6. Which levels provide a financial allowance on your NZBS PDRP pathway?

a)	Competent, Proficient, Expert/Accomplished	☐
b)	Expert/Accomplished level only	☐
c)	Proficient level only	☐
d)	Competent level only	☐
e)	Proficient and Expert/Accomplished levels	☐

7. How many days of paid leave are available to you to complete the initial preparation of a portfolio for the NZBS PDRP programme?

a)	0	☐
b)	1	☐
c)	2	☐
d)	3	☐
e)	4	☐

8. With whom should you agree the level of portfolio you will apply for before you begin any work on your portfolio?

a)	PDRP Co-ordinator	☐
b)	Clinical Nurse Leader	☐
c)	Clinical Coach	☐
d)	Area Manager	☐
e)	Charge Nurse	☐

9. The NZBS PDRP programme achieved a 5 year period of approval from:

a)	New Zealand Nurses Organisation	☐
b)	Nursing Council of New Zealand	☐
c)	NZBS Executive	☐
d)	New Zealand Qualifications Authority	☐
e)	The University of Auckland	☐

10. If you have recently been audited by Nursing Council, you are most likely to meet the criteria for which level NZBS PDRP?

a) None of them   ☐
b) Competent   ☐
c) Proficient   ☐
d) Expert   ☐
e) Accomplished   ☐

SECTION 2: Attitude to PDRP

In this section you will read a number of statements. Please indicate your level of agreement with each statement by ticking the appropriate box.

Self-evaluation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
11. My experience of continuing professional development in nursing has been positive	☐	☐	☐	☐	☐
12. Further learning will enhance my clinical skills	☐	☐	☐	☐	☐
13. I am capable of completing a PDRP portfolio	☐	☐	☐	☐	☐

Attitude to PDRP	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
14. I am motivated to complete a PDRP portfolio	☐	☐	☐	☐	☐
15. Completing a PDRP portfolio helps me to demonstrate my clinical capabilities	☐	☐	☐	☐	☐
16. A PDRP portfolio is needed to evidence my continued development as a healthcare professional	☐	☐	☐	☐	☐

Expectation that participation will meet personal goals	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
17. Producing a PDRP portfolio is useful for my career	☐	☐	☐	☐	☐
18. I am confused about what PDRP helps me to achieve	☐	☐	☐	☐	☐

Life transitions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
19. Completing a PDRP portfolio suits my learning style	□	□	□	□	□
20. I have sufficient time at home to complete the requirements for a PDRP portfolio	□	□	□	□	□
21. I have sufficient time at work to complete the requirements for a PDRP portfolio	□	□	□	□	□

Information	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
22. Information about getting started on the NZBS PDRP is readily available to me	□	□	□	□	□
23. My Professional Development Team is accessible to provide advice	□	□	□	□	□
24. Resources that help me to complete an NZBS PDRP portfolio are \available to me	□	□	□	□	□

Participation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
25. My peers are supportive of me completing a PDRP portfolio	□	□	□	□	□
26. My Charge Nurse encourages me to participate in the NZBS PDRP programme	□	□	□	□	□
27. My Clinical Nurse Leader encourages me to participate in the NZBS PDRP programme	□	□	□	□	□
28. My Clinical Coach encourages me to participate in the NZBS PDRP programme	□	□	□	□	□

SECTION 3: Factors influencing decisions to participate in PDRP

In this section, use the scale provided to indicate the extent to which each factor affects your decision to participate in PDRP for example,

If you thought that "PDRP assessors are members of the professional development team and know about New Zealand Blood Service" contributed 'Quite a bit' to your decision to participate, you would answer like this:

	Not at all	Very little	somewhat	Quite a bit	A great deal
PDRP assessors are members of the professional development team and know about New Zealand Blood Service	☐	☐	☐	✓	☐

Indicate the extent to which each factor affects your decision to participate in PDRP	Not at all	Very little	somewhat	Quite a bit	A great deal
29 Understanding the evidence that I am required to prepare for my PDRP portfolio	☐	☐	☐	☐	☐
30. Understanding the evidence that I am required to include in my PDRP portfolio	☐	☐	☐	☐	☐
31. Understanding Nursing Council competencies	☐	☐	☐	☐	☐
32. Understanding how to write a reflection on my clinical practice to include in my PDRP portfolio	☐	☐	☐	☐	☐
33. Understanding how to do a presentation to my colleagues to include in my PDRP portfolio	☐	☐	☐	☐	☐
34. Knowing how to get started with putting a portfolio together	☐	☐	☐	☐	☐
35. The encouragement I get from my workplace about completing PDRP	☐	☐	☐	☐	☐
36. The links I can see between completing PDRP requirements and my clinical practice	☐	☐	☐	☐	☐
37. Access to paid time off work to complete PDRP requirements	☐	☐	☐	☐	☐
38. Getting support when I need it from the Professional Development Team	☐	☐	☐	☐	☐
39. Being excluded from audit by Nursing Council if I participate in the NZBS PDRP programme	☐	☐	☐	☐	☐
40. The amount of my own time I will have to spend on completing PDRP requirements	☐	☐	☐	☐	☐
41. The allowance that is available for completing some levels of the NZBS PDRP	☐	☐	☐	☐	☐

42. Thinking I can actually write about what is being asked	☐	☐	☐	☐	☐
43. Feeling that developing a PDRP portfolio is a professional expectation	☐	☐	☐	☐	☐

Please use the space below to highlight any other factors you think affect participation in PDRP that you don't think have been covered in the list above.

SECTION 4: Demographics

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44. Please indicate your scope of practice by ticking the appropriate box below:

Enrolled Nurse   ☐
Registered Nurse   ☐

45. Are you:

Male?   ☐
Female?   ☐
Gender diverse?   ☐

46. Which of the following **initial** nursing qualifications do you hold?

Hospital Certificate in Nursing   ☐
Diploma in Nursing   ☐
Bachelor of Nursing   ☐

47. Please indicate any other qualifications you may hold from the list below:

Specialist nursing certificate   ☐

Non-nursing Bachelor Degree   ☐

Postgraduate Certificate   ☐

Postgraduate Diploma   ☐

Masters Degree   ☐

Other   ☐   Please list _____

48. Are you currently undertaking any professional study?		
Yes	☐	Go to next question
No	☐	Skip to question 7

49. What are you currently studying?

50. How many years have you been practising as a nurse?	
0-5 years	☐
6-10 years	☐
11-15 years	☐
16-20 years	☐
21-25 years	☐
26 or more years	☐

51. To which age-group do you belong?	
20-30 years	☐
31-40 years	☐
41-50 years	☐
51-60 years	☐
61-70 years	☐

52. I have already submitted (or transferred) a portfolio to the NZBS PDRP	
Yes	☐
No	☐

53. Do you work:	
Full time?	☐
Part time (for example, 0.8 or 0.5 FTE)	☐

54. How many years have you worked for NZBS?	
0-1 years	☐
2-5 years	☐
6-10 years	☐
10-15 years	☐
16 or more years	☐

55. In which NZBS region do you work?	
Northern	☐
Waikato	☐
Central	☐
Southern	☐

Thank-you for completing this questionnaire. Please look out for a summary of the key findings on the intranet in the next few months
Would you be interested in participating in the interview phase of this study?
If you answered yes, please use the contact details form attached to this questionnaire to contact Samantha Heath

Appendix M: Semi-structured interview schedule

1. Continuing competence requirements are a relatively recent addition to APC renewal. What has been your experience of the process?

2. What evidence do you have to provide? Probe: Why?

3. What would Nursing Council consider to be appropriate evidence for continuing competence validation?

4. Do you ever need help to complete your validation? Probe: What kind of help is required?

5. What options do nurses have available to them to assist completion of continuing competence requirements?

6. Have you ever participated in PDRP?
    Yes: Probe for reasons what
    No: Probe for reasons why not

7. In the survey, some nurses described themselves as being motivated to complete a PDRP portfolio, but only a few of them had chosen to do so. Why might nurses be motivated to complete PDRP?

8. In the survey, some nurses strongly agreed that their Charge Nurse (more than any other senior nurse) encouraged them to participate in the NZBS PDRP. Why might nurses think it was important for the Charge Nurse to encourage participation?

9. In the survey, some nurses indicated that factors related to PDRP requirements strongly affected their decision to participate in the NZBS PDRP. Why might a nurse's participation be affected by the requirements would affect their decision to participate?

10. In the survey, some nurses indicated that factors related to Nursing Council competencies affected their decision to participate in the NZBS PDRP. Why might a nurse's participation be affected by Nursing Council competencies?

11. In the survey, some nurses indicated that factors related to time for completion strongly affected their decision to participate in NZBS PDRP. Why might a nurse's decision to participate in PDRP be affected by time?

12. In the survey, some nurses indicated that factors related to the financial allowances available strongly affected their decision to participate in NZBS PDRP. Why might a nurse's decision to participate be affected by a financial allowance?

13. In the survey, some nurses indicated that factors related to age strongly affected their decision to participate in the NZBS PDRP. Why might a nurse's decision to participate be affected by age?

14. In the survey, some nurses indicated that factors related to available PDRP resources strongly affected their decision to participate in NZBS PDRP. Why might a nurse's decision to participate be affected by PDRP resources?

15. If you had the opportunity to change one things about PDRP at NZBS, what would that be?

16. If you had the opportunity to tell Nursing Council one thing about PDRP what would you say?

Appendix N: Questionnaire participant information sheet

**Enablers of nurses' engagement with
Continuing professional learning programmes**

INFORMATION SHEET: QUESTIONNAIRE PHASE

Dear

Recently you were provided with information about a research study which has been designed to find out about the factors that influence nurses' engagement with PDRP. The first phase of this study is a questionnaire or survey distributed to Registered and Enrolled nurses. The intention of the survey is to build a profile of the factors that influence nurses' decisions to participate in the Professional Development and Recognition Programme (PDRP) at New Zealand Blood Service. This profile will be used to form the basis of questions that will be asked during the second, interview phase of the study.

In the pack enclosed with this letter, you will find an information sheet about that project, together with a questionnaire. It is up to you to choose whether or not to complete the questionnaire and to return it in the stamped and pre-addressed envelope before 29th July 2016.

The questions in this survey have been developed from information found in the nursing and education literature which has something to say about adult learners' reasons for engaging with continuing professional learning. Some questions have also been taken, with permission, from a previous study that examined nurses' knowledge and attitudes to PDRP (Carryer, Budge and Russell, 2007). Questions relating to influencing factors found in the nursing and education literature are presented in the first 3 sections. The final section consists of demographic questions to help description of the overall sample of respondents.

All responses will be treated confidentially. Individuals will not be identifiable. Please note that completing and returning this questionnaire implies that you give your consent to take part.

All of the information that you provide to the researchers will be kept confidential and will be stored in the research supervisor's locked office at Massey University or in password protected documents on the researcher's computer. Only the researcher and her supervisors will have access to the information. The data from this part of the study will be secured in a locked cabinet and locked office for 5 years following the completion final report. When disposed of, the University confidential waste service will be used for printed materials, and digital documents will be deleted.

When the project is finished, the key findings of the study will be made available on the intranet. The results of the study may be published in journals or presented at conferences; however, the information will not include the names of any participant.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
Ask any questions about the study at any time during participation;

- Provide information on the understanding that your name will not be used;
- Not answer any of the questions posed;
- Be given access to a summary of the project findings when it finishes.

If you have any questions relating to the project, please call Samantha Heath on
██████████ .

Committee Approval Statement
This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 16/03. If you have any concerns about the conduct of this research, please contact Dr Andrew Chrystall, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43317 email humanethicsnorth@massey.ac.nz

Samantha Heath
Doctor of Education Candidate
Institute of Education
Massey University

Thank you for considering involvement in this project.

This information sheet is for you to keep

Appendix P: Interview participant information sheet

**Enablers of nurses' engagement with
Continuing professional learning programmes**

INFORMATION SHEET: INTERVIEW PHASE

You have indicated that you are interested in participating in the second phase of the above research study. This involves an interview that will last about 60 minutes which will be conducted in a private space on NZBS premises at a mutually convenient time. Interviews will be digitally recorded for later transcription. You will have an opportunity to read and approve the transcripts after the interview. All of the information that you provide to the researchers will be kept confidential and will be stored in the research supervisor's locked office at Massey University or in password protected documents on the researcher's computer. Only the researcher and her supervisors will have access to the information.

When the project is finished, you will receive a copy of the key findings of the study. The results of the study may be published in journals or presented at conferences; however, the information will not include the names of any participant. The data from this study will be secured in the research supervisor's locked cabinet and locked office for 5 years following the completion of the final publication. When disposed of, the University confidential waste service will be used for printed materials, and digital documents will be deleted.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name will not be used;
- Be given access to a summary of the project findings when it finishes.
- Withdraw from the interview phase up until the start of the analysis of the information you provided
- Not answer any of the questions posed
- If at any time you feel uncomfortable during recording of any session you can ask for the recorder to be turned off
- You are entitled to bring a support person with you if you wish.

If you have any questions relating to the project, please call Samantha Heath on ▮▮▮▮▮▮▮▮.

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 16/03. If you have any concerns about the conduct of this research, please contact Dr Andrew Chrystall, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43317 email humanethicsnorth@massey.ac.nz

Samantha Heath
Doctor of Education Candidate
Institute of Education
Massey University
Thank you for considering involvement in this project.

Appendix Q: Code Book of qualitative data

Theme	Code	Definition	Quotes
Meeting continuing competence requirements	Nursing Council Audit experience	Feelings related to the experience of being selected or the possibility of being selected for Nursing Council random certification audit	• ***Being excluded from auditing by nursing council was perhaps only or at least major affect for participating in the PDRP*** • So a lot of that was what you have to do for the PDRP anyway so the actual competencies weren't too hard. • I got audited last year. So, that was horrendous • Because I don't want to be audited because it's sprung on me. Oh, you gave me this timeframe to do this and then you're rushing everything. You can't think any more because you're rushing. I don't like to do it under stress. I'd rather really be ahead of the process.
	Learning about recertification requirements	Describing the processes involved in learning about Nursing Council competence requirements (recertification)	• Until I did my PDRP I don't think I fully understood the competency requirements. • You are kind of ticking it and saying yes, but unless you have a PDRP you don't actually have anyway of backing that up that you have met your competencies and you are still you know okay to practice • I had already been audited and then I look at the competent and go it is practically the same • Yes, cos I got audited. So, the audit that the Nursing Council does is pretty much the same as PDRP
	Meeting what was being asked during APC renewal	Knowing the kind of evidence required for declaration at on-line APC renewal showing depth and/or integrity of understanding	• I haven't had to provide proof of that, so you know I mean obviously a lot of that is done on trust by them too, that the RNs are completing them correctly and understanding them correctly • I think that with the Practicing Certificate you find it's pretty much just ticking off boxes and I think it kind of relies on the fact that you understand them and are doing the right things • I do have it in the back of my mind that I would need to prove in a written form by way of a portfolio that I am able to meet the types of competencies that they are looking for • It's just a rubber stamp exercise, you know just a sign off. • Well quite minimal really, it's simply getting online, paying the bill • Apart from actually filling out the form I haven't had to provide anything • It's just a challenge of putting it into a formal document • Well, you sort of dodge the bullet, don't you, for so many years?

Italics shows comments from free text responses in the survey

Theme	Code	Definition	Quotes
Meeting continuing competence requirements cont.			• I would have to look it up, I know there is evidence of education hours • I'm just presuming that they just probably want sixty hours education. Yes, one of the things. I don't know the others; I'm looking into it. • If they had just walked in one day and said show us evidence, I probably would be a bit lost with what to actually show them • Probably our training hours and KKS
	The value of the PDRP/Continuing requirements relationship	Illustrating the benefits of completing PDRP including recertification audit avoidance, career advancement, professional development or regulatory compliance	• ***I don't believe it makes me a better nurse. The fact that a lot of the teachings around plasma and platelets and that it benefits PDRP is what makes me combine the two*** • To be honest, I did it so that I wouldn't get audited • I knew it was here to stay so there was no point fighting it, but I had to work through it myself to see the value between doing a PDRP and the correlation with the competencies for our Practicing Certificate • It will definitely be easier for me if I will be choosing as random for audit. • To be honest they don't relate very well to me. I can't see a direct link, because if you're not interested in looking after your own professional development, it is just paying a bill at the end of the day, that's it • Probably that you are not going to get audited but in saying that it is not that hard to be audited anyway, so, because I have already done it I know how that, that works. So in terms of just normal practice every day I don't know about the benefits of PDRP

Italics shows comments from free text responses in the survey

Theme	Code	Definition	Quotes
Factors affecting engagement: **Time**	Personal time	Feelings about the time spent outside normal working hours to complete PDRP requirements. Excludes study leave	• ***I can say that it takes a lot of my personal time to complete a PDRP. As a solo parent working full time. This is a huge emotional stress that is not helpful in supporting my home and family life. It is a cost to my children and mental/emotional well-being that it is expected of me*** • A lot of people are not wanting to go home and then spend hours and hours and hours doing work, which they're effectively not paid for • I know I can do it in my own time but do I want to put myself through that kind of stress while working? • I think a lot of nurses are motivated but they begrudge giving up their own time to do it • I was just spending all my time on holiday doing my PDRP • Well, you don't want to be using up all your weekend • When I got audited, I got a week's holiday anyway so I spent that doing that • You have to be prepared to do it at home in your own time • I don't mind doing it in my own time. Yeah, I don't really mind doing it in my own time but I don't want to commit to anything that I can't complete and then I have to go to work and then, oh, I want to have two days. It's just managing time I guess • I think a lot people don't like to have to do things they consider work-related at home
	Having the time	Feelings about the amount of time anticipated for completion of a PDRP portfolio and how this was to be arranged includes reasons that impacted on time and time as an reason not to engage	• ***Time for completion is a major factor*** • ***Time required to complete portfolio*** • ***The biggest thing is the time it takes*** • So, it would take you more than two days • Time so that to me is off putting because I sort of sometimes think well If I am not going to be able to do the best possible job at all then I won't do it at all. • Well not having the time has put me off because I already know I am quite slow at things anyway • It took me longer than I thought it was going to be, it was weekends and evenings so yeah I'm lucky enough that I don't have young children at home • I'm missing the CPR component of it so I know it won't be completed until I finish that which is happening tomorrow so I can't miss it tomorrow.

Italics shows comments from free text responses in the survey

Theme	Code	Definition	Quotes
Factors affecting engagement: **Time cont.**	Making time	Describing being prepared to use time at home/personal time and work time to complete the task because of the importance or necessity of the outcomes	• And you have to accept that you've got to make it happen. You can't say, oh so and so says... Oh I can't be bothered doing it, I'm not going to do my PDRP because I've got to give up weekends. You have to accept the reality of the situation to be honest • It is one of those easy things to kind of put off and go I will do it, like a rainy day activity • Some feel guilty that they are off the floor and trying to find scraps of time during their working day • I just did it at home. I did things at home and did a lot at home and a lot of the teaching packages I did, I did at home. I taught my family quite a lot. But it had to be like that. If I wanted to do it, I had to do it outside of work. I didn't have a chance to do any inside of work, it was just impossibility
	Accessing and using study leave	Describing implementation of the MECA agreement for study leave specifically related to PDRP preparation or maintenance	• *It was only during this survey that I realised that we are entitled to 2 days' study leave. It would have been good if we were told that when we showed interest in doing our PDRP because it's a good motivator as well* • *Having the paid time given as 2 days spread out. This makes it difficult* • *After involving myself with this study/survey, I realised that I can avail 2 days' study leave during my PDRP completion. It would have helped me significantly with time management. Will utilise it next time* • *Staff have also started and not finished due to not being given the study time to do so* • Because you can request for some time to do your PDRP and I know it's been a struggle in the past to give you that particular date and you end up having to do it in your own time • I think some nurses might be thinking that PDRP should be at work time but they don't really get given that time. • I'm willing to do it but if they're not willing to give me the time then see you later • When I came here and they introduced PDLP, we could never get anybody to let us have the time off the floor to let us do the two days • You couldn't even get the time off, the two days a year • You know we have got half an hour and nothing is happening, people go off and do your PDRP, no that's not going to work. • A lot of negotiating with trying to get the time and I think some people feel the pressure of getting it done so a big factor in how your portfolio plays out

Theme	Code	Definition	Quotes
Factors affecting engagement: **Time cont.**			• It is quite important for your Charge Nurse to be supportive of it, because if they weren't then you would have to do it all at home which is quite difficult, • The two days' education time wasn't enough to get it done • But the actual reality was that suddenly, so and so is off sick, so and so is on annual leave so that time that you had actually planned for that particular day didn't eventuate
	Time to learn new skills	Additional skills to be learned ahead of PDRP engagement or to support its completion for self or others	• ***My lack of computer skills is an influence i.e. Time it would take me to type for myself*** • ***Time to learn how to do a self-assessment*** • I think half the problem with that is learning e-learn

Italics shows comments from free text responses in the survey

Theme	Code	Definition	Quotes
Factors affecting engagement: **Role of the Charge Nurse or direct manager**	PDRP friendly manager	Differentiating the characteristics of a manager who positively encouraged nurses to engage and complete PDRP and one who did not	• If you've got your boss saying you're good enough to do this portfolio, please do it – you are more likely to do it because your boss is saying you are good enough to do it • Oh definitely if you are endorsed by your Charge Nurse, it gives you confidence because then there is someone there that believes that you can do it • Well, she's the person in charge and if she doesn't lead people to do it then how would you feel encouraged to do it? • You have to get them to agree which level you are going to be, so I suppose by them being on board with it, makes it easier for some people to have the motivation I guess to it, like they feel like there is someone expecting them to do it a little bit if they have said you should do this at this level • If the Charge Nurse is on board with it then you are more likely to be able to get your study leave. Or even to have someone to go to • It is quite important for your Charge Nurse to be supportive of it, because if they weren't then you would have to do it all at home which is quite difficult • I found my CNL a go-to person and she was able to direct me and guide me because I was stumbling a little bit, with the computer side really. But also she was able to just point me in the right direction and sometimes I needed extra … I was stumbling on certain competencies and she was actually able to direct me through that. I found her the best person because she was here on site the whole time and I would say, I just need ten minutes of your time. And it would be on one competency and she would clarify it for me • None of us had done one because it wasn't encouraged. It wasn't spoken about • It wasn't pushed. Nobody was encouraged to do it

Theme	Code	Definition	Quotes
Factors affecting engagement: **PDRP requirements**	Options work	Understanding and feeling able to complete PDRP requirements (excludes Nursing Council competencies)	*Feeling what you have achieved so far is not on the right track at all* *For a beginner, PDRP is daunting* *I need clear expectations of what is required* *In my opinion because language and style and use of grammar varies The point presented is more important than academic style presentation* *In my opinion the point presented is more important than academic style presentation* - It's just the presentation I really don't want to do. - It's just understanding what's actually needing to be done - I think everything is actually easy because it's already in a pack - I think, once you've started to do it, yeah you know understanding the requirements I think was a big thing, I think when we first introduced PDRP people didn't quite understand the whole process, and didn't understand when they were sort of reading what the requirements were
	Presenting PDRP in other languages	Feeling able to use a language other than English to complete PDRP requirements in order to submit a portfolio for assessment	*For me personally writing long sentences in English to meet criteria was the biggest challenge barrier to completing the PDRP*

Italics shows comments from free text responses in the survey

Theme	Codes	Definition	Quotes
Factors affecting engagement: **PDRP Resources**	Elearning support	Describing the availability of online resources to support PDRP completion	• It's all online, so it can be accessed easily, although I did have to do it from work because I don't have facilities at home to do it. • Yeah coming to a different PDRP, like the old DHB one is very different to the way this one is structured, so it was nice to have it all in one place, you get a bit of a better feel for it. • I found all the e-learn, the apps and that – I thought they were really good. But I know that there are staff members here that only go on e-learn once a year when they've got to do their KKS quiz. • I think it's in e-Learn but I can't pinpoint I know exactly where it is, can't tell anyone exactly where you can find these things. I probably can find my way to find it but it's not something that I can access immediately • You just wonder whether it could be that resources again are I don't quite know where to start I know it's on the internet but what do I have to do to get there that kind of thing. • It's a problem though if you don't have access to e-Learn or you've forgotten your access to e-Learn

Theme	Codes	Definition	Quotes
Factors affecting engagement: **PDRP allowances**	Money as motivation	The influence of PDRP allowances paid on willingness to complete PDRP	• *The amount of time to complete versus the monetary gain is not worth the time or energy involved except that $74 per fortnight on one income would be missed if I didn't repeat my PDRP* • *I don't' think it is a good way of providing staff with extra money all be it not very much* • I don't know the numbers but that wouldn't be something that I actually consider too much • I don't think that should be a driver • It had no bearing on my decision, none whatsoever • But me personally, proficient financial – it wouldn't encourage me to do it. That would not be the carrot for me. It would be for personal development totally – not financial • It's just secondary, the money, it's just secondary. • I think if you are going to get a pay rise from doing a portfolio, then it's worth it. My own experience, the remuneration wasn't worth it. • I don't know because it is a lot of money but it still wasn't worth the upset it was causing me • Its $3500 pay rise, yeah definitely!

Italics shows comments from free text responses in the survey

Theme	Code	Definition	Quotes

Theme	Code	Definition	Quotes
Factors affecting engagement: **Nursing Council Competencies**	Peer assessments	Describing the investment required to complete a peer assessment of Nursing Council competencies for the relevant scope of practice	• ***I also have helped colleagues to complete competencies and that is another strain because I've been asked by 3-4 staff*** • ***Part of completing PDRP is a peer review and it is hard to look for a colleague to do your peer review as it entails time and effort for your colleague*** • Well I know from doing the peer review for someone else that took me a whole day at home from the beginning of the day to the end of the day just to do them for someone else • And to get a peer to do the same for you as an assessment is probably what stops them and it's definitely what stopped me • And of course one of the difficulties too I think is when they have their peer reviews, the other person's time so you know they can't afford that time
	Peer assessors	Feelings about asking others to complete the compulsory peer assessment	• Trying to get someone to do my competency was really hard because it's still not done • Peer assessment, yeah. And you don't want to keep going and asking and asking. • My peer assessment fell over because my peer actually left the Blood Service. So I had a hard time finding another peer to do my assessment because they were either doing their own or they were doing other things • I think it could be made a little bit more easier on the person doing your peer assessment, because it is a big job for that person who's just doing it out of wanting to help the other person • Some people may feel uncomfortable asking someone to do it, because of the commitment you're asking them for, and also there are only a certain number of people in a space that are comfortable to do it
	Competency validation	Interpreting and responding to each competency statement	• ***Knowledge of language required for competencies*** • Some of them you have to read a couple of times to try to decipher to see what they are actually wanting. A lot of it is to do with that language thing of how do I answer that? • If you are not sure how to do it. It is actually quite hard to try and write that stuff down and so I know that some people are struggling with that and I think they just give up. • I'm guessing they don't know what they need to write for each one but I find that really easy, not easy, but especially when you gave us the way to actually structure the way we write it. It's just been so much easier
Theme	**Code**	**Definition**	**Quotes**

Factors affecting engagement: **Nursing Council Competencies cont.…**	Competency statements	Expressing the perceived difficulty of the task	• That's where the big challenge is, and not just for me. I would say for most people, like putting that into words. • This is just a guess, maybe they find it hard to relate the Nursing Council competencies to our work because we're not the typical nursing job that you get in the hospitals. • Sometimes you have to think through it. It doesn't just hit you straight away • Some are easy to write based on the experiences. But some are like you have questions whether this is the right thing I'm writing • Actually writing those down was what I found the hardest • But again that was my first experience with having to do the competencies and writing all of the examples, you know I'd been ticking the boxes each year to get your Practicing Certificate. That was actually the first time I had actually had to sit and think of specific examples of what they meant. • The only barrier I had was writing those competencies. • Quite hard because it takes a long time you don't realise each of those domains and everything takes a long time

Italics shows comments from free text responses in the survey

Theme	Codes	Definition	Quotes

Factors affecting engagement: **Age**	Lifespan views	Discussion about the appropriateness of PDRP to nurses across the age ranges of nurses at NZBS	*Coming to the end of career not planning on undertaking PDRP* *Amount of time left in the workforce before retirement* *I found it so hard to complete and I am so close to retirement now I'm not going to bother* *Some staff at NZBS are at a stage in their working lives where PDRP will not benefit them as they are still wanting to work but time working on PDRP will not help professionally as they need to keep up with NZBS and Nursing Council requirements are training etc. The actual sitting down and doing PDRP is not benefit as they will be finishing their nursing careers in the next few years. Other factors such as attending training sessions, lectures and participating in perfecting the actual tasks at hand are more beneficial* - I'm not too sure. I can't really speak for them. But I guess if you're older, practising for a while, you may not see a value in actually doing anything because you just want a job, that's it. You don't really want to be doing anything else. - I can in some respects probably understand them not bothering or not wanting to bother to do PDRP, like I say it's initially a lot of work, and if they're coming to the end of their careers they're not, I guess sort of needing it to move into other roles or jobs or whatever - For new grads and stuff so you know I think new grads especially, it would benefit them hugely because then they've got you know, as they develop they've got their career in a portfolio that they can look back on, and draw on you know

*Italics shows comments from free text responses in the survey

Theme	Codes	Definition	Quotes
PDRP experience	Vicarious experience	Describing second hand situations or relating information about the experiences of others engaged with PDRP	• We saw [nurse name] go through the process and she always put a lot of pressure on herself and was quite vocal with how difficult it was and I think people hear that • When I've talked to people about PDRP and when I've talked to them about doing things like that – they're like, 'oh it's going to take ages'. • Initially seeing what she went through. She actually submitted her portfolio three times and had it sent back. And again it impacted on me, because she is this person was an epitome of an expert and you sort of think – oh god. What else do you want from me? Do you want a pound of flesh as well? • I think that there's a lot of second hand talk before you even go to look at it, everyone talks about the PDRP and those people say, oh gosh – it takes so long. Oh, you've got to do this. Gossip. Second hand information. Even before you get to even seeing what the PDRP actually is • So once I got rid of that second hand talk, chat and all that. The reality is their perceptions were so wrong. And their information was so wrong and it was all derogatory and negative • It does seem very sad to me that there's more negative out there than positive about it in general discussion that it seems a big task which is quite sad
	Overcoming hidden hurdles	Advising how and where help could be sought or provided	• And that would be my only advice to anyone doing PDRP is don't listen to anyone else and do what suits you. And if you want to have time in work time, it's up to you to liaise with your Charge Nurse, Clinical Nurse Leader to arrange it. It's not to do with anybody else • That others need to get on board, when you ask around it's not oh yeah I've done mine, yeah we're good, it's like ok and there's a big pause, and you think uh oh have you ever done one, no, well how do you know it's so hard, you know I'm here I'll give you a hand, it's not that bad • I think when you first start with NZBS, to actually have a one on one conversation with somebody who can clarify what NZBS PDRP is. Right from A, B, C before that second hand information sneaks in

Theme	Codes	Definition	Quotes
PDRP experience cont.	Personal experience of PDRP completion	Relating feelings and experiences of previous PDRP submissions which may not have been at NZBS but that affected the decision to participate at present	• I did my peer assessment and thought this is really good and handed it in and it was sent back going, oh no – that's not right. You need to start again and I was just sort of completely lost. I ended up going back and forth a few times and then being accepted with very minor changes to what I had originally written and I think that was quite disheartening really. • I think one of the initial barriers I had to PDRP is that I had seen how difficult it was when [nurse name] was doing it and you know, I sort of thought that at that point, the perception for me was that being audited would be a lot less work than having to submit my portfolio • So then I got to a point where I thought; you know what? It's really not worth my trauma to do it. Because it was getting to a point where it was getting me down • Every time I had a meeting with the person who ran the PDRP, she just got me more and more confused • Initially I wanted to do my PDRP for my own self and to further my own knowledge but it got to a point where actually no, I didn't want to do it anymore. And that's changed since I've been here – it's a different attitude towards it. • It's quite demoralising when you've spent a lot of your free time and it's crap. • You haven't got your evidence worded at the start the way it asked you to. You haven't done this. You haven't done this." Then you think, oh for God's sake • ***Not sure it is accurate method of evaluating an employee's work performance. I know some nurses who have completed excellent portfolios but who perform sub-par at work because they 'feel like it'***

Italics shows comments from free text responses in the survey

Theme	Codes	Definition	Quotes
Valency of PDRP	Declining to engage	Polite and reasonable reasons why PDRP completion might not be possible	• Find information or find examples or you know find relevant, relevant information that will help you in doing the PDRP is, you don't know what you are doing in the first place so how do you know whether the information is relevant? How often do I ask? Oh I don't, like all good nurses you never ask. • I was looking at doing it, and then funnily enough both times I've actually gone to commence doing it, first time I got pregnant so that kind of stopped it a little bit and the second time I was going to do it my father got very unwell so life got in the way • The other thing is that the PDRP – you don't HAVE to do it. It's not a compulsory thing; you don't NEED to do it to be a nurse. • It's so technical. It's like technical writing. Putting it into paper. I have to write everything up and be able to comply to what the standard is for or what is required to be evidence – the writing. So that's the huge challenge. • Well not having the time has put me off because I already know I am quite slow at things anyway • Another reason why I didn't do a PDRP when it came in was because I was still under that three years being audited so I didn't have to • *I am happy to put together a personal professional development portfolio which would reflect more accurately my clinical ability and competence. Some nurses should not have theirs. Proof of a paper exercise*

Italics shows comments from free text responses in the survey

Theme	Codes	Definition	Quotes
Feedback to NZBS	Shaping the NZBS PDRP	Suggestions about ways in which NZBS PDRP structures and/or processes could be amended	• I think just to have a clearer understanding of the expectations before I started. • It would be just the roster. They roster you two days off, do your PDRP and that's it • Maybe just having more and more time to do it. I think it's partly to do with the rostering as well sometimes. • Encouraging each other to do peer assessments because I think some people can be quite intimidated in doing other people's assessments when it comes to the PDRP. • Guess the whole explanation behind it, because like I say I think a lot of people, either get that initial pack and look at it and go this is way too complicated and too hard, and so don't do it, • Actually have a conversation where someone actually directs you on the true facts, the resources, what's available and the process. Right at the start so you are not tarnished by any negative comments about the PDRP • I think I would like to see the flow of access between going to one department say for your hours that you have worked and then just being able to pull it together a lot better. • So our old forms were like DHB specific forms, but you have one document which was your competencies, all of your yearly, so your front page, was like your name, where you worked and your line manager and then in that was your development plan, your goals for the year, your competencies and then at the end was like your yearly that you had done your First Aid and all of the other certificates and it was all just one document that you could kind of type in and then you would send it off to whoever and they would do their one and they were side by side, so your peer assessor could write theirs in next to yours rather than having to do two full separate documents • More accessible examples of, yeah you know for peer assessments. • People coming on a regular basis to go over what they've done and how to go forward and just even via email to keep in touch like [Nurse Educator] did with me • The need for a peer assessment in the form that it's in

Theme	Codes	Definition	Quotes
Feedback to NCNZ	Nursing Council feedback	Commentary for consideration by the regulator about PDRP	- We're such a unique organisation, that a lot of what we do here may not necessarily translate into a DHB environment, or a rest home environment, or any other environment so I think we're quite unique with the way our PDRP needs to be structured - Actually tell the Council… To start off with I didn't think it was necessary. I was one of those people. But I just did research and found that PDRP is necessary I think for every nurse. Different forms. Sometimes I wonder if there shouldn't be a little bit more flexibility with the actual competencies. I gather there is depending on which nursing you are in, but I've just found PDRP a wonderful learning tool. It was a good exercise for me personally. - Some would say it's a necessary evil, whereas I would say it's a necessary nicety in a way. It needs to be done. It's just somewhere along the way that intimidation that seems to be around it – you say PDRP or competencies and everybody seems to have a panic reaction initially and somehow, I don't know how it can be done, if it can be softened. I don't know how to word it, but it does – when you mention it to someone, usually there's a groan. - Probably again time for nurses to do it. More support, something like that, about the PDRP. Not only us nurses but the whole nursing staff. But that's PDRP. They cannot make it more easier because that's the rules that we have to follow. - I would say that at the end of the day it's only paperwork and if someone is really good at technical writing, that's an easy job to evidence in the paper. But on the other hand, there's a lot of good nurses that's not really good into writing but into a practical side to their practice they are the best. So half way for me, it's unfair. - As I said before, understanding the competencies and how they personally relate to you, I think it is really important because you have a better understanding of what is expected of you when you understand what those competencies are - I think if they had a National PDRP Programme that would make more sense, like the fact that there is all of these separate DHB's and businesses and all these things doing separate PDRP's and you all have to prove to Nursing Council that you are all meeting the same, why doesn't Nursing Council just put something on their website that is like, here is your PDRP, fill out these forms and everyone has the same one, so no matter where you go or where you work, what area you are in, they all… not necessarily look the same but they are like very similar, it makes it a lot easier for people to kind of keep it the same.

Theme	Codes	Definition	Quotes
Feedback to NCNZ cont.			- I think it would be try and cut the confusion, it is very confusing for people. When people first look at PDRP they will just give up because they think oh I don't know what you want and if people don't know what you want they will just go well I am not going to do it because it is too hard - I would say look at the language that you are using and look at your clientele and look at who is out there and wanting to do these things. Wanting to do the portfolio. Look at your audience because not everybody is the same. Not every expert is the same kind of expert. So look at your audience and look at who you are trying to get buy-in from to do these portfolios. Look at the language that you are using. - Look at the achievability of it. If it's not achievable, people won't do it. - There's a fine line between making it too easy that it just becomes a tick box, I don't want that, you need to be accountable, you need to be progressing with your development and you need to be able to show that, but we want that user friendly thing to encourage more people into it.