



Children's Nurses' Perceptions of Continuous Professional Development

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ABSTRACT

Continuous Professional Development (CPD), sometimes referred to as Lifelong Learning or Continuing Education, is a relevant and important issue for nurses, doctors and other professionals. However there is little specific literature that demonstrates children's nurses' perceptions about CPD. This study aimed to explore (1) what children's nurses perceive CPD to be; (2) examine whom children's nurses perceive to be responsible for CPD; (3) explore what factors children's nurses perceive could improve CPD and (4) to examine if children's nurses perceive clinical practice to be influenced by CPD. Three focus groups were undertaken with different grades of children's nurses working in an acute children's unit in the North West of England. Following this two hundred and forty questionnaires based on the analysis from the focus groups were sent to children's nurses across the North West of England. Eighty one questionnaires were returned which represented a 34% response rate and the data were analysed using thematic analysis. Numerical data were handled using descriptive statistics and presented in the text in graph form and tables. Respondents' qualitative comments were selected and presented in the text to clarify and support results and findings. The key findings were that most had positive perceptions of CPD and their relation to it. Most of the major barriers were perceived to be work linked and due to constraints that the individual felt unable to overcome. Also, despite difficulty in accessing relevant CPD, most participants perceived that their practice had been influenced considerably by CPD. Several recommendations are proposed which managers of children's nurses could implement to ensure their staff felt valued by the organisation. These include (1) providing relevant, appropriate and accessible CPD; (2) ensuring staffing establishments are calculated realistically

rather than historically; (3) improving liaison between health and education to ensure joint planning of CPD, (4) developing comprehensive and relevant Personal Development Plans for each individual and preparing appropriate training needs analysis based on the children's nurses needs rather than the availability of courses.

CHAPTER 1: BACKGROUND AND LITERATURE REVIEW

Within this chapter the researcher intends to present a background to the study and the rationale for undertaking the work. An overview of the literature reviewed and issues related to CPD will be explored. The chapter will conclude with a summary of the way in which CPD was positioned and a link to the methodology chapter will be provided.

1.1 Background to the study

Prior to her current job working with children with disabilities, the researcher, a qualified children's nurse, managed a busy Paediatric Unit in a District General Hospital for a number of years and became very aware of her role and responsibilities for staff development. However, although committed to CPD for both her staff and herself, it became increasingly apparent to the researcher that not all the children's nurses working within the Unit shared similar positive views related to CPD. From a management perspective, the researcher was intrigued as to why there was such an apparent difference between nurses' attitudes to CPD.

Appraisal interviews with senior members of staff were a regular part of the researcher's work related duties. During this activity, the researcher was surprised by the variety of reasons that staff gave for either continuing to develop themselves or for not demonstrating any recent professional development. The researcher became particularly concerned about the implications for the more junior staff within the unit, since a lack of commitment by some senior staff to CPD would have consequences for them. Part of the senior staff's responsibilities included supporting junior staff in compiling a Personal Development Plan (PDP). If these very senior staff did not see

CPD as a high priority then it seemed reasonable to assume that the more junior staff would be less likely to approach the sisters / charge nurse for support for their CPD.

Other concerns arose in relation to senior staff who did see CPD as a priority for staff but who felt that they could not release staff to fulfil training commitments due to staff shortages. Either way, the concern the researcher had was that the outcome for the junior nurses could be the same – a lack of opportunity for professional development. Informal discussions with the senior staff persuaded the researcher that the differences in perceptions relating to CPD were varied throughout all grades of staff. Examples were given of where staff had been nominated for a training course, and had been given time to attend, but had still opted out of the training. Many of the senior nursing staff, in the researcher's own setting, had practised children's nursing for many years, during a period of time when there had been much less emphasis on CPD. For some this could have meant that as long as they attended mandatory in-house sessions such as 'Moving and Handling' and 'Fire Awareness' they could stagnate on a personal development level with some degree of impunity.

1.2 Rationale for the study

In 2001 the UKCC (the regulatory body for nursing, midwifery and health visiting) published a set of standards and guidance, one of these was the PREP (CPD) standard (UKCC 2001). This standard made CPD mandatory. The publication of this standard resulted in the researcher reflecting on the possible consequences of professional development becoming mandatory for nurses. The standard required nurses who wanted to maintain their professional registration to meet two particular and specific requirements. Mandatory CPD meant nurses were told that they must:

1. 'Undertake at least five days or 35 hours of learning activity relevant to your practice during the three years prior to your renewal of registration'.
2. 'Maintain a personal professional profile (PPP) of your learning activity'.
3. 'Comply with any requests from the UKCC to audit how you have met these requirements'. (UKCC, 2001)

The researcher wondered what children's nurses' perceptions were regarding CPD. If staff were not committed to CPD, would it be likely that their practice would change following CPD? Did children's nurses actually take responsibility for CPD or did they expect the organization to assume the responsibility? If children's nurses only recognized mandatory training sessions as CPD, would the service they provided genuinely develop? Were the views of the children's nurse in one hospital representative of all children's nurses? The more the researcher considered the plethora of questions raised when considering the views of children's nurses relating to CPD, it became apparent that to obtain answers to any of the above, children's nurses would need to be asked about their perceptions regarding CPD. Also, as this would only explore the perceptions of the paediatric nurses in one District General Hospital, it seemed logical to find out how CPD was perceived by children's nurses working in other District General Hospitals. It was hoped that by undertaking a study to answer some of these questions, the data could be analysed and would help to provide insight into how paediatric nurses across the North-West of England perceive CPD.

1.3 Literature Review

1.3.1 Introduction

Continuous Professional Development (CPD) is an important and topical issue for all nurses, especially within the current political climate. The NHS Plan (2000), Clinical Governance (DoH 1998) and the introduction of PREP (Post Registration Education and Practice-UKCC 1990) all encourage, indeed insist, that nurses continue to increase their knowledge and skills subsequent to registration. A literature review was therefore undertaken to explore the key aspects of CPD and, in particular, what if anything had been written regarding CPD in relation to children's nurses. The literature search was undertaken using the Ingenta, Medline and CINAHL data bases. Searching for articles by hand and following up on relevant references from articles was also an integral part of the literature review. The following terms were used to guide the search.

- Continuous Professional Development
- CPD
- Lifelong Learning
- Continuous Education
- Nurses Development
- Paediatric / Children's Nurses' development

Terms such as Appraisal and Clinical Supervision were used in case they identified relevant articles. The Google search engine was also used as a back up system to ensure all eventualities were covered and although this did not prove fruitful for the initial literature search, it did identify some useful literature which pertained to other parts of the study.

One of the key questions that the researcher wanted to answer from the literature review was to identify whether the term CPD could be used interchangeably with terms such as lifelong learning or continuous education. Within the literature review a number of key areas are considered, these include defining CPD, comparing definitions and how they are applied and considering CPD from an international viewpoint. CPD is further explored by looking at its role in reinforcing the nursing profession, the impact of PREP, the issues around whether or not CPD should be mandatory or voluntary and issues of clinical competency. Later in the review the politics of CPD are explored as well as those intrinsic and extrinsic factors which impact on CPD. Finally the review moves toward considering the literature relating to children's nurses.

1.3.2 What the existing literature reveals

Continuous Professional Development is also often referred to as Lifelong Learning, Continuing Education or Lifelong Education. If CPD is to be demystified, it initially needs exploration to understand what is meant by the term and also to decide whether or not the terms, which are seemingly used interchangeably, are in reality interchangeable. The difficulty with the 'sloppy' use of different terms within the literature is that unless a definition is provided, the reader is left not knowing exactly what the writer actually does mean. A number of articles provide definitions and some of the key articles are briefly explored in this review of the literature.

1.3.3 The definition of CPD

As there appears to be no agreed definition for CPD amongst health professionals, it would seem appropriate to consider the very broad and generic view that continuing

professional education seems to relate to any learning experience a nurse has after their initial nurse registration. Jones-Schenk (2000), however, feels that lifelong learning is the means by which health care professionals can demonstrate that they are competent to practice, and that it is not just a tool for keeping up to date. It is important to note that this was particularly related to American nurses, although, may well be true of nurses working in the NHS. Ellis (2000) suggests that continuing professional education has become integral to career prospects, a view shared by Furtz and Pearcey (1991). DiMauro (2000) not only suggests that professional development educators understand the importance of professional development better than anyone else but clearly regards continuous professional development as lifelong learning. Dowsell et al (1998) identify pre registration students as lifelong learners when they have developed skills and attitudes which make them committed to continuing professional development. Despite its age, Merriam and Cunningham's definition of lifelong learning deserves mention. In 1989 they defined lifelong learning as a 'process of learning that continues throughout one's lifetime based on individual's needs, circumstances, interests, and learning skills'. This would seem to indicate that 'lifelong learning' cannot necessarily be interchanged with 'continuing professional development' which, as stated previously, may suggest a correlation to career prospects and a limitation to one's professional life. Laurent (1999) recognizes continuing education needs to be linked with training in order to ensure nurses maintain good practice. As he concedes that lifelong learning is fundamental to improving professional practice, both terms could be interchanged when used in this context. Dowsell et al (1998) conclude that nurses who participated in CPD found it had an effect on other areas of their lives. However Dowsell et al then continue by stating that there was a general consensus that 'lifelong learning' is a good thing.

The interchanging of the terms CPD and Lifelong Learning would appear to be confusing when used in this context by Dowsell et al. Perhaps the term 'Continuing Education' would have been more appropriate to use, and is perhaps better understood, if continuing education is considered as an element of both lifelong learning and professional development, a view upheld by Brunt (2000). As learning is seen by health professionals and educators as a life long process, CPD can be seen as an important catalyst for updating old knowledge and increasing skills to enable the practitioner to function effectively as they progress to positions with increased responsibility. While continuing education may be thought to be the provision of study days and courses by some, others, including Jarvis (1987) see continuing education as an activity, which involves the learner in self directed learning methods with a clear onus on the participant to keep updated. Jarvis goes further by declaring an expectation for courses to be supplied for the practitioner, although Jarvis does not state by whom. This definition for continuing education was clearly stretched by the American Nurses Association who postulated as long ago as 1984 that continual education was not only planned to encompass educational activities but could also be experiential. Whatever enhancement of practice occurs, they suggested, should lead to an improvement in the health of the public. It is interesting to note that Hinchcliffe (1994 p20) equates life-long learning to liberal – democratic values such as equality of opportunity, with an onus on 'facilitation instead of dictation'. CPD on the other hand is used as a preferential term to continuing education, indicating its 'professional' emphasis which would appear to be widely acknowledged by professionals. CPD is further defined as being not only a vehicle for maintenance and enhancement of knowledge, but that vehicle is directly linked to a plan devised by the

professional with consideration to the profession, employer and society. CPD equates to improved knowledge, which then leads to autonomy.

1.3.4 CPD– a role to play in reinforcing nursing as a profession.

If autonomy is an important concept to consider if nursing is to be thought of as a profession, then it can be seen that CPD has a definite role to play in reinforcing nursing as a profession. The Report of a Working Party (2000) set up by the NHS Executive to review how the medical profession complies with the Government requirements for Clinical Governance (2000 p1), defines CPD as a:

‘process of lifelong systematic learning for individuals (and sometimes teams) which enables them to meet the needs of patients, deliver healthcare outcomes and priorities of the population served, and at the same time maintain, expand and fulfil their own potentials’.

Although this report reviewed the CPD involvement of doctors, it is no less applicable to nurses. Clinical Governance is a Government initiative which, as the ‘lynchpin’ of a framework for quality in the NHS, gives several key principles for ensuring the NHS continually improves the standard of clinical care it offers, so that there is more uniformity of good care throughout the NHS. One of the key aims of Clinical Governance is to ensure local services deliver a high quality of care, supported by programmes of lifelong learning. This would indicate that CPD is also important if the government is to achieve their promises of an improved NHS. As the government identifies that ‘quality solutions depend on workforce solutions’ it is not surprising that ‘Clinical Governance –Quality in the New NHS’ (2000) also recognizes that staff need to enhance their skills through professional development and training if they are to meet the requirements for the delivery of a quality service.

It may be useful to regard CPD as the continuing development of the individual throughout their professional career as opposed to lifelong learning which can be thought of as a 'cradle to grave' continuum. CPD not only benefits the individual who is undertaking it, but has been identified by the Department of Health (DoH) as a means of improving standards of nursing care and motivating staff, which ultimately affects recruitment and retention in a positive way (Brown et al 2002). Perhaps Jarvis (1987) was right in assessing Lifelong Education as too complex a phenomenon to define when it seems impossible to identify whether it is a concept or a policy? So it would seem that CPD is viewed in relation to a professional post, as a means of ensuring that professionals practice at an acceptable standard and may be part of a macro process of lifelong learning and lifelong education. However, as there does not seem to be any agreed single definition for CPD, it may be necessary to discuss Lifelong Learning/Education in tandem with CPD in order not to omit important points.

1.3.5 CPD and PREP

The review of the literature also uncovered discussion about CPD and its mandatory status. Until 2002, the governing body for nurses was the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). This governing body was responsible for maintaining a register of qualified nurses, midwives and health visitors. Any nurse wanting to practice as a registered nurse in England & Wales had to be registered with the UKCC on a 'three yearly' basis. The UKCC set standards and guidelines for education, for nurses' conduct and also for practice (UKCC 2001). The UKCC had an advisory role to play and also were responsible for 'policing' the nursing profession. Allegations of misconduct were heard by the UKCC who would

decide whether or not a person was fit to practice and had the power to suspend or remove a nurse from the register. Prior to 2001, nurses had no legal responsibility to update themselves and it was possible for a nurse to have undertaken no further training since their initial qualification. With continual changes to care, nurses who did not update their own skills were in danger of becoming incompetent practitioners.

Although many nurses chose to keep themselves updated in order to provide effective care to patients, there was no legal requirement to do so. However, in the light of 'Clinical Governance: Quality in the NHS' (1998), the UKCC insisted that all nurses, midwives and health visitors undertake post registration education and practice (PREP), if they wanted to renew their registration- the only means of being able to practice as a registered nurse in the United Kingdom.

One of the PREP standards (UKCC 2001a) known as the 'continuing professional development standard', states that the practitioner must have undertaken and recorded their continuing professional development over the three years prior to the renewal of their registration. They must have undertaken thirty-five hours of 'learning activity relevant to practice' within the three -year period before re-registration is due. All nurses must record this learning activity by preparing a personal professional portfolio, which must be surrendered, for audit, to the UKCC on request (UKCC 2001).

In the UKCC Handbook (2001) the UKCC state plainly that CPD is no guarantee of a nurse's competence, but identifies CPD as being a 'key component of clinical

governance'. In other words, CPD was recognised as fundamental to the Government's framework for quality in the National Health Service.

1.3.6 CPD – mandatory or voluntary?

Why then was CPD made mandatory? Henwood (1999) suggests that successful CPD very much depends on the individual's attitude and whether they see the mandatory requirement as an obstacle or an opportunity. It is assumed by many health professionals that CPD enhances practice and improves competence. Should nurses, then, have the right to choose not to improve their practice and competence, when the outcome may well affect the patient detrimentally? Lowenthal (1981) would appear to support mandatory CPD when stating that although CPD does not guarantee competence, not complying was likely to lead to less competence. As nursing has evolved, with nurses seeing themselves as accountable practitioners, it would seem prudent for nurses to ensure their practice is updated in order to meet the needs of an ever changing service at the point of delivery. Jarvis (1987) feels that there is an onus on nurse educators to cultivate nurses with a predisposition to lifelong learning with the emphasis being on active rather than passive learners. If this became the norm, then the need for mandatory CPD may very well become obsolete. This would concur with Kersaitis's (1997) view that at present, if CPD was voluntary, uptake would be poor.

Although the American Nurses Association supported mandatory CPD initially, it has completely changed its position and now believes the individual should be responsible for identifying and evaluating their CPD requirements (Eustace 2001). Factors that negatively influence uptake of CPD do not necessarily subside because CPD becomes

mandatory. However, employers may be more willing to participate in providing opportunities for updating skills and knowledge when it is a mandatory requirement. This poses another concern. If employers provide CPD in order to enable their staff to re-register, will nurses only be offered the very minimum in development simply to meet the basic requirements? It may well be that nurses' see the minimum requirement of thirty five hours CPD in three years as their target maximum. It is probable that those who only achieve the very basic mandatory CPD may well have not achieved any when it was voluntary. Yuen (1991) notes that people do not learn when forced to but suggests that there is an expectation that in order to meet the demand for continuing nurse education, CPD would be a 'frequent and regular part' of nurses' lives. It is equally understood that people can attend a multitude of courses and learn absolutely nothing. Perry (1995) recognises that the published literature prior to enforcement of CPD indicated that nurses were in favour of CPD becoming mandatory. In 1987, when CPD was still in its infancy, Crotty and Bignell (1987) advocated solid professional education as being the building blocks to competent nursing practice. If this is so, then surely consideration must be given to the fact that without CPD incompetent nursing practice is likely. As nurse training is now University led (in partnership with practice) the presumed insecurity of non academic nurses who state that they will gain nothing from CPD will, hopefully, be a thing of the past. This view may not take into consideration the much talked of theory–practice gap which supposes that a University based education may not necessarily be the place for skills and other aspects of CPD, such as experiential expertise, to develop.

Although mandatory CPD is relatively new to the United Kingdom, in America the conception of mandatory CPD occurred in 1968. Following a conference which

involved 38 organizations, a national task force was formed to take mandatory CPD forward (Pratner et al 2001). By the mid 1980s twenty states had opted for mandatory CPD (Roberts 1996). Australia, on the other hand, has no mandatory CPD requirement for re-licensure for nurses but CPD is mandatory for some other health professionals. Brennan (1992) stated that the Royal Australasian College of Surgeons identified that reasons for having mandatory CPD relate to keeping the professional up to date and reinforcing the profession's public persona. It could be thought rather ironic that nursing did not warrant the same consideration!

In an empirical study by Kersaitis (1997) nurses working in Australia were surveyed to see how they felt about mandatory CPD. Although 88% (n=347) participated in CPD, the majority of nurses surveyed were against mandatory CPD. Kersaitis identified only 8% of nurses who did not participate in CPD. This would be in agreement with Puetz (1980) who noted that there would always be a core of nurses who would not voluntarily undertake CPD. This alone, however, would seem to be an unsubstantial argument for introducing mandatory CPD. Most arguments in favour of mandatory CPD will also result in counter arguments. The argument that it is necessary to implement mandatory CPD because the public need protecting from incompetent practitioners may find opposition in the fact that the undertaking of CPD may be mandatory, but the outcomes are not. Even so, a study by Prater (2001), which looked at the responses of Texas nurses to CPD, identified improvements in nursing skills when mandatory CPD had been imposed. Unfortunately it is uncertain whether or not the same results would be found if nurses could choose to participate in CPD. Prater also acknowledges that there was no way of knowing whether the responses were completely authentic, or aimed at giving what they thought was an acceptable

response. There could also be an argument around mandatory CPD when the intention to ensure all nurses have the opportunity to update is considered in relation to the possible contravention of the individual's right to choose whether to update or not.

1.3.7 CPD – Political inferences.

In Sweden, Andersson (2001) provokes thought by proposing that higher education reflects the changes in society. He suggests that this can mean institutions for nurse education being required to develop new degrees with the result that nurse education becomes more academic. This scenario is reflected, to some degree in the United Kingdom where the relationship between politics, health and education is almost symbiotic. However, the labour market also has a part to play in CPD as nurses seem to be particularly interested in keeping themselves updated when competition for posts is at a premium. It is accepted that Life Long Learning and CPD may occur both consciously and subconsciously. In Sweden, in the 1970s, a system of recurrent education was introduced in the hope that, along with other objectives, it would facilitate a conscious and subconscious way of altering values and attitudes. With the present British Government's 'NHS Plan (DoH 2000)' initiative, perhaps the higher agenda is to change nurses' values and attitudes by insisting on improved performance through updating and further training.

In the 1980s there was evidence, according to DeBack and Mentowski (1996), to suggest that education provided more competencies than experiential learning, although it could be argued that this would depend on the quality of the teaching in both cases. Also when it is stated that nurses with higher degrees reveal a higher degree of nursing competence than nurses with a lower level of academic

achievement, it should be considered that the nurse who undertakes further education may simply be more motivated, and therefore more receptive to utilize newly gained information in the workplace. Perhaps also, family circumstances need be taken into consideration. Someone with few family commitments and the finance to support themselves through further development, may appear more interested in CPD than a person with many family responsibilities and limited funds. The results of a study by Andersson (2001) revealed that nurses undertaking continuing education were rewarded, for example, by improved changes to their own self image and extended work relevant competencies. This did not equate to increased pay or responsibility in the workplace however, and Andersson raises the issue of who really benefits from CPD? The employer may actually gain more from an employee's professional development than the employee.

1.3.8 CPD and Clinical Competency

Harper's (2000) research study asked nurses if they thought that continuing education was necessary in order to be clinically competent. Although, not surprisingly, an overwhelming number of nurses agreed that it was, he did not explore the correlation between CPD and competency. Identifying an improvement in nursing competency requires nurses to critically analyze their practice and to be able to analyze critically calls for nurses to demonstrate intuition, reflection and expertise. Although Paul and Heaslip (1995) suggest that intuition, expertise and knowledge are born out of a critical thinking process, Brennan (1992) is adamant that the relationship between CPD and competence is unresolved. There seems to be no shortage in the literature for why there is an increased emphasis on CPD. Apart from the obvious relationship to mandatory PREP, nurses' perceptions of themselves could be a significant factor.

When the two levels of nursing were eradicated, the practical based enrolled nurses training was replaced by more academic nurse training. Nurses who receive a diploma or degree in nursing are perhaps more likely to be concerned about being thought of as 'professionals' than the nurse who came into nursing simply to 'care'. Thurston (1992 p12) suggests that not only is professional accountability an instigator to develop, but suggests that 'continual education mandates may serve as a motivator for life long learning'

This would reinforce the Government's plan for nursing practice to be evidence based. Again, this leads to consideration regarding who actually gains when the nurse is developed professionally. The nurse may, as was noted earlier, gain through improved self image and improved abilities, the nurse educators in higher education gain from an ever increasing demand for development and educational opportunities and the Government gain from the public's perceptions of a 'new' NHS. Whether the public actually gain at the point of local delivery of the service is questionable. Have they gained by being cared for by intellectually aware professionals? Is there a risk of the nurse's own development becoming more important to them than the care they are paid to administer? If it is agreed that CPD is vitally important to the development of nurses, is there a finite stage for nurse development? If not, when every nurse is qualified to doctorate level, who completes the very necessary basic hygiene tasks which are so important to patients?

DiMauro (2000) agrees that CPD should meet both intrinsic and external needs for the nurse. As well as expanding to meet the ever changing requirements of the service, to be truly effective, nurses need to be self aware and capable of self renewal. Apart

from simply undertaking further courses to develop, DiMauro suggests that nurses need to devise a plan of development for themselves, which takes into consideration their personal requirements. Creativity is encouraged, as is the ability to be open minded as this enables the nurse to grasp both structured and unstructured learning opportunities. Only then does DiMauro feel that nurses can develop beyond the minimal requirements needed to become facilitators for change, educators and leaders.

Relph (1993) states that the current nursing process has little evidence of benefiting patient care and suggests that nurses cannot be expected to be knowledgeable regarding the best practice for every situation. However, critical thinking is crucial in empowering the nurse to improved decision making, which in turn will affect patient care. As part of a study Relph instigated to consider the use of critical analysis or ritualism in guiding nursing practice, she was able to create a force field analysis. From this she identified that there were as many forces encouraging nurses to use critical analysis as there were resistances to prevent it. She raised concerns that nurses could be responsible for developing innovative changes for further ritualistic practices, rather than developing themselves as independent and autonomous thinkers.

1.3.9 CPD – Intrinsic & Extrinsic factors

There would appear to be several aspects of CPD. Updating knowledge and skills will serve to prepare the nurse for the present but ‘learning to learn’ or developing the habit of learning will help develop a nurse for the future. Carl Rogers (1961 p276) remarked, long before the requirement for CPD, that ‘the only learning that significantly influences behaviour is self- discovered, self appointed learning’. This

well known, generic view on humanity certainly would seem to be just as relevant to nurses today as it was prophetic in the 1960s.

Whatever development a nurse undertakes, literature would support the need for the workplace to be supportive if that new development is to be fruitful and bring about any improvements of care. Managers need to provide opportunity for newly developed staff to utilize their skills or the staff are in danger of losing motivation and having their enthusiasm for change quenched. Until evaluation of newly acquired skills and knowledge in the workplace becomes common place, CPD will be hard to prove as a tool for improving care. A case for tripartite satisfaction could be made if CPD were proven to benefit the individual, the service provided/ the consumer and at a different level, the political climate. Some concerns have been voiced that developing nurses will create a power shift and reduce the amount of control the Consultants have over them. This would seem contradictory to the aims of the Government document, 'Shifting the Balance of Power within the NHS, Securing Delivery' (DoH 2001) which aims to empower the service consumer, not the provider. Could there be a case for suggesting the development of all consumers so that they could actively meet the aims of the Government?

Eustace (2001) reasons that CPD is necessary if nurses are to be seen as competent when the work they do is constantly changing with a continually increased knowledge base. He noted that in certain states in America where CPD was mandatory, CPD uptake had increased, however, there had been little decline in disciplinary proceedings against members of the nursing profession. This would seem a rather important detail. It is assumed that CPD will improve patient care, though this still

needs to be proven. If CPD does not reduce the amount of disciplinary procedures taken against nurses for giving substandard care, can it be assumed that there have been any real improvements, even though the nurse has developed professionally? Should consideration be given to the fact that as more research is made available and nurses gain more evidence based learning, there may be an elevation in the minimum standard of acceptable care? This may be reflected in the change of boundaries for disciplinary, so that a nurse's plea of not knowing about an improvement in delivery of care would not be seen as an excuse, as nurses would be expected to have developed knowledge in this area. Again if a nurse had not bothered to obtain the appropriate knowledge to perform adequately in the workplace, would they actually benefit from mandatory CPD, or would it become a paper exercise? Eustace (2001) also reflected on the fact that it was in the interest of employing agencies in America to encourage CPD in order to reduce health care liability. With most employing agencies in the United Kingdom taking vicarious liability for their nursing staff, liability would be unlikely to reduce litigation for the agency though reducing the probability of liability by enhancing knowledge and skills would be beneficial to all concerned. Again the necessity for nurses to evaluate the effectiveness of CPD through positive client outcomes was highlighted, as was the need for nurse educators to acknowledge the need for graduate nurses who recognize their need for CPD. If mandatory CPD is to be justified, nurses must fulfil the expectations of the public they serve by being safe and effective practitioners. The consequences of CPD need to be identified in relation to positive patient outcomes, yet many nurses would need to be developed in order to execute this kind of evidence base. Perhaps it is a case of CPD begetting CPD!

1.3.10 CPD in relation to Children's Nurses.

Despite a plethora of research related to CPD, nothing has been identified within the reviewed literature that was purely related to children's nurses. Specialities such as radiology, dental, medical and oncology have all been seen worthy of specific research related to CPD so why have children's nurses, as a speciality, been neglected? Perhaps children's nurses have been party to research under a generic title. It is unlikely that children's nurses are uninterested in research when children's nurses such as Judith Ellis pioneered benchmarking in children's nursing as a useful tool for identifying the quality of practice against a standard determined by children's nurses. Could it be that children's nurses perceive themselves as the poor relation where CPD is concerned, especially when they work in a District General Hospital where development opportunities tend to be focused on the needs of the generic adult nurse as opposed to the requirements of the minority who work in specialist areas?

Whatever the cause for the lack of children's nursing specific data, it is unlikely that research relating to children's nurses and CPD would differ substantially, although it could differ in a subtle but important way. The requirements of PREP affect all registered nurses as does the political insistence for evidence based practice. Nursing in its entirety is evolving at an unprecedented pace with all nurses from every speciality needing to participate in CPD in order to adapt and improve their practice in line with political agendas and regulatory guidelines.

For nurses working to meet the sometimes unrealistic expectations of the public, adhering to their regulations for registered practice, embracing the continual changes of the political agenda and meeting their own requirements as an accountable practitioner, CPD may be seen as an integral tool of enablement. Carlisle (1991)

views CPD in the cold light of statistics and stresses the importance of CPD being cost effective. According to Carlisle, for PREP to be implemented effectively approximately 800,000 working days would need to be given to study leave at a cost of between 50 and 100 million pounds? As there is little conclusive evidence, so far, that would point to CPD resulting in the acquisition of knowledge which could be considered crucial to improving patient care, the benefits of CPD must be weighed against the costs.

1.4 Conclusion

Whatever the definition of CPD, whatever the arguments for or against making it mandatory and whatever the cost, CPD seems to be here to stay. Nolan et al (1994) agrees that the future of nursing must include development of nurses who are assertive and reflective as well as analytical. He also points out that to introduce mandatory CPD and not have the necessary support systems in place will make CPD impotent. With the emphasis within today's NHS to meet targets and create Cash Release Efficiency Savings (CRES) it has to be considered whether managers will see CPD as a budget priority. If, as has been suggested by Hewitt (1991) CPD leads to retention of staff, then an organization may feel the investment is worthwhile. If not, the quality of CPD an individual can afford, may meet the PREP requirements but may not develop the individual into a dynamic and more creative practitioner. Furthermore, if nurses are continuously professionally developed but are not given an outlet for utilizing these newly acquired skills and knowledge, then there could be a danger of nurses becoming de-motivated and lack professional challenge.

To conclude on a more optimistic note, if CPD is employed positively, innovatively and effectively, nurses could be change agents for replacing mediocrity for excellence and quantity for quality. According to Brown et al (2002) cost effectiveness analysis is uncommon in education research. To be confident that the substantial resource commitment to CPD is fruitful, analysis of both the value for money ethos of the training and the cost versus benefits of delivery of care need to be considered comparatively. However, if nurses perceive that CPD will meet their requirements and embrace the spirit of the concept of CPD, then financial resources, irrelevant of who provides them, will be fundamental to creating not only a visionary professional but also a nurse with the ability and expertise to revolutionize the service they deliver. It would be hoped that Smith (1994) would concede that the credibility of nursing as a profession would no longer require justification. If so, then how nurses perceive CPD may be an incredibly valuable perception. This then is the focus of the following research study.

In the following chapter, the methodology of the study has been presented which has been informed by the literature.

CHAPTER 2: METHODOLOGY

Within this chapter the researcher will present the aims and methods of the study. An overview of the research design will be given and the rationale for choosing mixed research methods discussed. Issues related to undertaking focus groups and questionnaire design as well as issues related to the choice of sampling will also be considered.

2.1 Statement of intent

The intention of this study is to examine children's nurses' perceptions and experiences regarding Continuous Professional Development (CPD).

The aims of the study are to:

- Explore what nurses' perceive CPD to be.
- Examine whom nurses' perceive to be responsible for CPD.
- Explore what factors nurses' perceive could improve CPD.
- Examine if nurses' perceive clinical practice to be influenced by CPD.

2.2 Overview of research design

Mixed methods were used for the research design drawing on elements of both quantitative and qualitative research.

In phase 1, focus groups were used to generate a broad overview of the issues related to CPD. The data from the focus groups were then analysed using thematic analysis.

Phase 2 involved devising a questionnaire based on data obtained from the focus groups and distributing the questionnaire to children's nurses working in the acute sector of District General Hospitals throughout the North West of England. The data

obtained from the questionnaire responses were analysed using a mix of descriptive statistics (for quantitative data) and thematic analysis (for qualitative responses). The analysis resulted in the production of the main themes the children's nurses had identified.

Focus groups and questionnaires were chosen because it was felt that they would generate the most useful data. A more detailed discussion of focus group methods and questionnaires are presented in the following sections.

2.3 An overview of research approaches and triangulation

Quantitative research methods, also referred to as empiricism and positivism, have been recognized historically as research methods that are able to yield hard, objective data.

They have been used to quantify or measure phenomena often producing scientific answers which enable change to be implemented (Carr 1994) and they are thought to be less likely to introduce bias than qualitative research. Quantitative research methods are identified as 'using a deductive process to knowledge attainment' (Duffy 1985 p226). Certainly funding was often made available for quantitative research projects (Duffy 1986) creating an elitist position and for years this was recognized as being the way to gain information, with qualitative research methods being thought of as a 'prelude to scientific enquiry'.

Quantitative research methods are concerned with quantifying relationships between variables. This type of research may be (1) descriptive, where no attempt is made to alter aspects of the research subject, or (2) experimental, where after initial observation/ measurement, changes are made and the subject observed or measured again to see what has occurred (Hopkins 2001). Quantitative research may also be 'quasi-experimental', where the researcher is able to examine causality when unable to maintain experimental control. To many researchers, the quantitative paradigm definitely dominates the field (Fielding 2001).

Conversely, qualitative research methods are generally seen as providing depth to research findings. Carr (1994) postulated that the relationship between researcher and subject could affect the validity of the data extrapolated, especially when they have developed a close relationship which lends itself to the researcher exploring their subjective experiences. It has been stated that qualitative data are prone to introducing bias because, by their nature, they are more subjective. Some qualitative researchers do not 'believe' in bias as they see it as being intrinsically part of subjectivity and they use high levels of reflexivity to understand their subjectivity.

Qualitative data are descriptive and are primarily presented in words as opposed to the numerical presentation of quantitative data. Foss (2002) suggests that employing both quantitative and qualitative research methods in the same project can be problematic and particularly so if both are used equally. However, Foss also acknowledges that the case for using qualitative research methods to provide insight when quantitative methods provide the overview is becoming accepted practice. Once thought of as second class research practice, the benefits of qualitative research methods when used

with quantitative methods now are acknowledged as bringing a new depth and richness to research subjects, or as Barbour (1991p40) suggests, this combined methodology is beneficial because it 'makes the whole greater than the sum of the parts!'

Using both quantitative and qualitative approaches to research, replaces traditional research paradigms for a combined methodological approach which gleans both hard and soft data and gives the researcher a more complete picture (Foss 2002). According to Webb et al (1981), when multiple research methods are used to measure the same independent entity the term 'triangulation' is used and is seen as a way of greatly reducing the uncertainty of interpretation. Denzin (1989) argues that by using triangulation as the research methodology, the intrinsic bias generated by using a single research method is reduced.

According to Fielding et al (1986) the data generated by using more than one research method can not only demonstrate completeness but can be used to enhance validity, if linked together. However, Fielding identifies this as 'the most challenging task in triangulation'. Triangulation it would seem, is only effective if the individual research methods are sound, but it does not necessarily guarantee good results. Triangulation may be used, not only as a tool for confirmation, but can also according to Jick (1979), as a way of adding completeness to the research data, providing a greater contextual awareness of the subject. This is particularly important in disciplines such as nursing where issues can be multifaceted and the researcher's efforts require enhancement (Shih 1997). However, this approach works best when one research method is used to a greater degree than another. Foss (2001) recognizes the problems

associated with combining different methodologies but agrees with Benner (1996) that nursing research requires research designs that reflect just how complex and multifaceted practical nursing knowledge is. Qualitative and quantitative methods, once seen as 'paradigm wars fought across several battlefields' by Tashakkori and Teddlie, (1998 p3) can now be seen to complement each other in modern day research. A view commended by Barbour (1999) who adds that the rarity of using multi method research with equal emphasis does not mean that it cannot be done, despite recognizing the requirement to cross paradigmatic barriers. However, Barbour also concedes that triangulation is often most successful when the researcher makes a clear decision as to which methodological stance is dominant, a view not shared by all researchers. Morgan (1998) suggests that instead of using one method in a complementary capacity, suggests that methods can be used in equal proportion to measure the same subject, but that this goes beyond 'triangulation' and should be referred to as 'true triangulation'. Bullock et al (1992 p82) sees triangulation as a partnership where, for instance, a hypothesis derived from qualitative data findings is tested by quantitative methods and similarly, qualitative studies are used to add metaphorical meat to the bones of quantitative data. They recognize that 'specific research methods such as an interview can have a quantitative dimension and data produced can be analyzed by a variety of methods'.

It was important to consider triangulation as a methodology for this research study as both quantitative and qualitative research methods were required in order to obtain the most relevant data. However, although, the evidence gained by qualitative method, in the case of the study presented in this thesis, the data collected from the focus groups, would be considered in relation to the data from the questionnaires, the two methods

were used in a complementary way and not as a means for verifying data. Even so, it was decided not to discount the use of triangulation completely as it was possible that during the study opportunity could arise where triangulation could be beneficial, confirming what Murphy et al (1998) suggested, that the research process was not just a basic continuum, but within the commencement and conclusion there were a myriad of 'feedback loops'.

2.4 Research methods

2.4.1 Focus Groups

In order to find out what the views of the local paediatric nurses were, the researcher decided that the use of focus groups, within her own work setting, would be effective as a means of generating enough relevant data to allow questionnaires to be devised and circulated to a much wider target audience. The aims of the study were used to create the core questions for the focus groups and additional prompts were developed to allow robust exploration of these core issues (see appendix 'ii'). By having questions developed directly from the aims it was hoped that the data generated would be specific in terms of the study and relevant for use in developing the questionnaire.

There is some discussion regarding when focus groups originated. Morgan (1997) states that focus groups originated in the 1920s. Confusingly, Sim (1998) advises that focus groups were most likely to have originated in the 1950s, but credits their conception to Robert Merton and his colleagues. Merton (1987) concurs that he and his colleagues were the first to use focus groups, but states that this was actually during the early part of World War II, which dates it to the early 1940s. Interestingly they were first used to evaluate radio broadcasts and their effectiveness in maintaining

domestic morale. Soon after the war the commercial benefits of data gleaned from focus groups was recognized and focus groups became a tool for market research (Lederman 1990).

Morgan (1997) declares that focus groups' major asset is in qualitative analysis. Partly for this reason focus groups were planned for this study. To enable a feasible and appropriate questionnaire to be designed, data would be required to identify the most popular themes relating to CPD. Focus groups have been defined many times in the literature. Powell and Single (1996) defined focus groups utilized in research as 'a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research'.

Krueger (1994) identified, in his definition that focus group interviews are able to 'tap into human tendencies'. Both aspects were valuable when requiring people to voice their opinions regarding CPD. Urden (2003) recognizes that focus groups can be used not only to gather data that can be subsequently used to design an evaluation tool, but may identify compelling data relating to feelings, perceptions and individual experiences. This was an important consideration when planning the research methods for this study. Krueger (1994) recommends focus groups to have between 6 to 12 participants to be effective and this guided the researcher's thinking when planning the focus groups. This is discussed further in the discussion of sampling later in the thesis. However, recruitment for focus groups can be problematic, since they are very dependant on the availability of participants, which means that the numbers in a series of focus groups can differ from the ideal. A series of three focus groups, were planned for this study and, as recommended by Shamdasani (1990), it was proposed to invite

more participants than required to allow for no-shows. Cote-Arsenault et al (1998) declared the benefits of having only 6 to 8 participants in focus groups that were to discuss sensitive issues. However, it was decided that discussing CPD in this study would be unlikely to be perceived as a particularly sensitive issue. By planning the focus groups to comprise staff of similar abilities and experience, it was hoped that participant interaction would be encouraged rather than stifled (Vaughn et al 1996).

As Kitzinger (1995) reflects, having a hierarchical structure within the groups would be likely to adversely affect the resulting data. It was therefore planned to hold a focus group for junior staff nurses (grade D), one for senior staff nurses (grade E) and finally one for Ward Sisters (grade F and G). Focus groups were also planned as a way to obtain data in order to devise a relevant questionnaire because, as Langford et al (2002) remark, few researchers would question the reliability and validity gleaned from this method.

Nominal group sessions (NGS) had been considered and it was accepted that Langford's research in which he compared outcomes for nominal group sessions to focus groups, was favourable to nominal group sessions, especially for external reliability. However it was reasoned that this study was not dependant on participants themselves identifying every salient point for CPD, neither was it feasible to hold groups for three hours at a time in an acute hospital environment. The decision to consider focus groups as the initial qualitative method was also based on Glitz et al's (2001) recommendation for the technique for focus groups or small groups. Glitz et al described involving a moderator or facilitator who would pose questions to the group, allowing the participants to describe their experience of the research subject, in this

case CPD, in their own words. The responses would, it was anticipated, be appropriately organized and analysed to provide the basis of the subsequent questionnaire.

2.4.2 Undertaking the focus groups

All the focus group participants were recruited from the researcher's own work place which enabled the researcher to discuss the reason for the study and for holding the groups informally prior to sending out invitations. As CPD affected all of the nurses on the paediatric unit to some extent it was hoped that the nurses would be willing to cooperate and attend.

The focus group participants were selected from the off duty rotas for the particular dates when an appropriate room could be booked. Invitations were sent to all the different grades of staff and it was anticipated that even if some of the staff could not or preferred not to attend, there would still be enough participants to make the focus groups viable.

Following the informal discussions with staff on an ad hoc basis, written information was circulated to the selected participants to further explain the reason for the study. It also ensured that participants realized that this was an optional exercise and gave them opportunity to raise any queries about the focus group or study prior to the facilitation of the focus groups. A consent form was also enclosed which established that the participants were giving informed consent. This was accomplished by asking the participants to confirm in writing that they had understood what the purpose of the focus groups was and what the data gained from the focus groups would be used for.

Providing a tick box sheet encouraged the participants to comply. They were asked to sign and return the completed consent forms for the researcher prior to the focus groups being held .See 5.2.2.

Prior to each of the focus groups being held, any outstanding consent forms were collected and any participants who had forgotten to return the forms were reminded of the content of the information sheet and asked to give verbal consent before the focus group commenced. There was also opportunity for the participants to raise any issues regarding the focus groups or research study as a verbal explanation of the participant's role in the focus group was clarified.

As Kitzinger (1995p301) suggested refreshments had been made available and the participants, seated in a circle, were encouraged to enjoy them during the focus groups as it was felt that this would promote a more relaxed and informal atmosphere and in some way reduce the impact of having their views taped.

The researcher, acting as moderator, introduced the subject and explained to the group that they would be given several specific points related to CPD which they were to consider as a group. After presenting each question for discussion the moderator was able to opt out of the discussion accepting a 'structured eavesdropping' role until the participants had fully exhausted the topic. Although the moderator aimed to maintain a low profile in the sessions, she occasional needed to 'throw in' a facilitative lead to the participants in order to keep the dialogue flowing. However the moderator felt that once the participants had engaged in discussion the focus group became almost self perpetuating, and she was able to achieve a low profile reasonable well. The aims of

the study were used as questions for discussion by the focus groups. This helped to keep the discussion focused and ensured that the information obtained from the focus group was both appropriate and relevant. In addition, the researcher had made note of some prompts under each of the aims that could be used if the discussion faltered (see appendix ii).

At the close of each session, the moderator once again reminded the participants of the reason for the study and the focus group; reiterated that their participation was voluntary and thanked them all for their contribution and participation.

2.4.3 Questionnaire

Questionnaires are one way of obtaining data from a large number of respondents inexpensively. As Frary (2003) stated, people are familiar with questionnaires, but may be put off from responding to questionnaires due to a number of flaws in the design. Unfortunately respondents may also not complete the questionnaire because they have received questionnaire overload, either in the form of market research or simply that previous questionnaires have been so poorly designed that the respondent completely loses interest part way through. Being aware that the questionnaire would only be as good as the weakest aspect of the questionnaire and taking into account the above considerations, the design of the questionnaire was an important part of the planning process. It was recognized that planning the questionnaire was also dependent upon themes identified from the focus groups as these would provide the structure for the questionnaire.

When planning to develop the questionnaire, several considerations were taken into account. For instance, exactly what data were required from the responses to the questionnaire? Who would be most likely to supply the necessary responses? In which form would the questionnaire be most likely to encourage responses? How could the completed questionnaire be delivered to the target population and how would the data gleaned be best analysed and interpreted? During the planning of the questionnaire, Labaw's (1980p1) four layers of questionnaire were considered. These were objectives, questions, words and layout. When planning the questionnaire the objectives were fairly straight forward. The questionnaire design was planned to obtain data from children's nurses, who work in an acute setting, about their views on CPD. However, it would be important to consider the other three objectives throughout the planning process if the first objective was to be fulfilled. Fowler (1995) proposes that the definition for a 'good' question is that when asked, it will produce reliable and valid answers regarding the subject matter of the questionnaire. This is compared to a 'bad' question which elicits an obscure, prohibiting or distorting response in relation to the subject matter of the questionnaire. It was therefore felt to be of immense importance for the questions to be unambiguous, easy to internalize and written in such a way as to encourage an honest response. By considering the rules that govern conversations and social encounters (Sudman, Bradburn and Schwarz 1996) the questions were planned with thought to the question context. It was planned to select mainly closed format questions, in the form of multiple choice questions. Certainly in planning this it was essential to offer enough options to appropriately cover the range of answers. However, the options would need to be distinct enough to prevent ambiguity.

By proposing to present the questions in a multiple choice format for most of the questionnaire, the researcher hoped to ensure that the questionnaire would not be too long or be too time consuming to complete. It was thought that each question must be specific with clear divisions between options if the respondent was to be encouraged to complete the questionnaire accurately. However it was also planned to include certain open ended questions to enable the respondent to describe certain responses more accurately. This would hopefully provide data as to why a respondent chose a particular option. The questions for the questionnaire were also planned carefully so that respondents not only had access to all the choices identified through focus groups analysis, but could choose the 'other' options if they had identified something other than the focus groups had identified. This would be particularly useful when analysing the data obtained from the completed questionnaires as it could create a theme not previously identified. Gendall (1998) quite rightly suggests that the most basic principle in designing a questionnaire is dependent on the target population. With this in mind, the questionnaire was planned to be as least time consuming as possible for the respondent; this was essential if nurses working in the extremely busy field of acute sector paediatrics were to be expected to take the time to complete and return the questionnaire. Belson (1981) points out the importance of not asking questions which will require too much effort from the respondent. This meant that the questionnaire would have to be concise and unambiguous. When planning the questionnaire, Labaw's (1989) proposition that the respondent's attitudes and opinions were of minor importance could not be reflected, as the aim of the questionnaire was to identify exactly what the respondent's opinions and attitudes were to CPD. However, Gendall's (1998) reminder that people's attitudes and opinions may differ greatly in the value placed on them from one individual to

another was noted. The wording for the questionnaire was planned carefully as it was recognized that the wording could encourage or dissuade a respondent from completing the questionnaire. Certainly the right wording would be vital if bias was to be prevented. Therefore, no leading questions were planned for the questionnaire. It was hoped that the questions could be configured objectively, with response categories being worded appropriately.

Another consideration when planning the wording for the questionnaire was to ensure that two questions were not being asked in one. This has been identified as a common mistake made in devising questionnaires (Frery 2003) which leads to the respondent answering one part of the question and the researcher being unsure of which part the respondent has answered. The questionnaire was planned to attach equal emphasis to the questions to prevent the researcher inadvertently introducing bias which could affect the respondents' choices. The wording for the questionnaire was also important if the respondent was to answer the questions honestly. It was important that the responses given were not linked to professionalism as it was possible that a nurse would be more likely to answer a question that gave them a more professional image, than if the true answer was linked by subjective wording that implied the respondent was less professional by answering in a particular way.

Another consideration when planning the questionnaire was the importance of ensuring all the questions were relevant. Frery (2003) discloses how irrelevant or unnecessary questions can result in respondents not completing the questionnaire, but if completed, may actually 'muddy the waters' by the addition of unclear data for a previously clear response.

The layout of the questionnaire was planned with a particular objective in mind. This was simply to make the questionnaire as user friendly as possible so that the respondent would be encouraged to complete it. This objective was supported by Fowler (1995) who comments that a questionnaire should lend itself to the questions being read, the instructions followed and the answers being recorded. It was therefore decided to plan the questionnaire in a design that would be easy to read, concise, written without jargon and presented in an easy to read format. It was thought that by using bold print or borders for specific parts of the questionnaire for example the headings, the wording would be reinforced and the format would be more readable and less stagnant. If the questionnaire was double sided then it would hopefully seem shorter and again it was hoped that respondents would be more inclined to complete it. It was also felt to be important that the respondent should find it self-explanatory and so it was planned to ensure that the instructions for completing the questionnaire were unambiguous. This would include the directions for the return of the questionnaires. Bearing in mind that Sudman, Bradburn and Schwarz (1996 p1) perceived a survey to be a social encounter as well as a series of cognitive tests, it was felt that this should be taken into account when planning the questionnaire, This meant that easy to answer, non threatening questions would begin the questionnaire and would lead on to more thought provoking questions. If the layout of the questionnaire helped the respondent build their confidence as they progressed through, then it was felt quite likely that the respondent would be stimulated enough to continue to completeness, and return the questionnaire as directed. For this to be successful it would be imperative to ensure that the flow of the questions was not interrupted by unnecessary or ambiguous questions, and that the layout of the

questionnaire ensured that the questions would flow in a logical sequence (Frery 2003).

For this study the researcher was able to distribute the questionnaires to children's nurses working in district general hospitals in the North West via the Managers of the various units. The researcher was a member of a Manager's Networking Group which met on a monthly basis, and which represented six key district general hospitals in the region. Through contact with this group the researcher was able to discuss the study with colleagues at the meeting. As a result the managers offered to help distribute the questionnaire to appropriate staff in their units and act as an initial point of contact. They also acted on behalf of the researcher in providing informal reminders about the questionnaires and they collected the completed questionnaires within a specific time frame and then returned the completed questionnaires to the researcher at the next appropriate Managers' Networking Group Meeting.

2.5 Sampling

2.5.1 Sampling issues related to focus group phase.

Sampling is a key element in research methodology and may dictate how closely the resulting data are reflective of the whole target population. It was therefore extremely important to consider the sampling criteria carefully when planning the research study. Webster (1985) defines a sample as 'a finite statistical population whose properties are studied to gain information about the whole'. Babbie (1979 p108) points out that sampling is not an option but that 'in virtually every case we must sample subjects for study' and also remarks that, 'the question isn't whether or not to sample, but how it can be done so that accurate conclusions can be made about many by

studying a few'. Therefore three focus groups were planned which would comprise D grade (junior staff nurses), E grade (senior staff nurses) and a combined G grade and F grade focus group (junior ward sisters and ward managers).

Although each focus group had been planned to enlist 6–8 participants as a reasonably achievable goal, it was felt that even allowing for a number of no-shows, 'children's nurses working in an acute paediatric setting in a District General Hospital' could still be represented and data obtained would be likely to reflect the views of this target population.

Planning to use 6-8 participants was based on the number of paediatric nurses who could feasibly be expected to be released from the workplace for the duration of the focus groups. It also included the number of staff who were not on duty, but who were likely to agree to attend the focus group in their own time, receiving time back in lieu. It was recognized that, at best, this could only be a 'guestimate', as the particular demand of the workload, sickness/ absence and other personal commitments could not be identified in advance.

There were various reasons for planning to use a convenience sample of the target population for this study. Probably the most obvious ones were related to resources. As Mugo (2003) relates financial resources alone would disallow a full census approach. Time also supports the decision to plan for a convenience sample. Certainly for the focus groups, the proposal to invite a selection of nurses working in the acute area setting seemed sensible, as this meant that no travel was involved and therefore no additional costs sustained. It also meant that the room in which the focus groups

would take place could be booked during the planning stage. It was planned to use a room central to where the target population were employed as it was hoped that this would reduce the number of no-shows.

As the moderator was also the manager of the unit it was extremely important to ensure that all staff invited to participate in the focus groups understood that they could choose whether to attend or not. This was made extremely clear within the information sheet and also in any informal discussions between a potential participant and the researcher / manager. The researcher carefully thought through the issue that her role as the manager could compromise her role as moderator. It was felt that this might result in the participants feeling that they could use the focus group as an opportunity to impress their manager. Alternatively it was felt that some participants might have been interested in participating but might have been a bit overwhelmed at the thought of sharing their thoughts and feelings in front of their manager. The researcher also carefully considered whether or not the participants would feel coerced as the researcher who was asking them to consider participating was also their manager; this might have meant that they did not truly feel able to decline to participate. However despite these concerns and the knowledge that it might have been ideal to have had a moderator not known to the participants it was felt that providing the aims of the study were made very clear and the need for the nurses to feel free to express their own views it was felt that the manager could undertake the role of moderator without unduly compromising the study. These issues are further discussed in Chapter 5 which addresses the ethical issues – see particularly sections 5.2.1, 5.2.2, 5.2.3 and 5.2.4.

The researcher did not take these decisions lightly and was aware of the guidance within Research Governance which proposes the need to be cautious about researching one's own practice setting. In the early stages of planning the research ward staff had been consulted and were broadly supportive of the study and remained so throughout the duration of the study.

2.5.2 Sampling issues related to questionnaire phase

Thompson (1999) relates how complexity (of nursing tasks) takes on different forms depending on the specific domain they are viewed in. Although the researcher recognized that children's nurses in the south, for instance, may have a different view regarding CPD to those in the north of England, or children's nurses in Scotland compared to those working in Northern Ireland, the proposed feasibility of the study was very much dependant on planning a manageable sample size for the research study. Therefore the researcher planned to use the criteria of 'children's nurses working in paediatric areas in District General Hospitals *'in the North West of England'* for the sample.

As both qualitative and quantitative research approaches require the sample to be representative of the target population, it was important to consider who to distribute the questionnaires to. By planning to discuss the aims of the study with four colleagues who managed Paediatric Units within District General Hospitals, and which were situated in the North West Region of England, it was hoped that an appropriate sample would be able to be identified. Certainly qualified children's nurses working at any of these paediatric units in these hospitals would meet the criteria for sampling for the target populations.

Using a convenience sample meant that it would be possible to access every children's nurse working in these areas. However, it was recognized that completing the questionnaire would be reliant on children's nurses being willing to take the time and effort to do so. Although the subjects were readily available, the data gleaned would rely on their honesty and willingness to complete the questionnaire.

Convenience sampling was proposed for this study despite recognizing that it was generally thought of as a 'poor' approach because it relied on subjects happening to be in the right place at the right time. It was precisely this factor that made convenience sampling absolutely the right approach for this study. This ensured that the sample would be easily accessible. As well as distributing questionnaires to each children's nurse working in the same unit in which the focus groups were to be held, it was also planned to distribute questionnaires to the sample by hand, via the manager or practice development sister of each of the four paediatric units. By attaching an envelope to each questionnaire, the completed questionnaires could be returned to the nurse's manager or practice development sister, without compromising confidentiality. This would also be inexpensive. By planning to make the sample so easily accessible, it was hoped that the time frame for questionnaire distribution and return would be reduced (Castles 1987).

Certainly other types of sampling were considered for the research study, but rejected in favour of convenience sampling. For instance, random sampling would most likely obtain good quality data with little bias (Burns 1995). However, the time restraints alone would not permit this approach. Also access for random sampling would be problematic, considering how geographically widespread the acute care settings were.

The cost also would have been prohibitive. The sampling was planned as 'selective' rather than theoretical, as the sample was planned at the outset of the study, and not decided during the course of the study on an analytical basis.(Sandelowski et al 1992 p302).

Having designed the most appropriate study to provide the required data the fieldwork was commenced and within chapter three the results are presented.

CHAPTER 3: RESULTS

Within this chapter the results of the study are presented in bar chart and table format with explanatory text. Any quotes to support the finding are presented in italics to prevent misunderstanding and promote clarity. The results from the three focus groups are considered independently, as are the results from the questionnaire responses.

3.1 Overview relating to the focus groups.

A total of thirteen nurses participated in the focus groups; six D grades, four E grades and three F/G grades (see Table 3.1.1). The focus groups comprised 11 female and two male nurses. The participants were all white British except one who was Filipino. On in depth analysis of the data five main themes emerged (see Table 3.1.1). The analysis, however, is presented primarily by grade.

3.1.1 Overview of process of thematic analysis of qualitative data

Qualitative data were obtained from the focus groups and from the written text based answer to the open questions in the questionnaires. Both the focus groups and the qualitative data from the questionnaires were analysed using thematic analysis. Attride-Stirling's (2001) approach provided guidance for the thematic analysis. (see Figure 3.1)

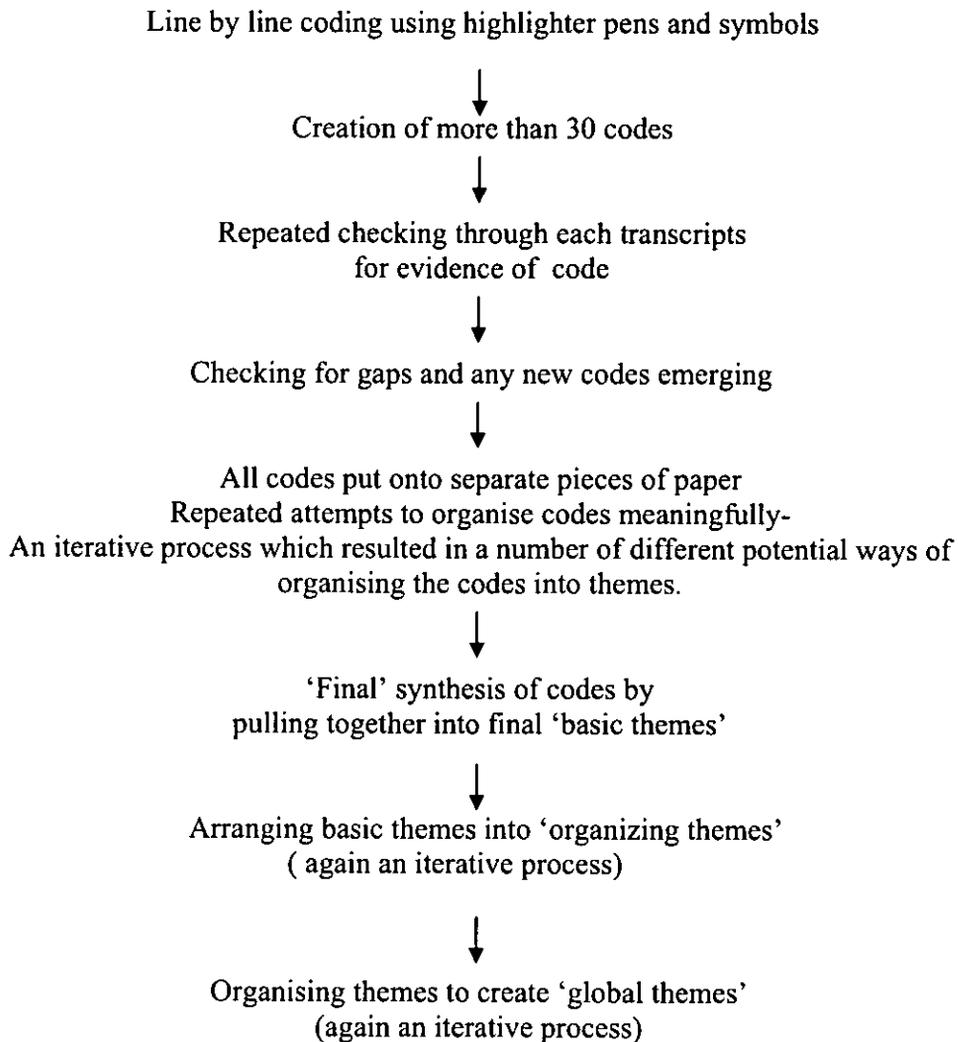
Following each focus group the audio tapes were listened to and transcribed as recommended by Gibson & Bamford (2001). Listening to the tapes and checking the transcriptions was a careful exercise that was undertaken to ensure all the dialogue

was noted. The responses to the questions were read and re-read to ensure understanding.

The qualitative data from the questionnaires and the focus groups were coded using a colour code system (in which each interesting idea or concept was allocated a different colour). However it soon required additional means of identifying coding to cater for the diversity and breadth of responses. This resulted in the researcher coding ideas/concepts/phrases using a combination of different colours and symbols. This was a rather long and repetitive process. However, analysing the data by hand in such a careful and methodical way meant that the researcher became comfortable and very familiar with the data. This meant that she understood the coding process and had a very clear idea of what was represented in each text and across the texts.

During the reading and coding of the focus group transcripts, general themes began to develop and it appeared that the codes could be drawn together under various theme headings. However, after re-visiting the data several times it became apparent that too many general themes were emerging and many of these themes overlapped one another. The general themes were then reviewed and those that were very similar or overlapped were compiled to create main themes. This process was iterative and undertaken carefully and rigorously. The complexity of moving towards a real sense of coherence is difficult to capture when writing down the process used. The writing tends to over-simplify a process that was time consuming, very frustrating at times but also very rewarding when the data did eventually get fitted within the main themes.

Figure 3.1 Stages of thematic analysis (based on Attride-Stirling)



(Same process used for analysing data from questionnaires)

The questionnaire responses also provided qualitative data. The numerical data were handled using descriptive statistics and presented in graph form using bar charts and tables. Appropriate qualitative comments were selected and presented in the text as quotes to clarify and confirm responses.

3.1.2 Results from D Grade Focus Group (n=6)

All the D grades participating in the focus group perceived CPD as both necessary and positive. All but one had a University background and had trained to Diploma level. All the D grades except one (n=5) were single with no dependants and stated that finance was not as great a barrier to CPD as time. This was followed by the comment 'you should compare time to what you get out of the study day' and others in the group suggested that this may show that they had wasted their time. One participant pointed out that when a new starter signed a contract they were signing a two way agreement, which put an onus on the employee to provide up to date nursing care and on the organization to provide CPD opportunities. The D grades felt that the more senior staff were given more training opportunities than them and that the senior staff resented them asking to leave the ward for pre arranged CPD when the ward was busy.

Themes	D Grades (n=6)	E Grades (n=4)	F/G Grades (n=3)
Attitudes to CPD	Necessary & positive (n=6)	Important to all (n=3) More important for younger nurses (n=1)	Essential for everyone (n=3) As senior staff, felt obligated to undertake CPD (n=3) Felt let down by organization because of speciality (n=3)
Responsibility for CPD	Shared between both individual and employer (n=6) Notion of two way contract (n=1)	Shared between both individual and employer (n=3) Responsibility of individual (n=1)	Shared between both individual and employer (n=3)
Main influences on CPD Time Workload Finance	Time most influenced CPD (n=5)	Time influenced all (n=4) Finance (n=3) Workload (n=4)	Motivation (n=3) Staff shortages (n=3) Finance (n=3)
Influence of grade	Felt more senior staff resented them leaving ward for CPD. Felt they were made to feel uncomfortable.(n=6) Felt they missed opportunities as more senior staff were given priority for CPD.(n=6)	Perceived that both D and F/G grades were given more opportunity for CPD. (n=4) Felt they were often asked to run the ward so that other grades could attend CPD.	Felt that opportunities were missed because they were responsible for maintaining safe staffing on the wards (n=3) Often undertook CPD in own time (n=1)
Access to & availability of relevant CPD	Aware of opportunity to undertake degree locally Considering accessing degree training locally (n=5)	Felt there was a lack of appropriate local CPD courses (n=4) Undertaking higher degree locally (n=1)	Recognized a lack of paediatric surgical courses locally (n=3) Achieved degree (n=1) Working toward degree(n=1) Achieved Diploma (n=1)

Some of the D grade group were unclear as to exactly what was meant by ‘continuous professional development’ and felt that this was linked to personal achievement. They identified CPD as standards for practice and necessary for updating their practice. They identified that ‘people could be set in their ways’ and felt that CPD provided the more junior nurses with the information they needed to bring about change in practice and prevented conflicting advice being given. They suggested that CPD enabled nurses to give the best care they could. Although financial implications were

secondary there was a consensus of agreement that CPD was often expensive with one nurse stating that '£200 for one day is too much'.

The D grade group identified one barrier as 'being taught by people who have been out of the profession for a long time'. They also felt that travelling miles to attend a study day where they were taught something they could have read from a book to be of little value. They found it quite daunting to attend CPD where other participants were far more experienced, especially if it meant giving a presentation. Newly qualified nurses stated that they did not feel comfortable applying for CPD as they expected the higher grades to be given the places, however, after the event they would find that no one had attended. They felt that they were in a no- win situation with derogatory comments being made about them by the other grades of staff if they did apply for CPD, and if they did not. They were concerned that they sometimes found that there was a pre requisite of attending another course before they could apply for the course they wanted to do which made CPD more difficult and admitted that they sometimes applied for inappropriate courses simply because they had been unsuccessful in getting on a course previously. They recognized that the work load factor, time management and short staffing all affected their perceptions of CPD and found it 'demoralizing when they only had two days off per week and were expected to spend one of them on CPD'. They were unhappy that more senior grades attended CPD and did not bother to give feedback.

All of the participants in the group recognized the difficulty in asking to be allowed off the ward to attend CPD if staff sickness had depleted the work force. They also stated that the *'staff who continue to come in to work and often work extra shifts or*

change their shifts to help out when other staff have taken time off, soon become exhausted and de-motivated and may end up not attending for CPD in order to allow safe cover on the ward'.

The D grade group suggested that CPD could be enhanced by information being cascaded from more senior grades of staff and by good preceptorship. They agreed that CPD would be fairer if all grades of staff were encouraged to attend instead of the more senior grades. Staff development groups were mentioned as a good way of encouraging CPD and they also felt that CPD would be enhanced by the sharing of good practice.

3.1.3 Results from E Grade Focus Group (n=4)

Although most (n=3) of the group clearly embraced CPD, one nurse felt that CPD was more for the younger nurses and that places on courses were wasted on them as they were looking toward retirement. Overall they viewed CPD as a form of lifelong learning, progressing with their education and suggested that nurses should never 'be standing still' so that they can maintain a professional status. The E Grade group suggested that CPD was not just relevant to academic areas but should be important in developing a person as a whole and may include developing an interest or hobby.

Predominant issues recognized by this group as barriers to CPD were finance and lack of time. However one nurse pointed out that they could 'make excuses for anything' and this was not disputed by the other group members. Another issue identified by this group was a dearth of relevant local courses such as paediatric orthopaedics. They felt that being part of a District General Hospital (DGH) was a barrier as many of the

interesting courses were held at tertiary centres. Again, shortage of staff was identified as an issue. They also suggested that family circumstances could contribute to the difficulty in accessing CPD. Although they all recognized time as a barrier to CPD, they agreed that it was important to make time to attend, or as one E grade stated, 'justify CPD and go for it!' The E grade group in particular mentioned jargon as being a barrier to CPD.

The E grade nurses suggested that several factors could enhance CPD. These included their own determination and motivation and their ability to question practice. They also felt that their prospects for promotion could encourage them to attend CPD. In house training and combined study days (multi agency) would encourage attendance at CPD. It was also stated that staff should have the opportunity to develop experientially.

3.1.4 Results from F/G Grade Focus Group (n=3)

The F/G grade group related CPD to maintaining standards of professional care and suggested that 'change in professional care equals change in nurses development'. It was determined that CPD was all about the patient rather than the individual but this was qualified by the comment, 'nurses are pushed into lifelong learning in order to meet patient / public expectations'. Discussing responsibility for CPD one nurse stated 'Trusts want nurses to be the best they can be and it is in their interest to develop staff to provide the service'.

This group also identified time, finance and staffing shortages as barriers to CPD. However they also raised the issue of personal circumstances, specifically one- parent families, as being a barrier to CPD. Being part of a District General Hospital was also

seen as problematic as it was felt that paediatrics were often forgotten. The distance to travel when suitable courses were held in the South of England was also identified as a barrier. Interestingly, the F/G grade group also stated that 'lack of support from peers' was a factor. Another point made was that they were less likely to have access to CPD because the unit did not have a Clinical Nurse Specialist in post. Lack of motivation, they suggested, was not restricted to their own motivation but felt that the motivation of others was a contributory factor to barriers to CPD. The group identified many of the factors the other groups had mentioned in relation to factors which could enhance CPD. They felt that the opportunity to develop experientially was very important and that having a good choice of subjects, courses to choose from was vitally important. Multi-agency approaches to nursing children and networking were felt to be factors and they also felt that appropriate delegation helped staff to develop. Individual Learning Accounts (ILA) and distance learning packages were also thought to be factors which could help CPD.

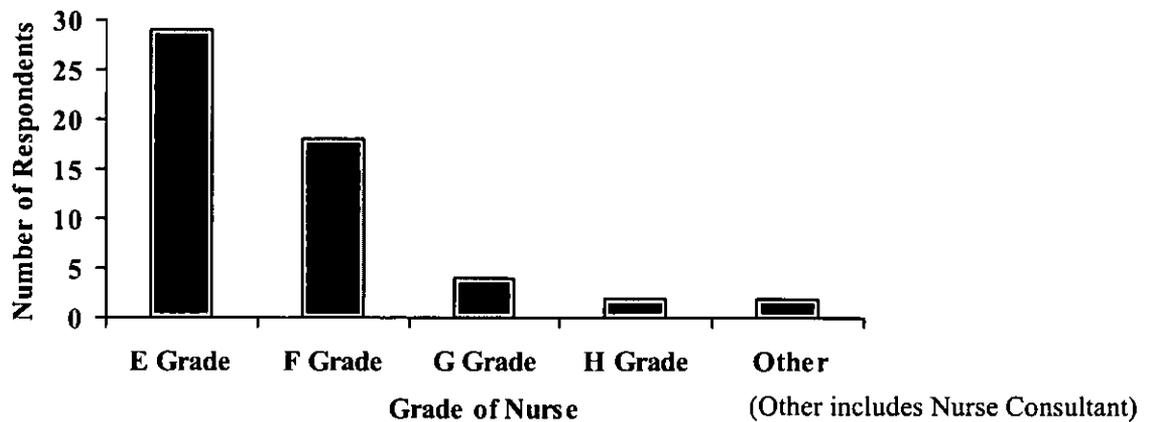
3.2 Results from the questionnaire.

A descriptive statistical analysis of data was undertaken. Results are presented as raw numbers and percentages. Written comments are interpreted as supporting material, where appropriate, in text. A total of 81 questionnaires were returned out of the 240 distributed, representing a 34% response rate.

3.2.1 Demographic data

The sample comprised 78 female respondents and only 2 male respondents (see Figure 3.1). They represented grades D,E,F,G H and other (see Figure 3.1). One respondent omitted to give a response to the question on gender.

Figure 3.2: Grade of respondents (n=80)

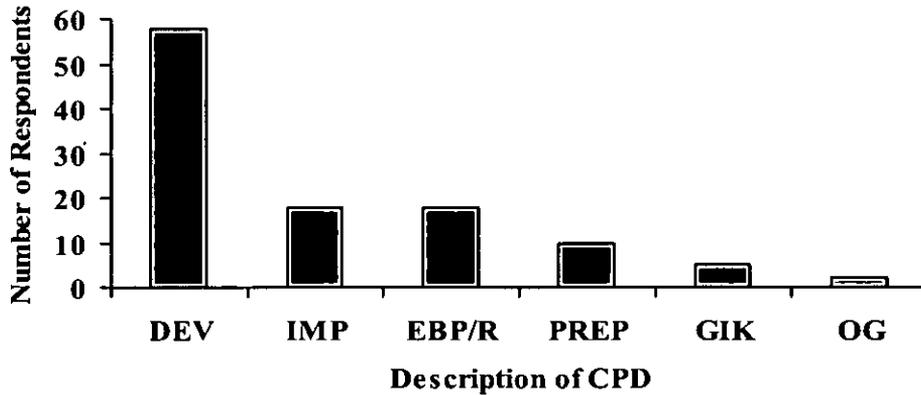


Although over half the respondents, 54 (67%) were D / E grade children’s nurses, it is interesting to note that 35 (43%), of all respondents had more than 10 years nursing experience, in fact only 28 (34%), of all respondents (n=80) had less than 5 years experience. This indicated that not all D / E grade nurses were lacking in experience. It was likely that a proportion of nurses did not view nursing as a compulsory career pathway, but remained at a particular grade by choice, irrespective of experience.

Thirty-five (38%) respondents stated that they had more than 10 years experience and 21 (31%), gave the actual number of years experience that they had (range 11 to 36 years, and average 16years).

When asked to describe CPD in their own words, the majority of respondents (n=57, 70%) related CPD to developing, maintaining or updating their skills and knowledge or abilities (see Figure 3.3). In contrast only two respondents described CPD as an on going process of learning.

Figure 3.3: Description of what respondents understand by CPD



- DEV: CPD related to developing, maintaining or updating skills/knowledge/abilities.
- IMP: CPD related to improving/enhancing practice or care provided to service users.
- EBP/R: CPD related to evidence based practice or research.
- PREP: CPD related to Post Registration Education and Practice.
- GIK: CPD related to way of identifying gaps in knowledge / development plan.
- OG: CPD related to being on-going process of learning.

3.2.2 Responsibility for CPD

When asked who they felt should be responsible for CPD, most respondents felt that both the employer and the employee should take responsibility for CPD (see Table 3.2).

	% of respondents	No. of respondents
You / the individual	10%	8
Employer	0	0
Shared between both	89%	72
Other	0	0

The notion of joint responsibility was very evident in some of the written comments made by respondents. The notion of safety was seen to be important by one respondent who stated:

'It is the individual's responsibility to ensure clinical and theoretical knowledge are up to date to maintain area of practice and ensure that UKCC requirements are met. It is the employer's responsibility to ensure

employees are safe and competent to carry out duties' (Female children's nurse, E grade with 5-10 year experience).

Another experienced member of staff saw improvement as an important component:

'In life we have to take responsibility for improvement, so in such an important job (paediatric nursing) this is even more important for staff and management' (Female children's nurse, E grade with 13 years experience).

The need for employers to be supportive and staff to be willing was seen as essential by a less experienced nurse:

'Staff should be willing to undertake further courses etc. to help in their professional development but to do this their employer should be supportive e.g for giving study days or helping financially when possible' (Female children's nurse, D grade, < 5 years experience).

Although in the minority (10%), some of the respondents felt the individual took sole responsibility. One of the F grades summed this up when she stated:

'As a registered practitioner you are responsible and accountable to continually develop and keep up to date. We are treating the public and they deserve to be protected – as is stated in our code. You cannot and should not rely on anyone else to keep you up to date – it is a personal commitment' (Female children's nurse, F grade with 12 years experience).

This was reinforced by an E grade nurse who said:

'The Code of Professional Conduct puts the responsibility on the individual practitioner to ensure that development is adequate for the role' (Female children's nurse, E grade with 20 years experience).

3.2.3 Barriers to and factors important to CPD

A number of major barriers were seen to exist in relation to CPD (see Table 3.3).

Time (70%), staffing (49%) and finance (44%) were seen to be the major barriers.

Table 3.3: Major & Minor Barriers to CPD

	Major Barriers		Minor Barriers	
	%	Number	%	Number
Time	70	57	25	20
Staffing	49	40	42	34
Finance	44	36	49	40
Availability (of courses)	31	25	43	35
Distance	25	20	46	37
Personal circumstances	23	19	55	45
Motivation	18	15	43	35

One of the D grade nurses summed up the problems of balancing adequate ward staffing and getting study days when she said it is:

'difficult to get study days / time owing as initially it is essential that the ward is adequately staffed – I feel that this is a barrier to CPD'. (Female children's nurse, D grade < 5 years experience).

Although the majority of nurses identified time, staffing and finance as major barriers, other nurses, as illustrated by the following quote, identified the pressures of full time work:

'If you work full time on a busy ward with increased workload, there is an increased demand on your own personal time and social life. Sometimes you can feel that you are working continuously'. (Female children's nurse, E grade with 14 years experience).

Having identified what the majority of respondents perceived as major barriers to CPD, it is interesting to compare these against what the respondents felt were only minimal barriers to CPD (see Figure 4)

The main minimal barrier to CPD was perceived as being 'Personal Circumstances' although 'Finance' was also rated by 40 respondents as being a minimal barrier. By comparison, only four more respondents claimed finance was a minimal barrier than perceived it as a major barrier.

Time, deemed as the most important barrier to CPD by 57 respondents, was rated as only a minor barrier to CPD by 20 respondents. One experienced E grade nurse explained:

'Lack of time affects everyone but it is a case of making the time. Some of the courses are very expensive and not everyone can afford them. Motivation – there is plenty of help to enable CPD. No one needs to remain as they are! There are times in every ones life when personal circumstances make learning difficult'. (Female, E grade paediatric nurse with 16 years experience).

Time was linked to distance by one respondent who declared:

'Many paediatric courses are run in the South of England thus increasing the time and cost required to attend. Personally I feel quite motivated although other team members may not be as motivated'. (Female children's nurse, E grade with between 5 – 10 years experience).

Again, comparing the data above with that of the 'major barriers to CPD' shows that more than twice the number of respondents felt that their own motivation was only a minimal barrier to CPD. One female children's nurse with < 1 years experience felt that barriers affecting all areas should not be viewed as major barriers.

'As staffing levels are a concern throughout the country I believe that this should be seen as a minimal barrier as it is a problem for all units. Steps should be taken to make training easier such as in-house training and by possibly having a specialist in all areas such as respiratory condition, metabolic conditions etc. in order to provide training within the workplace'.

When asked to rate how important factors were in improving CPD, respondents identified 'own determination' as the most important factor 73 respondents (n=81) agreed which accounted for 90 % of all respondents.

'Own motivation' was identified as the second most important factor with the 'opportunity to share good practice' coming third. Clearly, the respondents indicated that they regarded themselves as extremely important factors to improving CPD.

Surprisingly, although Table 3.3 showed that ‘Time’ was deemed as the overall major barrier to CPD, the data (see Table 3.4) clearly shows that ‘own determination’ and ‘own motivation’ were felt to be more important to respondents than being given time to undertake CPD.

However, as 57 respondents stated that ‘Time’ was their greatest barrier to CPD (see Table 3.3), it is not surprising that 53 respondents rated being given time as their most important factor (Table 3.4).

	Quite important		Extremely important	
	No. of respondents	% of respondents	No. of respondents	% of respondents
Own determination	8	10%	73	90%
Own motivation	17	21%	63	78%
Opportunity to develop through new experiences	27	33%	54	67%
If you were given time	28	35%	53	65%
Opportunity to use skills learnt through CPD in practice	33	41%	48	59

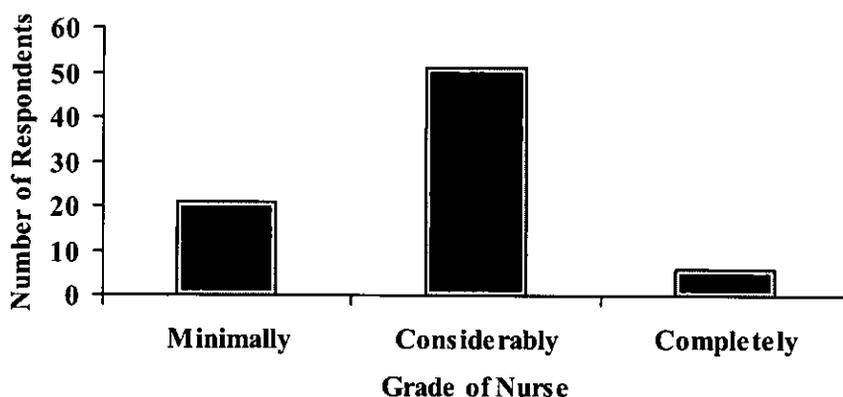
Relatively few respondents scored any factors as being ‘not important’ to improving CPD. However, five factors were identified as being of least importance. No rationale was provided as to why these factors were not deemed to be important. However, it is proposed that ‘distance learning packages’ and ‘individual learning accounts’ are the factors least commonly found in the workplace and this may explain why they are relatively undervalued (see Table 3.5).

	No. of respondents	% of respondents
Distance Learning packages	7	9%
Individual Learning Accounts	5	6%
Clinical Supervision	4	5%
Development Groups	4	5%
Preceptorship	2	2%

3.2.4 Influence CPD has on practice

When asked to what extent they thought their practice had been influenced by CPD, all respondents felt that their practice had been influenced to some extent.

Figure 3.4: The extent to which practice has been influenced by CPD (n=79)



Most, 52 respondents (64%) thought that their practice had been considerably influenced by CPD. Twenty one respondents (26%) however, thought their practice had been influenced minimally by CPD and six respondents (7%) claimed that their practice had been completely influenced by CPD. However, as responses demonstrated in Figure 3.3 were based solely on the respondent's subjective perceptions, comments made by the respondents were extremely valuable.

Some respondents, who perceived their practice as being only minimally influenced by CPD, made similar comments to those who perceived their practice to be considerably influenced. This would suggest that individual's perceptions can vary considerably based on similar evidence. Perhaps these responses reflect why one of the top five factors identified by respondents as being extremely important in

improving CPD was ‘opportunity to use skills learnt through CPD in practice’. Of those respondents who stated that their practice had only been minimally affected by CPD, some had only just qualified and might reasonably be considered to have had little access to CPD.

‘Have only just started but feel influenced because I have been on an induction and Paediatric Resuscitation Day’ (Male children’s nurse, D grade, with < 1 years experience).

However, other respondents who felt that CPD had minimally influenced practice identified alternative routes to maintaining CPD other than attending courses:

‘Attending in house (IV / Resus.) make me more skilled, confident and hopefully improves my practice. Articles that I have read / researched have changed the way I look at the care we provide – and hopefully improve it’. (Female children’s nurse, E grade with 5 – 10 years experience).

and

‘Due to PREP requirements I have ensured that my portfolio is kept up to date in order to maintain my registration. I haven’t been offered places on paid courses but have used preceptorship, Clinical Supervision to my advantage’. (Female children’s nurse, D grade with < 5 years experience).

Other respondents who stated that their practice had been considerably affected by CPD identified the various ways CPD had influenced their practice. One experienced F grade nurse stated:

‘Attendance at study days encourages reflection on practice and enables ‘sharing’ ideas and practice. I have adapted areas of practice following some study days. Researching specific areas of practice enables me to keep up to date with latest treatments and I alter my personal practice accordingly’. (Female children’s nurse, F grade with 5 – 10 years experience).

Another experienced respondent noted that:

‘I feel much more confident in my practice knowing that my knowledge base has a sound theoretical base that has been achieved by CPD’. (Female children’s nurse, E grade with 11 years experience).

Another respondent commented:

'Through preceptorship and I.V training' (Male children's nurse, D grade with < 5 years experience).

Respondents who thought their practice had been completely influenced by CPD were able to indicate a wide variety of ways in which their practice had been affected. An experienced F grade nurses stated:

'NEB's Management Course (identified as a need during appraisal process) – since been involved in recruitment & selection, managing poor performance, report writing, project management i.e developed pre admission clinic at second hospital site. Completed article on 'Head Lice' prior to returning to work from maternity leave – had an epidemic on the ward and was able to manage situation and support junior staff. Attended PLS course – able to teach resuscitation confidently on mandatory training day'. (Female children's nurse, F grade with 12 years experience).

Another nurse, a G grade, identified how two specific courses had influenced aspects of her role:

' Teaching certificate gave me insight, tools and skills to teach other team members. A degree developed me professionally to give me confidence and the skills to update my practice and keep updated as an on going process' (Female children's nurse, G grade, 36 years experience).

Analysis of the written comments shows that it is mainly staff at Sister / Ward Manager level who commented that they thought that their practice had been influenced completely by CPD. One of the major ways in which CPD appeared to affect respondents was the degree of confidence and / or competence it engendered. When asked why they thought their practice had been influenced by CPD, 19 respondents felt that their practice had been influenced because the organisation they worked for encouraged change following CPD. The Trust may well have encouraged changes in practice after CPD as a direct result of Government initiatives such as

Clinical Governance or the impact of the Department of Health Consultation Paper,' Supporting doctors, protecting patients' (DoH 1999).

	No. of respondents	% of respondents
The organisation I work for encourages changes in practice, following CPD.	19	23%
I am personally pro active in developing practice following CPD.	16	20%
The Government has promoted a culture of CPD and evidence based practice.	9	11%

Twenty respondents (25%) gave a positive response to more than one of the influencing factors. Seven respondents (9%) indicated that they felt all the factors contributed to why their practice was influenced by CPD. Seventeen respondents (21%) did not answer the question.

Having analysed the data from the focus groups and questionnaire responses and presented them in an appropriate format the findings were then presented in chapter 4.

CHAPTER 4: FINDINGS

Within this chapter the researcher intends to consider the results of the questionnaire responses in relation to the aims of the study and identify possible rationales for the concluding results.

4.1 Overview of findings

Very little research has been undertaken previously to explore the perceptions of children's nurses of CPD. The aims of this research were to explore nurses' perceptions of CPD, examine whom nurses perceive to be responsible for CPD, explore what factors nurses perceive could improve CPD and to examine if nurses perceive their clinical practice is influenced by CPD. The findings of the study have provided an insight into the perceptions of the participants, and although these findings cannot be claimed to be representative of all children's nurses, the findings are both interesting and potentially transferable.

Two main overall findings were constructed from this study, and although inter-related, the researcher will endeavour to discuss them individually and analytically before bringing them together and relating them to the previous literature.

The key findings are:

1. Mostly participants had positive perceptions of CPD and their relation to it. This finding is explored and presented under the following sub headings within the chapter.
 - *Altruistic acceptance of responsibility*
 - *Positive perceptions of responsibility for development*

- *Positive perceptions related to confidence and ownership*

2. Most of the major barriers were perceived to be work linked and due to constraints that the individual felt unable to overcome. Despite difficulties in accessing relevant CPD, most participants perceived that their practice was influenced considerably by CPD. This finding is explored and presented under the following sub headings within the chapter.

- *Staffing*
- *Finance*
- *Geographical barriers*
- *Impact of own determination and motivation*
- *Political influences on CPD*
- *Practice development following CPD*
- *Rationale for practice development following CPD*

4.2 Children's nurses positive perceptions of CPD

4.2.1 Altruistic acceptance of responsibility

The participants demonstrated an almost altruistic acceptance of responsibility for CPD despite the majority of the participants (89%, n=72) stating that the responsibility for CPD should be shared between employer and employee. Comments were made by the participants that clearly showed that they were committed to providing a safe service to their clients and recognised the need to develop their practice in order to ensure their practice was safe. As one D grade staff nurse commented -

'As a practising qualified nurse (individual) I can see a responsibility to myself and the patients in maintaining a good knowledge base and skill delivery through PREP and regular research, skill study days...'

4.2.2 Positive perceptions of responsibility for development

Surprisingly perhaps, PREP was not the main reason the participants undertook CPD, and although the mandatory requirement for PREP was mentioned by some participants, the majority of comments related to an onus on the individual to develop in order to be competent and provide a quality service. A positive recognition for the need to improve was therefore not PREP driven, but comments made by the participants suggested that they were acutely aware, as accountable practitioners, of their responsibility to their clients. They accepted the mandatory requirement of PREP as a necessity. As one experienced E grade participant points out:

'It is the individual's responsibility to ensure clinical and theoretical knowledge are up to date to maintain area of practice and ensure that UKCC requirements are met.....'

This positive perception of responsibility for development supports Jarvis's (1987), view that the occupation of nursing was 'undergoing a process of professionalisation'. Perhaps in 2004 the process is nearer completion and, as this research suggests, the participants see themselves as accountable professional practitioners. Certainly this was the view of one participant, who stated that,

'The Code of Professional Conduct puts the responsibility on the individual practitioner to ensure that development is adequate for the role.'

Andersson's (2000) study which looked at the effects of CPD amongst nurses in Sweden also found that CPD led to increased job satisfaction and improved self-confidence. However, Andersson did raise a concern as to how long nurses would be prepared to continue to raise their professional competence without increased

financial reward or increased professional recognition. In a study by Prater & Neatherlin (2001) in Texas, a correlation could be noted between a positive attitude to CPD and personal and professional benefits of CPD. However, any relationship between CPD and financial reward was not identified (nor was it the intention) through the current research.

One newly qualified participant was positive that barriers such as staffing levels should not be viewed as major barriers. This sort of attitude is not necessarily surprising when considered in relation to the findings of other published literature. Gopee (2001) for example, examined CPD and found that newly qualified nursing staff may have so much to learn in their first post, that they are undertaking CPD continually in the workplace. Fairly inexperienced staff may therefore not feel that staffing levels are a barrier to CPD as they are still receiving CPD on a day to day basis.

The research also demonstrated a 'fairness', in the perceptions of the participants towards whom they perceived should be responsible for CPD. Although an overwhelming majority (n = 72) stated that the responsibility should be shared between themselves and the employer, with a minority of participants advocating the employee as having sole responsibility, not one participant suggested that the employer should bear the sole responsibility for their CPD. Reasons given for a 'shared responsibility' included a recognition that the individual had a responsibility to maintain their clinical and theoretical knowledge up to date, but that the employer had a responsibility

'...to ensure employees are safe and competent to carry out duties'.(E grade staff nurse)

4.2.3 Positive perceptions related to confidence and ownership

Another positive perception towards CPD was that some participants commented that CPD contributed to confidence in their practice because they knew that their practice was based on a sound theoretical base. This consideration was supported by Andersson (2001) whose research in Sweden indicated that CPD led to 'enhanced work satisfaction, extended work relevant competence, the attainment of professional goals and enhanced self confidence'. However, within the focus groups, participants also identified that simply attending study days did not necessarily mean that they developed themselves, as there was a recognition that the individual needed to take ownership and apply themselves to CPD in order to gain a benefit from it. The need to proactively apply CPD to practice in order to benefit from it was demonstrated by comments made by an experienced F grade participant. These included the necessity for reflection on practice during study days and the ability to adapt areas of practice following study days. However, the research also highlighted the 'chicken and egg' situation when one participant recognised that a *'teaching certificate gave me insight, tools & skills....., the degree developed me professionally to give me the confidence and the skills to update my practice...'* So it would seem that in order to successfully apply CPD to practice, a level of CPD is required. Therefore if CPD motivates practitioners to undertake further CPD it would seem likely that practitioners who would not voluntarily undertake CPD may not necessarily find their practice improving from attending CPD simply because it was now a mandatory requirement. As Puetz (1992) suggests, the nurses who are most in need of CPD to update their

practice, may be the least likely to undertake CPD. Another positive perception the research identified was the participants' recognition that their own determination and motivation were extremely important in order for CPD to be successful. Determination and motivation were identified as the two most important factors for improving CPD (90% & 78% respectively), and participants rated these two personal factors above all the factors reliant upon a third party's intervention. Henwood (2000 p8) also identifies that the most powerful motivators (to CPD) were 'internal, not external'. Determination and motivation towards CPD showed a positive orientation towards CPD and participants saw themselves as the most important catalysts for development. DiMauro (2000) suggests that being better informed prepares the individual to anticipate change and future developments and by doing so increases job satisfaction for the individual. It would be likely then, that CPD prepares the individual so that they are able to perceive CPD in a positive way and to view themselves as an important component. Nolan et al (1994) propose that change is judged to be easier to implement when the practitioner is well motivated. It is in the best interest of an organisation, where change is endemic, to court positive perceptions to CPD by making CPD readily available to practitioners.

4.3 Work linked barriers and the difficulties overcoming these

4.3.1 Staffing

The majority 43% (n=35) of participants, felt that their own motivation could only be seen as a minor barrier to CPD. However, in contrast, most major barriers to CPD were related to work linked constraints such as time, staffing and finance, that the participants felt unable to overcome. This was supported by comments made by the participants of the focus group as well as respondents to the questionnaire. Comments

made during the focus group identified staffing, (lack of sufficient staff on the ward), as a major problem for nurses undertaking CPD. Interestingly different grades of nurses expressed different reasons for these barriers and also had different perceptions and experiences. CPD sessions were often missed when staff were unable to leave a ward due to the pressures of the workload, even when CPD had been pre arranged. Junior staff particularly, felt guilty when they asked to leave the ward to attend for CPD, when the ward was busy, as a result of the perceived attitudes of more senior staff. Comments from the more senior staff (E grade) showed that they were not aware that they had this unintentional effect on the more junior staff. Intriguingly, they felt that both the more junior staff / and more senior staff were given more opportunities for CPD than they received. This may have been a factor that contributed to an E grade participant stating that she sometimes felt that she was working continuously when working full time on a busy ward with increased workload. The pressures identified by this and other participants perhaps contribute to Crotty et al's (1987) view that there is a potential relationship between CPD and a reduction in 'burn out' factors. Attending CPD gives the nurse an opportunity to consider the theory relating to practice and when CPD is outside of the workplace, affords the practitioner a break from the stresses of a busy acute setting.

Shortage of staff was also identified as preventing staff who had attended study days having the time to incorporate newly learnt skills into their practice, or indeed having the time to teach newly learnt skills to others. This is particularly relevant as 'opportunity to use skills learnt through CPD in practice' was rated by the questionnaire respondents as the fifth most important factor for improving CPD. Andersson (2000 p92) suggests that if, following CPD, new competencies are not

encouraged or if they are devalued, the nurse is likely to feel less job satisfaction and may experience feelings of 'personal and professional inadequacy'. Henwood (2000 p8) acknowledges the importance of sharing CPD with colleagues in the workplace, and suggests that 'properly stimulated, knowledge and intellect grow exponentially when shared'.

4.3.2 Finance

Finance was another constraint that some participants (n=36) felt was a major barrier which was difficult to overcome. However, it is interesting to note that slightly more participants (n = 40) actually perceived finance to be only a minor barrier to CPD. Although comments reflected the need for the employer to share responsibility for financial support for CPD, it is likely that other circumstances such as family commitments, single parent status or part time employment may also contribute to the fact that finance was seen, by some, as a major barrier. Also, it is noteworthy to mention that all the participants who stated that the individual should bear responsibility alone for CPD, would all have been on the F Grade salary pay scale, even though they may not have been employed as F Grade nurses. Perhaps this higher income had a bearing on their willingness to take full responsibility for CPD. Indeed, personal circumstances were noted as a major barrier for participants, but as there was no specific criteria for personal circumstances, and as participants did not volunteer this information, it is impossible to know which particular circumstances participants referred to from the research. Some participants identified certain circumstances that were likely to have a financial implication; these included costs associated with travelling to work on a daily basis and child care costs. This was perhaps surprising

when compared to research by Kersaitis (1997) who found 'financial status' was the most common negative factor associated with CPD.

4.3.3 Geographical barriers

A particular factor that seemed to affect the focus group participants was the lack of local appropriate study days. The most interesting study days, particularly noted by surgical nurses, seemed mostly to be run in the South of England thus increasing time and cost required to attend. Furthermore, it meant that the difficulties of maintaining ward staffing, already identified as being a major barrier to CPD, were further challenged for an extra day. CPD that required attendance and an overnight stay created an additional challenge for nurses who had to use their annual leave entitlement in order to attend any study days that were not held locally. Puetz (1983) recognizes that there is indeed an inequality in geographical provision of CPD and research undertaken by Nolan et al (1994) demonstrated that nurses can feel bitter about being expected to self fund and sacrifice annual leave in order to attend CPD.

Many of the barriers to CPD are interrelated. For instance, the participant's own motivation and determination, which were important factors in improving CPD, were likely to be adversely affected when there were shortages of staff, lack of funding and a general feeling of being under valued.

4.4 Children's nurses perceive their practice to be influenced by CPD

No participant suggested that their practice had not been influenced by CPD at all and most participants' 64%, (n=52) thought that their practice had been considerably influenced by CPD. However, it is vital to consider how the participant's perceptions

varied in relation to how extensive this influence had been. For instance, one E grade participant felt her practice had only been minimally influenced by CPD, although she recognized that CPD, in this case in-house training, would,

'....make me more skilled, confident and hopefully improves my practice. Articles I have read / researched have changed the way I look at the care we provide – and hopefully improve it'.

Her description would suggest that CPD had had a more major impact on her and her practice than she was giving it credit for.

4.4.1 Impact of own determination and motivation

Perhaps the factors of own determination and motivation, identified as the two most important factors for improving CPD could be instrumental in participants stating that their practice had been considerably influenced by CPD. As is apparent by the comments made by the F grade participant who said her practice appeared to have been influenced by CPD *because* she had been motivated enough to attend the various CPD opportunities and had actually put into action what she had learnt from the training. For example, she had actively been involved in recruitment and selection after attending a relevant management course and subsequently developed a pre admission clinic at a second hospital site after attending project management. So it is likely that the effect of CPD in influencing practice is not only dependant upon the participant's perceptions, but also upon their own motivation and determination and opportunity to implement change. It may be considered that CPD promotes confidence in a practitioner, which contributes to their motivation / determination and consequently impacts on the service provision. Twenty- three per cent (n = 19) of participants felt that their practice had been influenced because their organisation encourages changes in practice, therefore the role of the organisation must not be

forgotten. It is interesting to consider that only 11% of participants, (n=9), felt that their practice had been influenced by CPD as a result of the Government promoting a culture of CPD.

4.4.2 Political influences on CPD

The necessity of meeting PREP requirements and the implications of the Government document 'Clinical Governance: Quality in the NHS (DoH 1998) clearly show that the National Health Service is under pressure from the Government to promote CPD in the form of lifelong learning in order to improve the quality of care. The NHS needs to actively comply with the request for evidence based practice through Clinical Governance and it is feasible that the fact that the organisation encourages changes in practice following CPD, could be directly linked to the fact that the organisation is being seen to comply with the Government initiatives which aim to promote a culture of CPD and evidence based practice.

4.4.3 Practice development following CPD

Even so, 20% (n = 16) of participants, felt that their practice had been influenced by CPD because they were personally proactive in developing practice following CPD. This again could link in with the fact that the participants felt themselves to be the main instrumental factor for improving practice following CPD. In a study undertaken by Slusher et al (2000), participants when asked if, following CPD, they had been able to implement changes in the workplace, 41.4% (n=179) affirmed that they had been able to do so. By contrast, in the same study, 40.7% stated that they had not been able to bring about changes in the workplace. However, the difference between a

participant identifying that practice has been influenced by CPD and actually changing practice themselves cannot be ignored.

4.4.4 Rationale for practice development following CPD

Eleven percent of participants, (n=9) thought that their practice had been influenced following CPD because the Government promoted a culture of CPD and evidence based practice. However, many of the respondents (n=20) identified that their practice had been influenced by CPD because of more than one of the factors and nine percent (n=7) of participants indicated that their practice had been influenced by CPD for all of the above reasons (the organisation encourages changes in practice following CPD, they were personally pro active in developing practice following CPD and the Government has promoted a culture of CPD and evidence based practice). Unfortunately, twenty one percent of participants, (n=17), did not respond when asked why their practice had been influenced by CPD and gave no indication of why they had omitted to do so. One possibility was that the participants were unable to identify why their practice had been influenced by CPD, or bearing in mind that this was the very last question of the questionnaire, perhaps the reason was simply that the participants had lost interest at this point.

4.5 Conclusion

Discussion of the findings of the study will have given some insight into the perceptions of the respondents. These perceptions are only valid if the data was obtained ethically. To ensure that these perceptions were gained in an ethically sound manner the following chapter will consider the ethical consideration for the study.

CHAPTER 5 ETHICAL ISSUES

Within this chapter the researcher intends to consider the ethical issues which were associated with the various steps of the research study and also the application of recommended principles for avoiding ethical compromise.

5.1 Introduction

Ethics, conceived as an entity related to philosophy by Plato, has continued to develop as a concept throughout the decades. Although ethical issues may sometimes be considered to have most relevance to subjects in clinical / experimental research, they do have major relevance to all research participants. It is important to consider the relevant ethical issues in this study, in relation to the focus group participants and questionnaire respondents.

Beauchamp and Childress (1994) suggest four principles that researchers should abide by when undertaking any type of research. These comprise (1) autonomy, which extols the researcher to respect the individual's ability to decide (2) nonmaleficence which means that the researcher has a responsibility to avoid putting a participant at risk; (3) beneficence, the principle of balancing the good that will be gained from the research against the risk to the participants; and (4) justice, the responsibility for the researcher to treat all participants with equity. These principles guided the researcher in planning, designing, implementing the research and through all subsequent stages including analysis and writing up the study.

5.2 Ethical issues relating to the focus groups

Focus groups consist of selected individuals meeting under the auspices of a moderator to discuss specific elements in which it is expected they will share their views, experiences and opinions. Castles (1987) recognises that the 'scientific rights' a researcher has are balanced by the responsibility they have to protect the participant. Researchers therefore have an obligation to search for knowledge while bearing in mind the rights of the participants. There is an onus placed on the researcher, in this case the moderator, to ensure that these principles are adhered to throughout the focus groups. The moderator also needs to be aware of the possibility of ethical issues developing within the focus groups. Smith (1995) advises any researcher who anticipates ethical issues being raised during the focus group to consider discourse with an objective, informed individual who is not in any way related to the study prior to the focus groups taking place. Whilst the researcher did not anticipate any ethically sensitive issues being discussed she did discuss the importance of ethical considerations with her supervisory team before commencing the study.

5.2.1 Selection of participants

Several ethical issues must be considered when arranging the focus groups which are separate to those that may be raised once the focus group takes place. The first ethical issue, relating to the principles of justice and autonomy, is the selection of the participants. Participants should not be selected because the researcher feels they would present certain views but all the whole target population should be offered the opportunity to participate. The researcher has a responsibility to ensure that the participants know that participation is completely voluntary and that they can decline the offer to participate and that their decision will be respected.

For this project the researcher was aware that as the participant's manager, it was possible that participants could feel under pressure to attend. Babbie (1990) suggests that researchers may not always clearly define the line between 'coercion and persuasion'. The researcher/moderator/manager gave information to the potential participants to make it clear that they were being invited to consider participation. The researcher/moderator/manager wanted to be sure that any mild persuasion from her perspective would not be perceived as coercion by the participant and care was taken to ensure this did not happen.

5.2.2 Information to participants

To enable participants to decide whether to participate in the focus group they need to be given enough information. The participants should be informed of the procedure for the research so that they understand what the focus groups are and what they will be expected to discuss. They need to be informed about the purpose of the research as this may be a major factor in their decision regarding their participation. They must also be made aware of any possible risks and if there are any benefits. In this study, verbal information was reinforced with written information so that the participant could make an informed choice regarding participation. The information explained the aims of the research and what participation in the groups entailed. Nurses who agreed to participate were asked to complete a consent form which again identified the various elements of the research (see appendices).

5.2.3 The choice for participants

Castles (1987) suggests choice is an important aspect of participation. Choice must be an informed choice where the participant is in receipt of all the information required

for them to decide whether or not to participate. Not only does choice relate to the information given to the participants, but it also relates to the option the participant has to withdraw from the research at any time. Again researchers have a responsibility to ensure participants are aware of these choices and that choosing not to participate will not have any consequences to them. It is important to remember that it is not only the researcher who can make the participant feel coerced into participating, but peer pressure may also be a factor that the researcher must be aware of. The researcher did not anticipate that peer pressure would be problematic in this study and the study design was undertaken in such a way to avoid any such pressure since potential participants were contacted on an individual basis.

5.2.4 Confidentiality and Anonymity

Researchers have a responsibility to be honest with the participants, particularly in relation to what they are promising them. Babbie (1990) suggests that when confidentiality is promised the researcher is stating that although they know who gave a particular response, the information will not be divulged. Anonymity, however, is when a participant cannot be identified as the individual responsible for giving a particular response. It is also important for the researcher to be aware that they cannot promise confidentiality on someone else's behalf. For this study it was therefore important that all participants who gave written consent to participate also agreed to 'maintain confidentiality for whatever views are expressed during the small group discussion'. The consent agreement was further discussed prior to the commencement of the focus groups to ensure every participant understood the need to respect any views given and to ensure views, related to individuals, were not spoken about outside of the group (see 2.4.2 & appendix v)

5.2.5 Anonymity – a practical application

It was essential that anonymity was protected throughout the research process and therefore no list was made of the names of the individuals who had been invited to participate in the focus groups. All questionnaires were completely anonymous and when returned from a particular paediatric unit were mixed together with other completed questionnaires to prevent any inadvertent disclosure of identity. Similarly any quotes presented in the research were not attributed to an individual by name.

5.3 Ethical issues relating to questionnaire survey.

5.3.1 Anonymity

Anonymity is vitally important if respondents to questionnaires are to give honest responses. Even though the questionnaires are anonymous, it is possible in a fairly small sample that comments, and sometimes handwriting, can disclose a respondent's identity. This can be unavoidable and steps must be taken by the researcher to ensure the completed questionnaires are held securely to prevent a breach of confidentiality and anonymity. Babbie (1990) points out that occasionally researchers conducting surveys which appear to be anonymous covertly mark the questionnaires in order to be able to identify the person or establishment responsible for completing them. This not only contravenes the ethical consideration of anonymity and confidentiality but also compromises the principle of nonmaleficence. Politically sensitive responses made by an individual, in the belief that they were totally anonymous, could jeopardize a person's career prospects if attributed publicly to the person who made them. All these were taken into consideration when devising the questionnaire and there was no way of tracing a questionnaire back to an individual.

5.4 Data Protection

Another ethical consideration was to ensure that individuals who participated in the research, both the focus groups and the questionnaires, had their personal or professional information safeguarded. With this in mind no details were documented of the focus group participants and the tape recordings were simply labelled by the grade of participants. Transcripts did not refer to any individual by name and were stored securely to comply with the Data Protection Act (1989). All materials were used only for the purpose that they had been generated for and that the participants had agreed to. Only limited amounts of demographic data were requested from participants and this was always presented in such a way that individuals could not be traced. All data were physically stored in a secure manner and the electronic data were also stored in line with requirements of the Ethics Committee.

The researcher recognizes the importance of adhering to data protection principles and ensuring anonymity for the participants / respondents not only for the duration of the research study but also when the results are presented or disseminated.

5.5 Ethical issues related to dissemination of findings.

The researcher recognised the importance of making sure that the participants' time was not wasted by ensuring that the findings of the study will be disseminated. The researcher realised that this study was likely to influence practice albeit to a small degree, and this was felt to be a sobering responsibility by the researcher. The first priority was to disseminate findings back to the managers who had participated in the research study by acting as gatekeepers as it was felt that the findings would be particularly valuable to them in helping to consider issues related to professional

development. In addition it was important to ensure that the researcher disseminated the findings to the settings/units who had participated. There was also an imperative for the health research to be disseminated more widely in line with 'knowledge transfer' (part of the National NHS R&D programme). Ongoing and informal feedback to the units has occurred but the researcher plans to provide a copy of the research thesis to the unit whose staff participated in the focus groups. Copies will also be available for the other units who participated if they request a copy for their unit learning resources. The researcher will also consider the potential of writing an article for publication based on the research study.

5.6 Conclusion

Ethical issues are an important aspect of any research project. Researchers must be prepared to address any ethical issues which may arise unexpectedly. Smith (1995) relates how a researcher may 'discover' something while a focus group is in progress which necessitates further discussion with the individual after the group has concluded. Similarly, comments and responses received from a questionnaire may complicate the research and require the researcher to delve into an issue not previously considered before the research study can continue. Over disclosure is seen by Smith and others as a serious ethical concern as the consequences to an individual disclosing something to colleagues during a focus group may be dire if confidentiality is not honoured. By adhering to the principles described by Beauchamp and Childress (1994) discussed earlier, the researcher aimed to ensure ethical considerations were dealt with in the best interests of all concerned within the research. Having considered the ethical aspects of the study the researcher considers the limitations to the study in the next chapter.

CHAPTER 6: EVALUATION OF THE STUDY

Within this chapter the researcher will identify and discuss the limitations that became apparent during the undertaking of the study. These will not only include the limitations related to the different aspects of the research but also the limitations related to the researcher herself.

6.1 Introduction

All research projects have limitations; in this respect this study is no different. In the following section the researcher will explore the key limitations of the study. These limitations do not represent or reflect a careless attitude or approach taken by the researcher as most of the limitations arose during the course of the study and were, to a degree, out of her control. Where challenges arose that could have created limitations, steps were taken to try and ensure that they did not have a major effect on the study. The following areas that may have limited the study will be considered: the existing literature base; the tools (questionnaire, focus groups) used in the study; the technology supporting the study; the sample; and finally, the researcher herself.

6.2 Existing Literature Base

Identifying suitable literature was an area that would, were another study to be embarked on, be undertaken differently. As there were no articles found relating specifically to children's nurses and CPD, the researcher felt it necessary to obtain any articles at all that mentioned CPD. Initially this could have been streamlined (by using a more systematic search strategy). This would have reduced the amount of time taken reading a plethora of vaguely useful articles. In hindsight, a few good articles identified early on may have provided a cascade effect of further literature and

appropriate referencing material. However, as with other areas, the researcher's skills developed during the course of the study and were utilized when reviewing subsequent literature for inclusion in the thesis. Whilst many articles reviewed were subsequently discounted as adding nothing relevant to an understanding of children's nurses and CPD; they did play an essential role in placing the specific literature in the context of the wider literature base.

6.3 The tools (questionnaire, focus groups) used in the study

In hindsight a number of changes or amendments could be made if the study were to be replicated.

6.3.1 *Questionnaire related issues*

Were the study to be undertaken again, the researcher would be far more specific regarding some of the options offered on the questionnaires. For instance, 'personal circumstances' is given as an option related to barriers to CPD but does not define specifically what the personal circumstances are, which in retrospect could have provided useful information. Instead the researcher relied upon the respondent volunteering the specific circumstances, which did not occur. However, whilst the questionnaire did not always request specifics, it did allow participants the opportunity to indicate that personal circumstances did play a role as a barrier to CPD.

The researcher, from a management perspective, identifies the lack of specific data relating to 'availability of paediatric courses' as a limitation. The questionnaire relies on respondents clarifying their choice for why they perceived this to be a barrier and although many respondents did identify this as a barrier, and identified that a 'good

choice of subject availability was extremely important', many did not clarify this further. Had more respondents clearly commented on what specific subject matter they felt would have been beneficial to their development, this could have been influential in helping managers and educators identify and provide the training that children's nurses feel is extremely important but not currently accessible.

6.3.2 *Focus group related issues*

Although considered a successful exercise by the researcher, the focus groups may have benefited from a completely objective facilitator who had no previous ties with the staff. As the researcher was also the manager, it is impossible to know whether or not this had any 'limiting' effect on the resulting discussion and data generated. However it should also be considered that having a facilitator they were all familiar with, may have reduced the time the participants needed to feel comfortable enough to actively participate and so may have been a positive element rather than a limitation. Also, although the researcher had experience of managing and facilitating sessions, it was the first time she had facilitated a focus group within a research project. This meant that the researcher was learning the practicalities of running a research focus group as part of the study.

6.4 The technology supporting the study

Although the focus groups were felt to be successful at the time, investing in more appropriate recording equipment would have made transcribing the tapes following the interviews easier. The standard tape recorder used, picked up every sound in the room and at times it was difficult to hear what the quieter participants had said when every rustle in the room seemed to have been recorded at the same time. Fortunately,

because the tapes were transcribed almost immediately, any comments that could not be identified after listening to the tape were remembered by the researcher. Even so, a mental note was made to ensure better and more appropriate recording equipment be acquired, should a further study be undertaken that required focus group input. This was a steep learning curve for the researcher who feels that any of her future studies would benefit from the knowledge gained from this experience.

6.5 The sample

One of the main limitations of this study was the sample size. The focus groups were unexpectedly small due to unavoidable staffing restrictions, although it is debatable as to whether the data generated from the focus groups would have differed if the groups had been larger. However, the response to the survey was disappointing with only eighty one completed responses from two hundred and forty distributed questionnaires, and it was felt that more responses may have provided a greater depth of relevant data or at least reinforced the data obtained. However, the situation dictated the method of distribution and return of questionnaires and it is unlikely that this could have been improved under the circumstances. Also, as a high proportion of children's nurses opted not to take part in the study, consideration must be given to why this occurred. Could it have been that the nurses who did not participate had specific work or family reasons for not participating which could perhaps have added a new perspective to the study had they taken part?

The study is limited because it only looks at the perceptions of children's nurses working in the acute sector in the North West of England. It cannot therefore claim to be representative of the views of all children's nurses. However, as the sample

represented a wide spectrum of hospitals throughout the North West, it was felt to be a useful and informative study which did represent the views of children's nurses in the North West Region.

As only two questionnaire respondents were male, the researcher was concerned that the study was biased toward the female nurse perspective. However, as children's nursing still has a predominantly female workforce, (although male participation is increasing), it was felt that this would not unduly affect the results of the study.

6.6 Analysis

The researcher recognizes the importance of using computer software to support data analysis. The researcher purchased the software, and her competence in using the software was an initial limitation until this was addressed through learning and training. However, the low resulting number of completed questionnaires meant that the software was unsuitable for purpose. Any future study which produces an increased number of questionnaire responses would undoubtedly benefit from computer supported data analysis. However, the researcher felt that manually analysing the data using thematic analysis certainly helped her to feel more confident and fluent with the data. (see 6.7.3)

6.7 Evaluation of issues related to the researcher

The researcher's academic skills and ability was also a significant issue. Having had very limited previous experience (primarily from undertaking an undergraduate research project) the researcher had to read copious research literature relating to the various aspects of the research study. This not only prolonged the time taken to undertake the study but meant that every step of the research required advisory

support from the research supervisor. Due to the researcher's 'very basic' education, her confidence to undertake and complete the research study regularly needed reinforcing.

6.7.1 Lack of experience with focus group methodology

Not only were the focus groups a completely new concept to the researcher, but because she was acting as moderator as well as being the participant's manager she felt a responsibility for ensuring that all ethical concerns (see section 5.1) were considered while ensuring the focus groups successfully produced the necessary data. There was also a keen awareness to ensure her role as manager was neither compromised nor allowed to interfere with conducting the focus group appropriately. (see 2.4.2)

6.7.2 Issues related to language

As a virtual novice to the world of research the jargon and terminology became another barrier for the researcher. Different research terms which meant the same thing confused the researcher initially. This was compounded when coming across 'newly invented' terms, often while reviewing American literature, as these added to the confusion. However these concerns dissipated as the research study progressed and as the researcher became more familiar with the language of research.

6.7.3 Issues related to technology

With little more than a basic knowledge of information technology skills it is not surprising that some of the technological issues also became barriers for the researcher. Choosing and using audio recording equipment for the focus groups

resulted in inferior sound quality on the audio tapes which, had the researcher not transcribed almost immediately following the focus groups, could have resulted in only partial transcripts and possibly even necessitated repeating the focus groups.

Basic IT skills were helpful but were of little use when considering analysing the data by using specialist software. The researcher, having purchased the software, then needed to learn how to use it even though it was decided eventually to analyse the data manually for this study.

6.7.4 Issues around the research questionnaire

The researcher's limited knowledge of questionnaire design also needed to be overcome if a questionnaire was to be not only fit for purpose but one which would encourage respondents to complete. It was also extremely important that the questionnaire would supply enough information to meet the needs of the aims of the study, allowing the researcher to convert the information into working data. Reading around questionnaire design before devising the questionnaire was important in order to appreciate the many aspects of good questionnaire design and hopefully avoid the many pitfalls (see 2.4.3).

6.7.5 Issues related to data analysis

Every step of the research was a learning curve for the researcher and none steeper than learning to analyse data. Despite reading copiously around the subject the researcher found that only by actually taking a very simple step by step approach did her understanding of data analysis improve. Data analysis was time consuming and repetitive. It was sometimes illuminating and requiring dogged determination but it

always rewarded the researcher with yet another concept or theme to work with or another insight into the perceptions of the participants/respondents. (see chapter 3)

6.7.6 Issues related to compiling the thesis

Having never pulled all the elements of a thesis together created another learning curve for the researcher. Compiling the thesis meant facing the task of 'writing up' and this was daunting. Needing to pull everything together in a coherent written document whilst using academic/research language was difficult and whilst it became a bit easier as time went on it was always a challenge for the researcher. Important aspects included ensuring the chapters flowed in a logical sequence and this was helped by ensuring introductory and concluding paragraphs linked the chapters together. Cross referencing helped give the thesis further structure. The researcher tried to ensure all aspects of the research study were recorded in a chronological manner.

6.7.7 Overview of the learning process

Undertaking a research study was a journey into unfamiliar territory. Inspired by the central concept of the study and enthusiastic in addressing the aims of the study but lacking in practical knowledge and experience was a frustrating experience. Learning to manage data and communicating research ideas, an important part of the journey, resulted in renewed confidence and motivation to complete the research as effectively as possible.

6.8 Conclusion

In conclusion the researcher feels that the limitations, although they might seem to be plentiful, do not detract unduly from the results of the study. Certainly the study was a worthwhile project which despite the limitations was successful, not only in providing a vehicle for developing the researcher's understanding of research, but in actually meeting the aims and objectives set out in the initial proposal.

Having evaluated the study, in the next chapter the researcher will present the recommendations that could be made to managers of children's nurses and nurse educators and also in respect to any future research studies relating to CPD.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

Within this chapter the researcher intends to conclude the study by considering how the study met the aims presented in chapter 2 and will attempt to make recommendations which could be beneficial to managers of children's nurses, nurse educators and to any future research studies of CPD.

The study intended to explore what children's nurses perceived CPD to be, examine who children's nurses perceive to be responsible for CPD, explore what factors children's nurses perceive could improve CPD and examine if children's nurses perceived clinical practice to be influenced by CPD. Certainly the study was successful in exploring what children's nurses perceived CPD to be with the findings revealing that the majority of children's nurses (n=57) related CPD to developing, maintaining or updating skills/ knowledge/ abilities.

The study also successfully identified that the majority of children's nurses (n=72) regarded the responsibility for CPD to be a joint responsibility between the nurse and the employer. Interestingly the study also showed that only 10% (n=8) of the nurses felt that they had sole responsibility for their CPD. The study examined the factors that children's nurses perceived could improve CPD and specifically identified five main factors, (their own determination, their own motivation, having the opportunity to develop through new experiences, being given time for CPD and having the opportunity to use skills learnt through CPD). They also identified the main barriers to CPD.

The study was also successful in identifying that an overwhelming majority of children's nurses perceived that their practice had been influenced considerably by CPD.

7.1 The Management Perspective

Besides successfully meeting the intended objectives, the study gave an insight into how children's nurses felt about CPD and how important it was to them. Interestingly it provided an unusual insight into the problems encountered, perceived or actual, by the different grades of nurses. The findings of this study could be useful for managers so that they could avoid some of the challenges and barriers experienced by nurses in this study. This could involve ensuring that the staff feel valued by the organisation by:

1. Providing relevant, appropriate and accessible CPD.
2. Ensuring staffing establishments were calculated realistically rather than historically to allow staff to attend CPD.
3. Improving liaison between education and health to ensure joint planning of CPD, making sure that the CPD is offered at appropriate times that do not create / add to existing staffing problems (e.g in the evening or at weekends).
4. Developing a more comprehensive and relevant Personal Development Plan for each individual.
5. Preparing an appropriate training needs analysis based on the individuals he/she manages rather than the availability of courses.

In addition, recognition by managers for staff who have undertaken personal development in their own time or at their own expense through perhaps ex gratias

payments being available for nurses who gave presentations or feedback sessions about this training as this would allow other staff who were unable to attend to benefit from the training.

Managers are often tasked with encouraging the workforce to embrace government targets and reports. Recently there have been a plethora of reports that have focused on the need to have staff who have the right skills in the right place who are meeting the needs of patients and their families. These reports include Agenda for Change (DoH 2004,2005) and the emphasis on the knowledge and skills framework (KSF) (DoH 2004, Skills for Health); and the impetus of 'working differently' (DoH 2002). By facilitating CPD for all staff and encouraging changes in practice following CPD Managers are empowering staff to meet the requirement of Clinical Governance (see for example, DoH 2001-'Building a safer NHS for patients – implementing an organisation with a memory').

7.2 Benefits of a valued workforce

From the comments made by the nurses the study showed that most children's nurses are committed to CPD because they take their responsibility to be safe and competent practitioners seriously. Competent, highly motivated staff are an organisations most important and most costly resource (see for example the Knowledge Skills Framework). Organisations also avoid the tragic lessons learned when CPD is not integral within an organisation's thinking and where skills deficit effects patient care (see for example, 'The Kennedy Report'. The report of the public enquiry into children's heart surgery at the Bristol Royal Infirmary DoH 2002). Perhaps of even more importance, an organisation that tangibly demonstrates how it values its

workforce by ensuring staff are competent in the job they do, may actually improve its retention figures and reduce the number of nurses who leave the nursing profession (see for example, DoH 2001 making a difference: the nursing, midwifery and health visiting contribution).By providing appropriate opportunities for relevant and necessary CPD the organisation improves its workforce and subsequently the service it provides. Perhaps of even more importance, an organisation that tangibly demonstrates how it values its workforce by ensuring staff are competent in the job they do, may actually improve its retention figures and reduce the number of nurses who leave the nursing profession.

7.3 The Education Perspective

The Royal College of Nursing (RCN), who are committed to CPD, feel strongly that nurse education should be led by nursing outcomes or achievements rather than by the recommendations of the Nursing and Midwifery Council (NMC, formally UKCC) who equate CPD to the number of hours spent undertaking CPD. In their Education Taskforce Policy Statement (2002) they demonstrate that they are committed to the concept of a 'Higher Education Workforce' where nurses are supported by their employers to undertake CPD but with the responsibility for ensuring they are competent for practice firmly remaining with individual nurse. This is a clear requirement highlighted in the Kennedy report as well as considered within the 'Children's NSF' (see DoH & DfES 2004 NSF for Children, Young People and Maternity Services).Educators of nurses can only benefit from the perceptions of children's nurses toward CPD gained during this study, especially when considering the type and availability of courses offered and how children's

nurses perceive their practice to have been affected. Nurse Educators may also benefit from this study by recognizing factors which may lead to retention of staff.

The considerable cost of training student nurses must be viewed with concern when so many student nurses either do not complete their training or decide not to remain within the field of nursing after qualifying. The Report by the Comptroller and Auditor General (2001) identified that despite nursing campaigns and increased numbers of applications for nurse training, 20% of all student nurses did not complete their training. Although there are a variety of reasons for this occurrence, it could be suggested that if nurses felt valued by their organizations and had specific personal development plans which related to a career pathway the retention rate could be positively affected.

The Higher Education Academy, who work in partnership with a variety of 'stakeholders' including higher education institutions, are clear in their 'Strategic Plan 2005 -2010' that one of their main aims is to improve the student learning experience. It could be considered that student nurses are far more likely to have an improved learning experience if their preceptors are themselves supported with appropriate and relevant CPD.

As part of the Government's Agenda for Change initiative, the NHS Knowledge and Skills Framework (2004) lays out recommendations for revolutionising nurses' pay structure to ensure nurses who have developed and improved practice are recognised with financial incentives. However,

encouraging nurses with expert skills to remain in the clinical field with more opportunities for promotion must be tempered with the reality of how nurses perceive CPD. Unless nurses are provided with appropriate and relevant CPD opportunities and given the scope to put them into practice, taking ownership of improving practice and receiving recognition for their achievements, the Agenda for Change will be a successful model in theory only.

7.4 Dissemination of Results

If 'the ultimate purpose of health research is to improve patient care' (Coomarasamy et al 2001p 183) any research that may effect nursing, and subsequently the care nurses provide, needs to be shared. With this in mind the following strategies are planned for dissemination of the research study.

- 1) Distribution of a copy of the research to each paediatric unit that participated in the research study.
- 2) Presentation of the results of the research study at the Paediatric Manager's Liaison Meeting, the members of which were instrumental in questionnaire distribution and collection.
- 3) Submission of elements of the research for publication in order to disseminate the results of the study to a wider population.

7.5 Conclusion

In hindsight all research could have been done differently or better in some way. The lessons learned whilst undertaking this study suggest that future work is needed in this area to develop a more complete understanding of the issues.

Researching continuous professional development is complex but future studies should consider:

1. having a much larger sample size;
2. including community based children's nurses to identify the differences encountered by the acute sector nurses compared to the community based nurses; and
3. looking more closely at the personal circumstances children's nurses state have been barriers to their CPD.
4. considering the implication of CPD in relation to recruitment and retention of children's nurses.

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APPENDICES

The Programme of Research:

Children's Nurses' Perceptions of Continuous Professional Development (CPD)

Introduction and Literature Review

From April 1st 2001 the United Kingdom Central Council (UKCC) will be auditing Continual Professional Development (CPD) among Nurses, Midwives and Health Visitors (Register 2001). Whether referred to as CPD, Prep (Post Registration Education and Practice), Continuous Education or simply as Lifelong Learning, nurses along with other health care professionals will have to show evidence of keeping themselves updated. CPD can be defined in many ways although basically it required that nurses demonstrate they have updated their knowledge and skills through for example study days, writing papers, undertaking courses. Nurses are becoming more aware of the need to develop professionally with education being recognized as an important element of that development (Nolan et al 1994). However, although CPD is now mandatory, nurses have had little clarification regarding who has the ultimate responsibility for the costs (Selvey 1992) and what effects CPD has in the workplace. Obstacles to CPD have been described as institutional by Galloway (2000) including the cost, but Paton (1991) considers whether the provision of courses would suffer if employees agree to fund CPD.

Paediatric nurses, like all health professionals, can no longer see CPD as an optional extra but must see it as a means to remaining on the UKCC register (White 2000). Although CPD is promoted for personal growth (Traynor 1999) it could be suggested that individuals who opt out are not actually able to demonstrate their fitness to practice as accountable practitioners (Sayer 1998). With the government's white paper 'A First Class Service' QHS Executive 1998), lifelong learning is identified as a tool for improving professional practice and raising standards of care in the health service. This would suggest that far from simply promoting personal growth, the government sees CPD as the means for improving nurses' abilities and as such is inextricably linked to clinical governance (Healy 1998). As there is little research which reflects the perceptions of nurses relating to CPD it is intended that this study will facilitate a better understanding of why or why not CPD is implemented and whether or not it influences practice. A number of obstacles (e.g., resistance to CPD by some nurses, organizational constraints) may be confronted during the process of the research - however, the researcher has considerable management experience and feels that she will be able to navigate any such difficulties.

Statement of intent

The intention of this study is to examine paediatric nurses' perceptions and experiences regarding Continuous Professional Development (CPD).

Aims of the study

The aims of the study are to:

- Explore what nurses' perceive CPD to be.
- Examine whom nurses' perceive to be responsible for CPD.
- Examine the potential barriers nurses' perceive to their achieving CPD.
- Explore what factors nurses' perceive could improve CPD
- Examine if nurses' perceive clinical practice to be influenced by CPD.

Methodology

The methodology for this study will be divided into three distinct stages.

Stage 1: This stage will comprise a review of relevant literature, which will, when explored, provide a context against which the research data can be compared. The literature review will increase the researcher's awareness to the number of themes likely to be identified.

Stage 2: Three small groups consisting of six nurses of the same or similar grades (D, E and F/G) will be interviewed and their views regarding CPD audio-taped. During the facilitated discussion in the small group interviews, questions reflecting the aims of the study will be introduced. All these groups will consist of children's trained nurses who work on a paediatric unit in a District General Hospital. After analysing the taped interviews using thematic analysis, a postal questionnaire will be devised which will relate to the main themes identified during the small group interviews and from the reviewed literature.

Stage 3: In this stage the questionnaires will be sent to 500 children's nurses in the North West of England through their managers. This will help make the research representative of children's nurses. The completed questionnaires will be collated. The data from the questionnaires will be analysed using descriptive and inferential statistics, as appropriate. The qualitative data will be coded using the thematic analysis approach used in stage 2 of the study.

Funding and Budget considerations

The researcher anticipates that the study will be self-funded. The main cost being time and the cost of photocopying 500 questionnaires. Ethical approval is not seen to be an issue as the topic area is unlikely to disclose patient data.

Project schedule

0-6 months:	Undertake literature review. Develop agenda for small group discussions.
7 - 11 months:	Undertake small group discussions, analyse taped discussions, devise and develop a questionnaire.
12 - 15 months:	Distribute questionnaire and analyse responses.
16 - 24 months:	Write up thesis, write papers and submit.

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Focus Group Agenda

Question 1

What do you think is meant by 'CPD'?

- *have you heard it referred to by another term?*

Question 2

Do you feel CPD is important to you as nurses?

- *do you think CPD is important to you on a personal level?*

Question 3

Why do you think it is important?

- *Do you know what the PREP requirement is?*

- *How do you feel about CPD being mandatory?*

Question 4

Whom do you think should be responsible for CPD?

- *What about the employer's role in CPD?*

Question 5

What is your rationale for your response?

Question 6

What do you think can encourage you to undertake CPD?

- *do you all agree?*

- *are there any other viewpoints?*

Question 7

What do you think can prevent or impede you accessing CPD?

- *how could these barriers be overcome?*

- *do you think your employer can help with these barriers?*

Question 8

What do you think the benefits of CPD are?

- *for you as accountable practitioners?*

- *for the organisation?*

- *for the service user?*

- *for the profession?*

Question 9

Do you think practice is influenced by CPD

- *can you think of any examples?*

- *what would encourage you to change your practice following CPD?*

Question 12

How important is the role of the organisation in encouraging the uptake of CPD?

- *do you feel you are offered adequate CPD?*

Children's Nurses' Perceptions of Continuous Professional Development (CPD)

-Information sheet

What is the study about?

You have been invited to take part in this study because you are a children's nurse. The study aims to explore children's nurses' perceptions of CPD to find out whom they perceive to be responsible for CPD, what they think prevents or enhances their achieving CPD and if they feel that CPD influences practice.

Why is there a need for this study?

CPD has now become mandatory in the form of PREP (Post registration and Practice). The Government is also linking clinical governance to lifelong learning so it is important to ascertain how children's nurses view CPD.

Discussion Group:

The discussion group that you have been invited to attend will be audio taped. After the interview the tape will be analysed, along with the grade D and grade E tapes, and a questionnaire devised which will incorporate the various issues identified.

The questionnaire will then be distributed widely to children's nurses in the North-West. Using thematic analysis the completed questionnaires will identify common issues, and the resulting information will be compared to information gleaned from the literature search.

The completed research project will hopefully be available by the end of 2002.

Information sheet for small focus groups.

Thank you for agreeing to take part in this research project. The research is entitled 'Children's Nurses' Perceptions of Continuous Professional Development'. The aim of the research is to identify the various perceptions children's nurses have about CPD.

Initially three small groups of staff at different grades e.g grade D, E and F/G will be asked to take part in a facilitated discussion about CPD. The discussion will be audio taped and following all the discussions a questionnaire will be devised which will subsequently be distributed to children's nurses throughout the North-West.

Once the completed questionnaires are returned the various themes will be identified and these will be considered in the light of previous research. At the conclusion of the research project an understanding of children's nurses' perceptions regarding CPD will be identified.

Continuous Professional Development may also be known as 'Lifelong Learning', or 'Continuing Education'.

Participant Consent

The participant should complete the following: Please delete as necessary

Have you read the information sheet? Yes / No

Have you had opportunity to ask questions and discuss the study? Yes / No

Have you received satisfactory answers to all your questions? Yes /No

Are you willing to take part in a facilitated discussion group which will be audio taped? Yes / No

Will you agree to maintain confidentiality for whatever views are expressed during the small group discussion? Yes / No

Are you in agreement that any themes explored during discussion may be used when devising the questionnaire? Yes / No

Signed:

Date:

Name printed:

Please return to:

Children's Nurses' Perceptions of Continuous Professional Development

I am very interested in finding out what children's nurses' think about continuous professional development. I would be extremely grateful if you could spare a few minutes to complete the attached questionnaire please.

I am hopeful that the results of this research will provide an insight into children's nurses' perceptions regarding C.P.D. At present there is very little research published on this subject, particular to children's nurses.

All questionnaires will be completely anonymous. A copy of the completed research will be made available to your unit.

Thank you very much indeed.

1a) Please tick the relevant box:

Male

Female

1b) What grade are you practising at:

D

E

F

G

H

Other, please state

1c) Length of time you have worked in paediatrics:

Less than 1 year

1 to less than 5 years

5 to 10 years

More than 10 years, please state

2) In your own words, please describe what you understand about Continuous Professional Development.....

3) Who do you think should be responsible for Continuous Professional Development? (please tick)

- You / the Individual
- Employer
- Shared between both
- Other (please state)

Please provide comments which you think help to explain your choice:

4) Please indicate to what extent you think the following are barriers to CPD:

	Not a barrier	minimal barrier	major barrier
1.Lack of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.Finance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.Personal circumstances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.Availability of Paediatric courses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.Distance to travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.Insufficient staffing in your clinical area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other(s) – please state...			
8...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide comments to further clarify your choices.

5) How important are the following factors in improving Continuous Professional Development?

	Not at all important	Quite Important	Extremely important
1.Preceptorship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.Clinical Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.Development groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.Your own determination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.If you were given time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.Your own motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.Opportunity to share good practice with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.Relevant In-House training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.Opportunity to develop yourself through new clinical experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.Good choice of subject availability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.Distance learning packages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.Individual learning accounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.Opportunity to use your skills learnt through CPD in practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.Appropriate timing of learning opportunities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please state what and rank in order of importance)

15...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6) To what extent do you think that your practice has been influenced by Continuous Professional Development? (please tick)

- Not at all
- Minimally
- Considerably
- Completely

7) If you do think your practice has been influenced by CPD please give examples.

- 1)
- 2)
- 3)

8) Why do you think that your practice has been influenced by CPD? (please tick any that you feel apply)

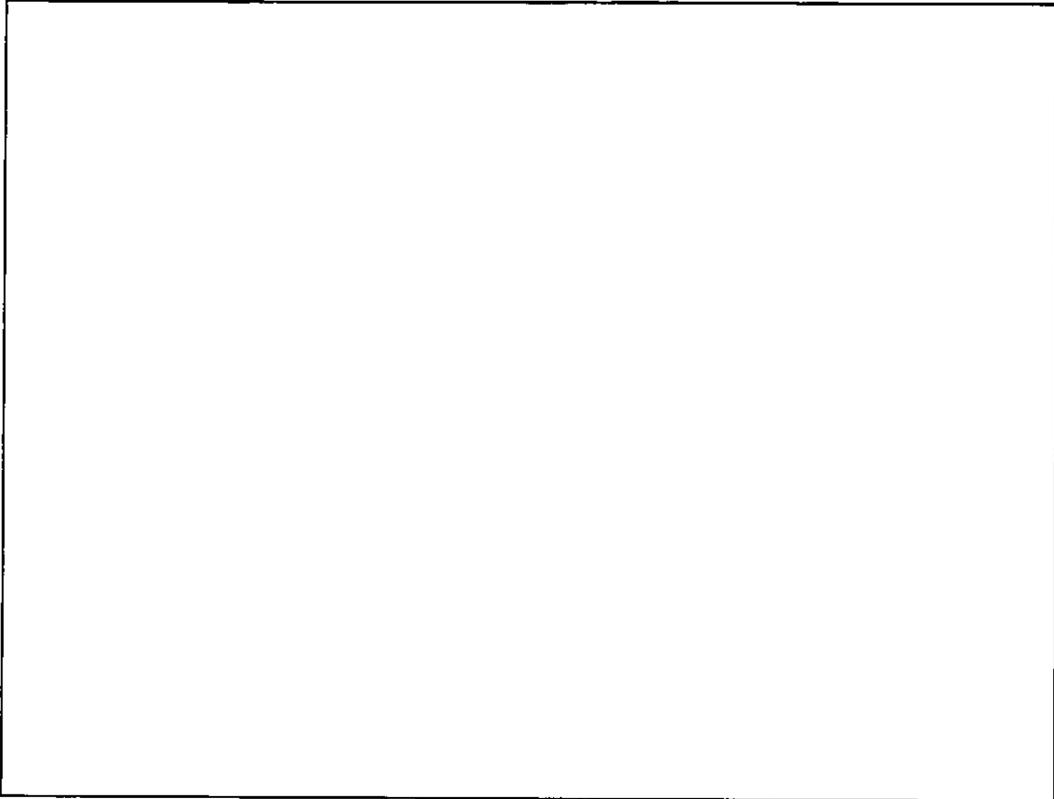
The organization I work for encourages changes in practice following CPD.

I am personally pro active in developing practice following CPD.

The Government has promoted a culture of CPD and evidence based practice.

Other, please state:

9) If you do not feel that your practice has been influenced by CPD, please state why not:



Thank you very much for completing the questionnaire. Would you please pass it on to your manager for collection before the end of February 2002.

Yours sincerely,

Pauline Wilson.